Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 21, 2017	2016_509617_0030	033017-16	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

PINECREST
1220 VALLEY DRIVE KENORA ON P9N 2W7

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

SHEILA CLARK (617), JULIE KUORIKOSKI (621), KATHERINE BARCA (625)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 2016

During the course of the Resident Quality Inspection, the Inspectors conducted a daily walk through of the resident home areas and various common areas, made direct observation of the delivery of care and services provided to the residents, observed staff to resident interactions, reviewed health care records including the "Resident Care and Safety Routine" sheet (kardex) and various policies, procedures and programs of the home.

Additional intakes regarding two Critical Incident System reports for alleged staff to resident and resident to resident abuse that the home submitted to the Director, were inspected during this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer/District Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Nursing Office Scheduler, Human Resources Manager, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Assessment Instrument/Minimal Data Set (RAI/MDS) Coordinator, Personal Support Workers (PSWs), Food Service Supervisor, Cook, Dietary Aides (DAs), Activation Manager, Activation Aides (AAs), Environmental Service Supervisor (ESS), Maintenance Engineer, Housekeeping Aides (HAs), Agency Companion, residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **15 WN(s)**
- **11 VPC(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents were fully respected and promoted including the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

On December 15, 2016, Inspector #625 observed resident #033 assisted with personal care in a washroom, and the resident was visible from the nursing station and hallway on a specific unit.

During an interview with Inspector #625 on December 15, 2016, PSW #137 acknowledged that resident #033 was exposed and verified that no privacy curtain was present to shield the resident when the door was opened as staff entered and exited the room. The PSW also identified that the same visualization of residents occurred when residents used the toileting area closer to the tub room, as there was no privacy curtain in place. The Inspector attended this area with the PSW and verified that the toileting area, including the toilet, was visible from the hallway outside of the doorway when the door was opened. PSW #137 stated that toileting residents in this manner was not dignified.

On December 16, 2016, Inspector #625 interviewed the DOC who stated that a curtain should be present in each of the two toileting areas on the particular unit to provide privacy to the residents as they were toileted and acknowledged that visualizing the residents during the act of toileting did not promote resident dignity.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the rights of residents are fully respected and promoted including the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

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

During stage one of the inspection, resident #007 was identified through a Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment that required additional inspection regarding an issue with their vision.

Inspector #621 observed resident #007 not to have a device to correct their vision in use.

Inspector #621 reviewed resident #007's plan of care including the most current care plan which identified that the device to correct their vision was lost and included interventions for staff regarding the use of this device even though it was lost.

During an interview with PSW #116, and RN #104, they both reported to Inspector #621 that resident #007's device to correct their vision was lost approximately one year ago, and a decision was made by the resident's Substitute Decision Maker (SDM) not to replace it.

RN #104 reviewed resident #007's current care plan and reported to the Inspector that the interventions identifying that staff were to provide care of resident #007's lost device to correct their vision did not provide clear directions.

During an interview with the DOC, they identified to Inspector #621 that it was their expectation that when a resident's plan of care was updated by registered staff it was to provide clear directions to staff. [s. 6. (1) (c)]

2. During stage one of the inspection, resident #002 was identified as requiring additional inspection regarding the use of two potential restraint devices on their wheelchair.

Resident #002 was observed on four occasions by Inspectors #617 and #625 to be seated in their wheelchair with two types of restraint devices applied.

A review of resident #002's health care record (HCR) indicated that their assessment, physician's order, SDM consent, care plan and documentation was inconsistent for the use of four different types of restraint devices on their wheelchair including the two that were observed by Inspectors #617 and #625.

During an interview with Inspector #625, PSW #119 confirmed that resident #002 currently used two of the four restraint devices on their wheelchair, and further explained to the Inspector that resident #002's plan of care did not provide clear direction to staff regarding the use of restraint devices for their wheelchair.

During an interview with Inspector #625, PSW #120 stated that resident #002 used one of the four restraint devices listed in their HCR. PSW #120 further explained to the

Inspector that resident #002's plan of care did not provide clear direction to staff regarding the use of restraint devices for their wheelchair.

During an interview with Inspector #625, the ADOC stated that resident #002's current plan of care, did not provide clear direction to staff related to the resident's restraint device use for their wheelchair, as the information contained was not consistent or current. [s. 6. (1) (c)]

3. During stage one of the inspection, resident #008 was identified as requiring additional inspection regarding potential wheelchair restraint devices in which Inspector #625 observed that two potential restraint devices were being used on their wheelchair.

Inspector #625 reviewed resident #008's HCR which indicated their physician's order, SDM consent, and care plan were inconsistent with the use of three different restraint devices on their wheelchair including the two that were observed by Inspector #625.

During an interview with Inspector #625, RPN #105 stated that resident #008's current plan of care did not provide clear direction with respect to the current use of the two restraint devices on their wheelchair, and that old information in the care plan should have been removed for clarity.

During an interview with Inspector #625, the DOC stated that resident #008's current the care plan interventions were "definitely unclear" as to the use of their restraint devices on their wheelchair. [s. 6. (1) (c)]

4. The licensee has 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.

During stage one of the inspection, it was identified through a RAI MDS assessment that resident #003 was a continence care risk and required additional inspection.

Inspector #625 reviewed resident #003's current care plan regarding continence which listed interventions that staff were to place a continence device within reach for the resident to use.

Inspector #625 observed resident #003 use the washroom, and did not use the continence device listed in their care plan.

During an interview with Inspector #625, resident #003 stated that they used the washroom with some assistance from staff, to maintain continence.

During an interview with Inspector #625, PSW #139 stated that resident #003 used the washroom with some assistance from the staff to maintain continence and did not use the continence device listed in their current care plan.

During an interview with Inspector #625, PSW #124 stated that resident #003 did not use a continence device. The PSW stated that they had worked with resident #003 since they were admitted to the home and could not recall the resident ever using a continence device. [s. 6. (2)]

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

During stage one of the inspection, it was identified through a RAI MDS assessment that resident #005 was a continence care risk and required additional inspection.

Inspector #625 reviewed resident #005's current care plan regarding continence care, which identified interventions that required staff to offer or provide assistance to the washroom at specific intervals during the day.

During an interview with Inspector #625, resident #005's family member stated that the resident had previously been found by their family in their wheelchair after being incontinent. The family member stated that resident #005 was not always provided assistance to the washroom at specific intervals of the day as listed on their posted kardex in their room.

At a certain time of the day, Inspector #625 observed PSW #124 assist resident #005 to the washroom and did not observe staff provide or offer the resident assistance to the washroom as indicated in their care plan.

During an interview with Inspector #625, resident #005 confirmed that they were not provided or offered assistance at scheduled intervals each day, at certain times they would have to call for assistance and would be incontinent while waiting.

During interviews with Inspector #625, PSW #124 stated that resident #005 required assistance to the washroom at scheduled intervals during the day to maintain their

continence. The PSW stated that resident #005 was not always provided or offered this assistance consistently as indicated in their care plan, but was supposed to be.

During an interview with Inspector, RN #103 stated that resident #005 was inconsistently provided or offered assistance to the washroom as was identified in the resident's care plan which resulted in their incontinence. [s. 6. (7)]

6. During stage one of the inspection, it was identified through a RAI MDS assessment that resident #007 was a continence care risk and required additional inspection.

During interviews with Inspector #625, regarding the continence care that had been provided to resident #007, RPN #129 and PSW #137 stated that they had used a certain lift device to assist them in the washroom, and had left the resident unsupervised while in they were in the device. RPN #129 stated that resident #007 was not able to let staff know when they were ready to be assisted out of the washroom.

Inspector #625 reviewed resident #007's current care plan and kardex, which identified that the resident required constant supervision and was not be left unattended in the lift device used to assist them to the washroom. The care plan was inconsistent with the type of lift device Inspector #625 observed being used.

During interviews with Inspector #625, PSWs #137 and #138 both confirmed that the type of lift they used to assist resident #007 to the washroom and leaving them unattended while in the device was not consistent with the care required as identified in their care plan.

During an interview with Inspector #625, the DOC stated that resident #007's current care plans and kardex identified that staff were to use the type of lifting device described in their care plan and that staff were not to leave the resident unattended but were to provide constant supervision when using the device. [s. 6. (7)]

7. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

During stage one of the inspection, Inspector #621 interviewed resident #001's family who reported that the resident at times did not get their bath twice a week which required additional inspection.

Inspector #617 interviewed resident #001 who explained that they were to receive a bath on two scheduled days a week and required assistance from the staff. Resident #001 confirmed to the Inspector that at times they did not get their bath twice a week as scheduled.

A review of resident #001's current care plan and kardex located at the nursing station indicated that they required staff assistance with bathing, and were scheduled to be bathed on two specific days a week on a certain shift.

Inspector #617 interviewed PSW #141 who confirmed that resident #001 was scheduled to be bathed on those two specific days a week on a certain shift. PSW #141 further explained to the Inspector that they were to document that they gave resident #001 a bath.

Inspector #617 reviewed the bathing documentation completed for resident #001 for the months of September, October, November, and December,2016, and found missing documentation for their scheduled baths on two occasions in September, 2016, and on one occasion in November 2016.

Inspector #617 interviewed the DOC, who confirmed to the Inspector that there was no documentation of resident #001's scheduled baths for a total of three occasions over the months of September and November 2016. [s. 6. (9) 1.]

8. Inspector #617 interviewed resident #005 who reported that they enjoyed their tub bath and was not able to confirm how often they were offered a bath or when they last were bathed.

A review of resident #005's current care plan and kardex indicated that they required staff assistance with bathing, and were scheduled to be bathed on two specific days a week on a certain shift.

Inspector #617 interviewed PSW #124 who confirmed that resident #005 was to be bathed on those two specific days a week on a certain shift. PSW #124 further explained to the Inspector that they were to document that they gave resident #001 a bath.

Inspector #617 reviewed the bathing documentation completed for resident #005 for the months of September, October, November and December, 2016, and found missing documentation for their scheduled baths on the following dates:

-three occasions in September 2016,
-four occasions in November 2016, and
-two occasions in December 2016.

Inspector #617 interviewed the DOC, who confirmed to the Inspector that there was no documentation of resident #005's scheduled baths for a total of nine occasions over the months of September, November, and December 2016. [s. 6. (9) 1.]

9. Inspector #617 interviewed resident #021 who explained that they enjoy their tub bath and have not ever refused to be bathed.

A review of resident #021's current care plan and kardex indicated that that they were scheduled to be bathed on two specific days a week on a certain shift.

Inspector #617 interviewed PSW #142 who confirmed that resident #021 was scheduled to be bathed on those two specific days a week on a certain shift. PSW #142 further explained to the Inspector that they were to document that they gave the resident a bath.

Inspector #617 reviewed the bathing documentation completed for resident #021 for the months of September, October, November and December, 2016, and found missing documentation for their scheduled baths on the following dates:
-three occasions in October 2016,
-four occasions in November 2016, and
-two occasions in December 2016.

On December 15, 2016, Inspector #617 interviewed the DOC, who confirmed to the Inspector that there was no documentation of resident #021's scheduled baths for a total of nine occasions over the months of October, November, and December 2016. [s. 6. (9) 1.]

10. The licensee has 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 change or care set out in the plan of care was no longer necessary.

During stage one of the inspection resident #002 was identified as requiring additional inspection regarding falls prevention.

RN #111 was interviewed by Inspector #617 and they reported that resident #002 had two falls in December 2016, with no injury.

Inspector #621 reviewed resident #002's plan of care and identified in the progress notes of the electronic health record (Goldcare), a subsequent fall without injury which also occurred in December 2016.

Inspector #621 observed resident #002 in their room and identified the use of two safety mats by their bed.

Inspector #621 reviewed resident #002's current care plan and kardex, which identified that they were at risk for falling and interventions to mitigate the risk included the use of only one safety mat by their bed.

During an interview with PSW's #120 and #119, they reported to Inspector #621 that resident #002 required two safety mats positioned on the floor by their bed, while the resident was lying in bed. Both PSWs confirmed to the Inspector that resident #002's kardex was not updated with the required use of the two mats to mitigate their risk of falling as it indicated the use of only one mat.

RPN #102 reported to the Inspector that resident #002 now required the use of two safety mats due to their risk of falls and confirmed that their care plan and kardex were not updated to reflect the resident's current care needs, and should have been.

During an interview with the DOC, they identified to Inspector #621 that it was their expectation that when resident care needs changed that the resident's plan of care was updated by registered staff to reflect their current needs. [s. 6. (10) (b)]

11. On two occasions in December 2016, Inspector #621 observed resident #007 using two different potential restraint devices on their wheelchair.

A review of resident #007's current assessments and care plan indicated interventions for these two different restraint devices to be used on their wheelchair.

During an interview with Inspector #625 PSW #138 and PSW #137, they stated that resident #007 no longer required the use of these devices as restraints and "needed to be reassessed for their use".

During an interview with Inspector #625 the DOC confirmed that the resident no longer required the use of restraint devices on their wheelchair and their plan of care required to be updated to reflect their current needs. [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 to ensure that:
-the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident,
-the care set out in the plan of care is provided to the resident as specified in the plan, 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 of care is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

Inspector observed fluid stains and food debris on the right corner of the seat and seat deck of resident #007's wheelchair.

During an interview with PSW #142, they reported to Inspector #621 that PSW staff were responsible for completing wheelchair and walker cleaning as outlined on a weekly "Ambulatory Aides Cleaning Schedule" located in the "Individualized Resident Care Binder". PSW #142 identified that all residents' wheelchairs and walkers were scheduled to be cleaned weekly. They reported that an automatic washer was available for deep cleaning of wheelchairs when cleaning of fabric could not be done sufficiently by hand washing. However, PSW #142 reported to the Inspector that they did not use the automatic wheelchair washer as they had forgotten how to run the machine, so they were only cleaning the wheelchairs manually.

PSW #142 confirmed to Inspector #621 that resident #007's wheelchair had not been cleaned as their wheelchair was visibly soiled and stained. [s. 15. (2) (a)]

2. On two separate occasions, resident #003's walker was observed by Inspector #625 and Inspector #621 to have debris and old food crumbs on its frame above one particular wheel and the seat.

During an interview with RN #107, they reported to Inspector #621 that cleaning of resident wheelchairs and walkers were scheduled to be completed weekly by PSW staff, and that PSW staff were to track completion of cleaning on the weekly cleaning schedule kept in the "Individualized Resident Unit Binder" on each unit. RN #107 identified that cleaning entailed use of designated cleaning solution for hand washing resident walkers or wheelchairs, and/or the automatic washer to machine wash walkers and wheelchairs where manual cleaning would be insufficient.

RN #107 reviewed the "Ambulatory Aides Cleaning Schedule" as found in the "Individualized Resident Unit Binder" for a specific unit which identified that resident #003's walker was to be cleaned on a certain day in December 2016. RN #107 confirmed that PSW staff had not signed off that this resident's walker had been cleaned.

During an interview with resident #003, they reported to the Inspector that they had not observed staff clean their walker, and identified that no staff person came to take their walker for cleaning in the previous week.

RN #107 confirmed to Inspector #621 that resident #003's walker continued to have food

debris and dust on their walker as identified previously by the Inspector, and appeared as if it had not been cleaned for some time.

During an interview with the DOC, they reported to Inspector #621 that it was their expectation that PSW staff complete cleaning of all resident wheelchairs and walkers weekly as per the cleaning schedule for their respective unit. [s. 15. (2) (a)]

3. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During stage one of the inspection, Inspector #617 observed the arm rest on resident #002's wheelchair to be loose and in disrepair. At that time, the Inspector interviewed resident #002's family member who reported that the wheelchair was in disrepair, and although the family had requested the home fix the wheelchair, the wheelchair was still not fixed.

Inspector #625 observed resident #002 sitting in a wheelchair and the arm rest was in disrepair.

During an interview with Inspector #625, two resident #002's family members both stated that the resident had altered skin integrity due to contact with the disrepair of the arm rest.

During interviews with PSWs #138 and #145, they stated that if they observed wheelchairs requiring repair, they would notify registered nursing staff who would then notify the Activation Manager to arrange the repair.

During an interview with Inspector #625, RN #103 stated that they would notify the Activation Manager if they were aware of wheelchair arm rests requiring repair as the Activation Manager would then complete or arrange the repair work required.

During an interview with Inspector #625, the Activation Manager stated that the arm rest of resident #002's wheelchair required repair and, depending on the extent of the damage, the arm may need to be completely replaced. The Activation Manager stated that they were notified that resident #002's wheelchair required repair two weeks prior.

A review of the home's policy "Wheelchair/Walker – Safety, Maintenance and Cleaning – NUR 365" last revised February of 2010, identified that resident equipment was to be

maintained in good condition complying with safety and infection control practice and that staff were to check before using the equipment to ensure that it was safe, looking for any tears, loose fitting parts, screws or missing pieces and were to report unsafe chairs to the Adjuvant immediately. [s. 15. (2) (c)]

4. During stage one of the inspection, Inspector #625 observed a particular arm cushion of resident #005's wheelchair to be in disrepair.

During an interview with Inspector #625, PSWs #139 and #147 they both stated that they had not informed anyone of the arm rest in disrepair for resident #005's wheelchair. [s. 15. (2) (c)]

5. Inspector #625 observed the toilet seat in a resident room to have brown staining on the bottom of the seat over approximately 20 to 25 centimeters (cm) on one side and five to ten cm on the other side of the interior perimeter and a scratched finish with two gouges in the top of it

During interviews with PSWs #138, #145, and HA #118, they all reported to the Inspector that, if they observed toilet seats in disrepair, they would notify registered nursing staff who would then notify the Maintenance Department to fix it. During an interview with RN #103, they confirmed to the Inspector that if they were made aware of toilet seats in disrepair or stained, they would then notify the Maintenance Department.

During an interview with the ADOC, they stated that toilet seats stained and in disrepair should be replaced and that staff should have notified the Maintenance Department of items requiring repair.

During an interview with Inspector #625, Environmental Services Supervisor (ESS), confirmed that this resident's toilet seat was stained and in disrepair, and needed to be replaced. [s. 15. (2) (c)]

6. During stage one of the inspection, two resident rooms on a particular unit were identified as requiring additional inspection regarding room disrepair. On two separate occasions in December 2016, Inspector #625 observed both of these resident rooms to have sagging ceiling tiles.

Inspector #625 further observed damage on this particular unit, including the:
-baseboard and corner wall outside of a resident's room to have baseboard peeling away

from the wall and ripped over an area of approximately 15 cm by 15 cm;
-pieces of baseboard torn and missing, wall paper peeling and the metal edge of the corner exposed across from a resident's room over an area of approximately 20 cm by 20 cm;
-drywall outside of the television lounge to have metal edging, scrapes and gouges over an area approximately 30 cm by 20 cm;
-laminate edge missing from behind the railing outside of the television lounge over an area approximately 30 cm by five cm;
-flooring in the hallway outside of the television lounge to be indented and cracked over an area of approximately four meters in length by two-three cm in width by up to one cm in depth; and
-an area beside a resident's room to have a piece of baseboard missing over an area of approximately ten by 20 cm; the wall corner to have two deep gouges with metal edging bent and exposed across from this resident's room over an area of approximately ten cm by three cm.

Inspector #625 conducted an interview with both the ESS and the Maintenance Engineer #148 who acknowledged the several areas of disrepair to the ceiling, walls, and floor on this particular unit in both the common areas and in certain resident rooms that required to be repaired. [s. 15. (2) (c)]

7. Inspector #625 observed the call bell in the shared washroom for three resident's rooms to be made from gauze wrap. The call bell cord in the shared washroom for another resident's room was observed by Inspector #625 to have a call bell cord that was made from a fibrous material which was brown from being soiled.

During an interview with Inspector #625, the ESS acknowledged that the call bell cord in the shared residents' washrooms was a “Band-Aid” like material. The ESS stated that the call bell cords should be made from a rubber-like material.

During a second interview with Inspector #625, the ESS stated that they had conducted an audit of the washrooms in the home and were in the process of replacing the cords made from gauze wrap.

During an interview with Inspector #625, the DOC stated that using gauze wrap as a replacement for a call bell cord in resident washrooms was not appropriate and that the cord could not be properly disinfected. The DOC stated that if the call bell cords required replacement, staff should have notified the Maintenance Department to replace the cord

with an appropriate one. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of every investigation regarding abuse and neglect was reported to the Director.

The home submitted a Critical Incident (CI) Report to the Director regarding alleged staff to resident abuse. The CI report indicated that on the same day that the report had been submitted to the Director, resident #010's family member reported to the DOC that this resident told them a nurse came into the resident's room at a particular time of day and engaged in a physical and verbal altercation. The CI report indicated contributing factors to the incident that included resident #010s medical diagnosis and current medical conditions.

A review of the home's investigation indicated that the allegation of staff to resident abuse was unfounded.

A review of the home's policy titled, "Zero Tolerance of Abuse and/or Neglect-ADM450", revised on June 2015, indicated that the home was to report to the Director the results of

every investigation conducted under this policy, and any action the home took in response to any incident of resident abuse or neglect.

A review of the CI reporting system indicated that the home did not amend the original CI report to identify the results of their investigation.

On December 15, 2016, Inspector #617 interviewed the DOC, who confirmed that the alleged staff to resident abuse did not occur and that the home failed to submit in writing to the Director the conclusion of their investigation. [s. 23. (2)] (617)

2. The home submitted a CI report to the Director regarding alleged resident to resident abuse. The CI report indicated that resident #011 was sitting in a common area waiting for staff to assist them and resident #012 was found by staff to be sitting beside resident #011 in this common area touching resident #011 in an inappropriate manner.

A review of the home's investigation indicated that resident to resident abuse did occur.

A review of the CI reporting system indicated that the home did not amend the original CI report submitted to identify the results of their investigation.

On December 15, 2016, Inspector #617 interviewed the DOC, who confirmed that the home failed to submit in writing to the Director their conclusion of their investigation. [s. 23. (2)] (617)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the results of every investigation regarding abuse and neglect is reported to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1.The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions regarding weights were documented.

During stage one of the inspection, Inspectors #621 and #625 reviewed monthly weight records from the electronic health record (Goldcare) and identified missing monthly weights for residents #001, #009, #013, #015 and #016.

During an interview with Inspectors #621 and #625, RN #100 explained that resident weights were completed by the eighth of every month by PSWs and that they recorded the measured weight on the resident's bath records found on each unit. RN #100 identified that registered nursing staff were responsible to review and transcribe the monthly weights from these bath records and enter them into Goldcare.

During an interview with the RD, they reported to Inspector #621 that residents were to be weighed on the first bath day of each month and the PSWs were to weigh all residents at least monthly. They also indicated that resident weights were to be recorded by PSWs on the bath sheets located in the resident care binders found on each unit, and that Registered staff were responsible for entering this data into Goldcare for the monthly weight report. The RD additionally stated that all monthly weights were to be centrally located in Goldcare for reference.

On December 8, 2016, the RD and Inspector #621 reviewed the monthly weight records from Goldcare and the RD confirmed missing monthly weights for the following residents:
-resident #001 missing one monthly weight;
-resident #014 missing two monthly weights;
-resident #013 missing two monthly weights;
-resident #015 missing two monthly weights; and
-resident #016 missing one monthly weight. [s. 30. (2)] (617)

2. During a review of resident's weights during the stage one census review, it was noted by Inspector #625 that monthly resident weights were missing from residents' Goldcare records.

Inspector #625 reviewed the monthly weights listed in the vital signs section of Goldcare and noted that for a particular month, weights were missing for the following residents on a specific unit: residents #034, #023, #024, #035, #027, and #005. Additionally the Inspector identified that the following residents on this unit were missing weights for this particular month in Goldcare: residents #020, #036, #028, #037, #009, #031, and #010. In total, for this particular month, 34 per cent of the residents, did not have a monthly weight recorded in Goldcare.

During the stage one census review, Inspector #625 also identified that, in addition to missing one particular monthly weight from Goldcare records, resident #034 was also missing monthly weights for two additional months, and resident #027 was also missing an additional monthly weight.

During an interview with Inspector #625, the RD confirmed that monthly weights were missing for the aforementioned residents. The RD further explained that nursing staff were expected to obtain monthly resident weights and enter the values into Goldcare and, without these values entered monthly, it was impossible to complete an accurate assessment of residents for quarterly reviews and referrals and was "difficult to make an adequate judgement as to whether they are getting adequate nutrition" [s. 30. (2)] (617)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions regarding weights are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the staffing plan included a back-up plan for personal care staffing that addressed situations when staff cannot come to work.

During stage one of the inspection, Inspector #621 interviewed resident #001's family and they reported that the resident, at times did not receive their bath twice a week.

Inspector #617 interviewed resident #001 and they explained to the Inspector that they were scheduled a tub bath on two specific days and required assistance from the staff to bathe. Resident #001 confirmed to the Inspector that at times they did not receive their bath twice a week as scheduled.

A review of resident #001's assessment indicated that they required physical help to bathe and their care plan indicated that they were scheduled to receive a bath on a certain shift two specific days each week.

A review of resident #001's completed documentation indicated that they did not receive a bath due to a nursing staff shortage on a particular unit as follows:
-one day in November, 2016, indicated the bath was not provided due to the unit being "short staffed", signed by PSW #138 and;
-one day in December, 2016, indicated the bath was not provided due to the unit being "short staffed"; signed by PSW #151.

Inspector #617 interviewed resident #021 who also lived on this particular unit who stated that they were not sure when their bath was scheduled and relied on staff to assist them.

A review of resident #021's assessment indicated that they required physical help to bathe and their care plan indicated that they were scheduled to receive a bath on a certain shift two specific days each week.

A review of resident #021's completed documentation indicated that they did not receive a bath due to a nursing staff shortage on this particular unit as follows:
-one day in November, 2016, indicated the bath was not provided due to the unit being "short staffed" signed by PSW #110; and
-one day in December, 2016, indicated the bath was not provided due to the unit being "short staffed" signed by PSW #151.

A review of the nursing department staffing compliment submitted by the Nursing Office Scheduler (NOS) #150, indicated that on a certain shift on this unit specific nursing staff were to be scheduled to work.

In an interview with NOS #150 they confirmed to the Inspector that on the following days, this unit was short staffed:
-the day when resident #021 missed their bath in November, 2016;
-the day when resident #001 missed their bath in November, 2016; and
-the day when both residents #001 and #021 missed their baths in December, 2016.

NOS #150 further clarified to the Inspector that the staff shortage on the aforementioned dates was a result of either a sick call or unfilled scheduled shift that they were not able to replace even at overtime.

Inspector #617 interviewed PSW #122 and PSW #116 who both reported that this unit had worked short staffed on a certain shift more often during the past four months.

A review of the staffing compliment submitted by NOS #150 indicated this unit worked short staffed on a certain shift over the following months:
-for the month of September, 2016, 37 per cent of the time,
-for the month of October, 2016, 40 per cent of the time,
-for the month of November, 2016, 33 per cent of the time, and
-for the month of December, 2016, 42 per cent of the time.

In an interview with PSW #122 and PSW #116 they explained to the Inspector that PSWs were scheduled to complete five resident baths on a certain shift and when working with one PSW short some residents had missed their scheduled bath due to increased work load and the potential for safety risk to the residents. PSW #122 and PSW #116 both confirmed to the Inspector that those residents who were not provided with their baths, would have to wait for their next scheduled bath time and that there was no back-up plan to make up the missed bath.

On December 15, 2016, Inspector #617 interviewed the DOC who confirmed the home's written staffing plan did not include a back-up plan for personal care staffing that addressed situations when staff cannot come to work. [s. 31. (3)] (617)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staffing plan includes a back up plan for personal care staffing that addresses situations when staff cannot come to work, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of a resident by a physical device was included in a resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

During a resident observation on a day in December, 2016, Inspector #625 identified that resident #008 used an adaptive device with their mobility aide.

Inspector #625 reviewed resident #008's care plan that identified interventions for the resident to use the observed adaptive device, as well an additional device.

The Inspector reviewed resident #008's health care record which identified that a current physician's order was missing for the use of the observed adaptive device as well as the additional device.

During an interview with Inspector #625 on December 15, 2016, RPN #105 confirmed that a current physician's order for the use of the two adaptive devices was missing. [s. 31. (2) 4.] (625)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the restraining of a resident by a physical device is included in the resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items.

During stage one of the inspection, Inspector #625 observed the shared bathrooms of eight resident rooms and noted throughout the observations, unlabelled and used personal care items that included:

- plastic drinking cups
- toothbrushes and denture brushes
- denture cups
- washbasins
- bedpan
- urinals and urine collection hats
- hair brushes and combs
- razors, electric and disposable
- soap dish
- foot callous remover
- tweezers
- toenail clippers

On two separate occasions in December, 2016, Inspector #621 observed a number of unlabelled and used resident personal care items and products in tub rooms of specific units that included:

- disposable razors
- hair brushes and combs

- unwrapped bar of soap
- women's deodorant
- nail clippers

During interviews with PSW #110 and PSW #115 respectively, they stated to Inspector #621 that labeling of personal care items and products was to be done by staff on the resident's admission and when new items were acquired. PSWs #110 and #115 also identified to the Inspector that all personal care items that were brought to the tub room and/or taken from the home's stock supplies for use with a resident (with exception of labelled nail clippers which were stored by room number on the tub room wall) were to be returned to the resident's room immediately after bath care was completed, with staff ensuring that items were labelled.

Inspector #621 reviewed the home's policy titled "IPAC Routine Precautions-OHS 410", last revised September 2015, which identified under the "Resident Supplies and Equipment" section that personal care supplies (lotions, creams, soaps, razors, hairbrushes, antiperspirants, etc) must be dedicated to one resident, and not shared between residents. All items must be marked with resident identification to prevent unintended use by others. Additionally, the policy identified, that disposable equipment (e.g., basins) must be dedicated to one resident and marked with resident identification, sanitized after each use and disposed of at discharge.

During an interview on December 12, 2016, with the DOC, they reported to Inspector #621 that PSW staff were expected to label all resident personal care items with the resident's name and that these items were to be kept in a dedicated shower bag or basket labelled with the resident's name, and locked up either in the unit tub room or kept in the resident's room. [s. 37. (1) (a)] (621)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with any other weight change that compromised the resident’s health status were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

During stage one of the inspection, resident #005 was identified as requiring additional inspection regarding their weight change. Inspector #625 interviewed resident #005's family who stated that the resident had a significant weight change over a three month period.

Inspector #625 reviewed the monthly weights listed in the vital signs section of Goldcare for resident #005 and reviewed their recorded weights over the three month period. During this three month period the Inspector noted that the resident was missing a weight entry for one of the three months and that they had significant weight change.

A review by Inspector #625 of the home’s policy “Weighing Residents - NUR 405" revised October of 2014, identified that each resident’s weight was to be measured and recorded each month. The policy stated that PSWs were to weigh residents once a month during the first bath of the month and that the Registrant was to enter the weight into the computer record under “vital signs” on the day it was taken. The policy also identified that weight changes would be automatically calculated and the Dietitian would be automatically informed.

During an interview with Inspector #625, the RD confirmed that resident #005 had a significant weight change over this three month period that was brought to their attention by the family. The RD acknowledged that there was no weight listed in Goldcare for one month during this three month period when the significant weight change was identified. If the missing weight was documented, the RD would have acknowledged the resident's weight change earlier, completed their nutrition quarterly assessment with accuracy and put in place a plan to help the resident with their nutritional status. [s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with any weight change that compromises their health status are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the planned menu items were offered and available at each meal and snack.

Inspector #625 observed the lunch meal service on December 6, 2016.

Inspector #625 reviewed the Therapeutic Production Menu for December 6, 2016, puree menu which listed puree sweet and sour meatballs, mashed potatoes and puree squash or Tre Puree roast chicken as entrée options and chocolate pudding as a dessert option. The Inspector had not observed these items being served.

During an interview with Inspector #625 on December 6, 2016, Cook #153 stated that they had served puree chicken with lemon sauce, puree tomato basil bread and puree carrots, and not the meatballs, mashed potatoes, squash, roast chicken or chocolate pudding listed on the Therapeutic Production Menu.

During an interview on December 14, 2016, with Inspector #625, the Food Services Supervisor (FSS) referred to the seven-day menu for substitutions. The FSS stated that they were not aware of any substitutions made for the sweet and sour meatballs, mashed potatoes, puree roast chicken or lack of chocolate pudding as a dessert option.

Inspector #625 observed the dinner meal service on December 12, 2016.

Inspector #625 reviewed the Therapeutic Production Menu for December 12, 2016, puree menu which listed puree macaroni and cheese. The Inspector had not observed this item being served.

During an interview with Inspector #625 on December 12, 2016, Dietary Aide (DA) #154 stated that they had puree chicken, peas and potatoes or puree beef, carrots and potatoes to serve as pureed entrees. The DA did not have puree macaroni and cheese as was listed on the Therapeutic Production Menu.

During an interview on December 14, 2016, with Inspector #625, the FSS referred to the seven-day menu for substitutions. The FSS stated that they were not aware of any substitutions made for the puree macaroni and cheese entrée.

Inspector #625 observed the lunch meal service on December 14, 2016.

Inspector #625 reviewed the Therapeutic Production Menu for December 14, 2016, puree menu which listed puree ham casserole, puree bread, puree peas or puree beef stroganoff as entrée options and puree thickened canned mandarin oranges. The Inspector had observed the pureed ham casserole offered and the rest of the planned menu items were not available.

During an interview with Inspector #625 on December 14, 2016, DA #156 stated that they had served puree ham and broccoli, not puree ham casserole and puree peas. The DA stated that they had Tre Puree beef, not puree beef stroganoff available.

During an interview on December 14, 2016, with Inspector #625, the FSS referred to the seven-day menu for substitutions. The FSS stated that they were not aware of any substitutions made to any Therapeutic Production Menu items for the December 14th lunch service. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

On December 15, 2016, Inspector #625 observed a premium air freshener on a certain unit near the nursing station that was accessible to residents. The container had Workplace Hazardous Materials Information System (WHMIS) symbols for Class A - Compressed Gas, Class B - Flammable and Combustible Material, Class D Division Two - Materials Causing Other Toxic Effects and a consumer product label for explosive.

On December 15, 2016, RPN/PSW #129 and PSW #127 stated that residents had access to the area where the air freshener was located. They acknowledged that the air freshener was present, accessible to residents, and had the identified WHMIS and consumer product labels on it. The RPN then moved the air freshener to a location that was not accessible to residents. [s. 91.] (625)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are labelled properly and kept inaccessible to residents at all times, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the required policy for medication management system specifically regarding drug administration, Regulation 79/10, s.114 (2) was complied with.

Inspector #617 reviewed the Narcotic Drug Count sheet for a specific unit located in the locked medication room which indicated that on a day in December, 2016, at a certain time, a controlled substance count was signed off by two RPNs in which the following number of a particular controlled substance of a certain dose were left:
-resident #002 had six tablets,
-resident #018 has nine tablets, and
-resident #019 had six tablets.

Later this same day, both Inspector #617 and RPN #102, conducted a controlled substance count comparing the number of this particular controlled substance of a

certain dose left in the blister packages for residents #002, #018 and #019 to the documented narcotic control count completed earlier that day. The actual number of the particular controlled substance tablets left in residents #002, #018 and #019's blister packages was less than the number listed on the control count as follows:
-resident #002 had five tablets,
-resident #018 had eight tablets, and
-resident #019 had five tablets.

Inspector interviewed RPN #102, who explained that during a medication pass on that day, they administered the following number of that particular controlled substance of that certain dose to the following residents:
-resident #002, one tablet,
-resident #018, one tablet, and
-resident #019, one tablet.

RPN #102 further confirmed to the Inspector that immediately after administering the controlled substance tablets to the three residents, they did not sign for the medication on the residents' medication administration record.

Further, on this same day, Inspector interviewed RPN #104 and RPN #105 assigned to resident medication administration on two different units. Both RPN #104 and RPN #105 showed and reported to the Inspector that they had administered controlled substances at their medication pass and at that time signed for the medication on the residents' administration records and updated the controlled substance count.

A review of the home's policy titled "Medication Program-Narcotic and Controlled Drug Maintenance", revised on February 2010, indicated that medication and the administration records are to be kept with each medication cart to be completed as the drug was given.

In an interview with the DOC, it was confirmed to the Inspector that the registered staff were to document the administration of controlled substance medication immediately after being administered in accordance with the home's policy and their College of Nurses' standard of practice. [s. 8. (1) (b)] (617)

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

On December 5, and 8, 2016, Inspector #621 observed on a particular unit, the clean utility room door across from a resident's room opened and the room unsupervised. There was a laminated notice on the door which read "In the interest of resident safety, close this door". Within the room, the Inspector observed a linen cart, an assortment of slings, one hydraulic lift, one oxygen concentrator and four oxygen canisters.

On December 5, 2016, Inspector #621 observed on a particular unit, clean utility room door #100 open and the room unsupervised. There was a laminated notice on the door which read "Benefits of oxygen room, Keep door closed". Within the room, the Inspector observed a shelf with continence care product inventory and an oxygen canister.

Additionally on this same unit, Inspector #621 observed on December 5, and 8, 2016, the doors for storage rooms #101, #103, #105 and #106 open, unlocked and unsupervised. Within the rooms, the Inspector observed storage of furniture, stacked bed frames and mattresses, as well as electric wheelchairs. On December 8, 2016, Inspector #621 observed for a period of 15 minutes resident #020 seated on their wheelchair in storage room #101, with the room door open and the area unsupervised.

On December 6, 7, and 8, 2016, Inspector #621 observed the mail room located across from the Administration offices in the main corridor to be open and unsupervised.

During interviews on December 5, and 8, 2016, HA #117 and #118, RPN #112, RNs #103 and #111, and the Human Resources Manager, reported to Inspector #621 that non-residential rooms were to be kept closed and locked when unsupervised by staff.

On December 5, 2016, HAs #117 and #118 confirmed to the Inspector that the clean utility room door which was situated across from a resident room on a particular unit was a non-residential area and should have been locked, but instead was found open and unsupervised.

On December 8, 2016, RN #103 confirmed to the Inspector that that the clean utility room door on a particular unit was a non-residential area and should have been locked, but instead was found open and unsupervised.

On December 5, 2016, RN #111 confirmed to the Inspector that the clean utility room on a particular unit, as well as storage room doors #101, #103, #105 and #106 were non-residential areas and should have been locked, but instead were found open and unsupervised.

On December 8, 2016, RPN #112 confirmed to the Inspector that storage room doors #101, #103, #105 and #106 were open, unsupervised and had door handles which could not be locked after closing. Additionally, RPN #112 confirmed that a resident was in storage room #101 alone, and should not have been.

On December 8, 2016, the Human Resources Manager confirmed to the Inspector that the home's mail room was a non-residential area and should have been locked, but instead was found open and unsupervised.

During an interview on December 12, 2016, with the DOC, they reported to Inspector #621 that it was their expectation that non-residential care areas in the home were kept closed and locked at all times when unsupervised by staff. [s. 9. (1) 2.]

WN #14: 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. (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:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

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

On three separate occasions in December 2016, Inspector #625 observed resident #029 seated in a wheelchair with a restraint device incorrectly applied.

During an interview with Inspector #625, about resident #029's restraint device application, the RPN #121 stated that the device was used to restrain the resident and proceeded to attempt to correct its application.

A review of the manufacturer's application instructions for the restraint device application identified that the observed application of the restraint device was incorrect posing a safety risk to resident #029.

During an interview with Inspector #625, about resident #029's restraint device application, the DOC stated that the device was not applied correctly. [s. 110. (1) 1.]

2. On separate occasions in December 2016, Inspector #625 observed resident #039 in their particular wheelchair with a restraint device incorrectly applied which compromised

the resident's safety.

During an interview with Inspector #625, regarding resident #039's positioning in the wheelchair, the resident's Agency Companion stated that staff had recently attended the resident, but that the resident required further assistance with their positioning.

During an interview with Inspector #625 regarding resident #039's positioning in their wheelchair, RPN #131 described that the restraint device was improperly applied.

A review of the home's policy titled "Minimizing Restraint - Personal Assistive Safety Device Use" last revised November of 2015, indicated that any time a restraint device was used, staff were to apply the device in accordance with manufacturer's instructions. [s. 110. (1) 1.]

3. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee failed to ensure that every release of the device and all repositioning was documented.

During stage one of the inspection, resident #008 was identified as requiring additional inspection regarding a potential restraint. Inspector #625 observed that resident #008 used a wheelchair with two restraint devices applied.

A review of resident #008's "Physical Restraint Monitoring" record for a period in December 2016, identified that 90 per cent of the required entries were not signed, including entries indicating the repositioning of the resident while restrained, and indicating that the restraint device was released.

Inspector #625 then reviewed the "Physical Restraint Monitoring" records for the residents on a particular unit and identified that:
- 90 per cent of the required entries were not signed for resident #011;
- 89 per cent of the required entries were not signed for resident #024;
- 87per cent of the required entries were not signed for resident #029;
- 89 per cent of the required entries were not signed for resident #030;
- 90 per cent of the required entries were not signed for resident #031;
- 89 per cent of the required entries were not signed for resident #027;
- 88 per cent of the required entries were not signed for resident #009; and
- 93 per cent of the required entries were not signed for resident #032.

During interviews with Inspector #625, PSWs #128 and #124 stated that the residents on this unit were monitored as required with respect to their restraint devices, but that the required documentation of their monitoring for every release and all repositioning was not documented as required on "Physical Restraint Monitoring" records. [s. 110. (7) 6.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that the improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents was communicated to the Residents' Council on an ongoing basis.

During an interview with resident #025 on December 8, 2016, it was reported to Inspector #621 that during the past ten years as Residents' Council President, they did not recall a time when the home communicated to the Residents' Council as part of the quality improvement and utilization review system, the improvements made to the quality of accommodations, care, services, programs and good provided to residents.

Inspector #621 reviewed copies of the Residents' Council minutes over the past year between December 2015, and December 2016. The Inspector found no record of the home communicating to Residents' Council its quality improvement and utilization system.

During an interview with the Adminstrator on December 8, 2016, they confirmed to Inspector #621 that the home has not provided communication to Residents' Council on the home's quality improvement and utilization review system as per legislative requirements. [s. 228. 3.]

Issued on this 23rd day of February, 2017

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

Original report signed by the inspector.