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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 5, 2017	2017_673554_0023	014854-17	Resident Quality Inspection

Licensee/Titulaire de permis

MEDLAW CORPORATION LIMITED
42 Elgin Street Thornhill ON L3T 1W4

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

PINECREST NURSING HOME (2731)
3418 County Road 36 R.R. #2 BOBCAYGEON ON K0M 1A0

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

KELLY BURNS (554), CRISTINA MONTOYA (461), JENNIFER BATTEN (672), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 05-06, 10-13, 16-20, and October 23-25, 2017

Resident Quality Inspection Intake #014854-17, was inspected concurrent with intake(s) #005826-17, and #020103-17.

Summary of Intakes:
1) #05826-17 - Complaint - specific to, alleged neglect, continence care, bedtime

routines, qualifications of staff, screening measures (criminal reference checks), infection prevention and control, and maintenance of the long-term care home; 2) #020103-17 - Complaint - specific to, medications, and medication incidents, responsive behaviours, continence care, shortage of staff affecting resident care, housekeeping, and pest control.

During the course of the inspection, the inspector(s) spoke with The Licensee, Administrator, Director of Care, Nursing Clerk, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Maintenance Worker, Housekeeping Aid(s), Food Service Supervisor, Dietary Aid(s), Registered Dietitian, Activity Assistant, Activity Aid(s), Physio-Therapy Assistant, Physiotherapist, Resident Council President, Families, and residents.

During the course of the inspection, the inspector(s) toured the long-term care home; observed meal service, and snack service, staff to resident interactions, resident to resident interactions; reviewed clinical health records, Resident Council Minutes, Maintenance Requests binder, maintenance routines, and schedules, housekeeping routines and schedules, personnel files specific to qualifications and screening measures (random); reviewed licensee policies, specifically Minimizing Restraints, Use of Oxygen, Skin and Wound Care, Medical Management Team-Terms of Reference, Medication Pass, Medication Reconciliation, Medication Incident Reporting, Self-Administration of Medications, Responsive Behaviours, specifically Caring for a Resident Who Is Verbally or Physically Aggressive, Falls Prevention and Management Program, Physiotherapy Outcome Measures and Falls Prevention Report, Prevention of Abuse and Neglect, Hand Hygiene, Routine Practices - PPE (personal protective equipment), Use of Non-Sterile Gloves, Reporting of Concerns and Complaints, Continence Care and Bowel Care Management Program, Audit of Resident's Personal Belongings, Elimination of Odours, Meal Service, Mealtime Room Service, Nourishment Service, and Recommended Serving Temperatures.

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
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

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

- **21 WN(s)**
- **14 VPC(s)**
- **7 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. 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 :

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

Related to Intake #005826-17:

During the initial tour of the long-term care home, Inspector #554 observed the following:

- Tub-Shower Room – The ceiling area in the room was observed to have discolouration on two of its ceiling tiles. A third ceiling tile, adjacent to the discoloured ceiling tiles, was observed wet. The discoloured ceiling tiles were indicative of microbial growth.
- The shower stall, also located in the tub-shower room, was observed to have areas of discolouration along the ceramic tile walls, and flooring of the shower stall.
- Ceramic Wall Tile, in the tub-shower room, was observed to have discolouration, along the edging of one of the wall tiles.
- Ceiling Tiles were observed to be missing in an area within the service hallway; pipes in the same area were visible.

There was noticeable 'stale' odour in the tub-shower room.

Personal Support Worker #111, and #113 indicated, to Inspector #554, that there has been issues with pipes leaking in the tub-shower room, and indicated that the room also is known to have a 'strange odour'. Personal Support Worker #111 and #113 indicated that the Maintenance Worker, and management, specifically the Director of Care are aware of the pipes leaking, and the odour in the tub-shower room.

The affected ceiling area, described above, was brought to the attention of the Director of Care (DOC), by Inspector #554. The Director of Care indicated that the discoloured ceiling tiles were caused by a roof leak, approximately a year ago, and indicated it was his/her belief that the leak had been repaired. The DOC indicated being uncertain as to why the ceiling tiles were still discoloured, and directed Inspector #554 to speak with the Maintenance Worker or the Administrator. The DOC indicated that staff had complained about odours in the tub room, and that one particular staff had voiced concern about another identified issue in the tub-shower room. The Director indicated that he/she had placed a request in the Maintenance Request binder for the Maintenance Worker to follow up, with the staff's concern. The Director of Care indicated that a dehumidifier and a fan had been placed into the tub-shower room to help with air circulation, in hopes such

would help with odours in the tub-shower room.

The Maintenance Request binder was reviewed, by Inspector #554, with the following documented:
- On an identified date – there were two separate entries, written by the Director of Care, which indicated that an identified observation by staff had been brought to his/her attention. The identified issue, of the concern, relates to the tub-shower room.

The Maintenance Worker indicated, to Inspector #554, being unaware of the discoloured ceiling tiles in the tub-shower room, but indicated being aware that the pipes in the ceiling, of the room, had been leaking on and off. The Maintenance Worker indicated that the leaking pipe was from a drainage pipe on the roof. The Maintenance Worker indicated that he/she did not routinely check the pipes in the tub-shower room for leaks, and indicated he/she relies on staff to advise him/her if the pipe (in the tub-shower room) is leaking; Maintenance Worker was unable to recall the last date he/she had checked the pipes in the identified room, for leaks.

The Maintenance Worker indicated that the Licensee was aware of the drainage pipe leaking, into the ceiling, above the tub-shower room. The Maintenance Manager indicated that there is second leak in the ceiling above the service hallway, indicating that the leak is also from a draining pipe, but not the same pipe as the one leaking into the tub-shower room. The Maintenance Worker indicated that he/she was not aware of any plans in place to fix the leaking drainage pipes and directed the Inspector to speak with the Licensee. The Maintenance Worker indicated he/she was unsure if the Administrator was aware of the leaking pipes, as he/she reports directly to the Licensee for issues related to maintenance.

The Administrator indicated, to Inspector #554, being unaware that the drainage pipe in the ceiling above the tub-shower room leaked, and further indicated being unaware of any other leaks in the long-term care home. The Administrator indicated that he/she was not aware that there were discoloured ceiling tiles in the tub-shower room.

The Licensee indicated, to Inspector #554, that he/she was not aware of any issues in the tub-shower room, specifically leaking pipes and or discoloured ceiling tiles.

The licensee failed to ensure that the home, furnishings, and equipment are maintained in a safe condition and in a good state of repair, specifically as such relates to the tub-shower room.

2) On an identified date, Inspector #554 observed that three (of the five) exhaust fans in the tub-shower room were non-operational. The following day, Inspector #554, met with the Maintenance Worker, and the Licensee regarding the observed exhaust fans, in the tub-shower room. The Maintenance Worker indicated initially that all exhaust fans were 'in a good state of repair and that all were working', and indicated he/she was unsure as to why three of the five exhaust fans were not operational during observations by the Inspector. During a subsequent interview, with the Maintenance Worker, it was determined that the three exhaust fans, observed non-operational, had been blocked off by the Maintenance Worker. The Maintenance Worker indicated that it was his/her belief that the tub-shower room did not need all five exhaust fans circulating. The Maintenance Worker indicated having no qualifications specific to the HVAC system.

The Administrator, and the Licensee indicated being unaware that the Maintenance Worker had blocked off sections of the exhaust fans.

The licensee failed to ensure that the home, furnishings, and equipment are maintained in a safe condition and in a good state of repair, specifically, non-operating exhaust fans, in the tub-shower room.

3) Subsequent Observations were as follows:

- Ceiling Tiles – observed to have discolouration in the staff lounge-locker room, and in an identified resident room.
- Windows – windows in four identified resident rooms, were observed open, the windows would not close. Inspector #554 observed the resident rooms to be cool. Paint on wooden window encasement (frames) in nine resident rooms were observed to be cracked and/or chipped.
- Counter-Top Vanity– one resident washroom was observed to have corrosion on the metal frame supporting the vanity; the corrosion ran the entire length of the metal frame.
- Clothing Wardrobe – laminate, on the wardrobe, was observed chipped, and or non-existent in two identified resident rooms.

Personal Support Workers #111, Registered Practical Nurse #109 and Housekeeping Aid #127, all indicated, to Inspector #554, that issues needing repair are placed into the Maintenance Request binder, for follow up by the maintenance worker.

Housekeeping Aid #127 indicated, to Inspector #554, that there has been ongoing issues

with windows in the home not closing from the inside, and indicated that often staff have to go outside to close the resident windows.

The Maintenance Request binder was reviewed, by Inspector #554, for the period of approximately two months. The above identified areas needing repair were not indicated in the maintenance request binder.

The Maintenance Worker, and the Administrator indicated, to Inspector #554, that they were unaware of the identified issues. The Maintenance Worker indicated he/she relies on staff to place concerns into the maintenance request binder so that he/she can fix items needing repair.

The licensee failed to ensure that the home, furnishings, windows, and equipment are maintained in a safe condition and in a good state of repair. [s.15 (2) (c)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 399/15, s. 1.

Findings/Faits saillants :

1. The licensee has failed to ensure that all personnel hired on or after January 01, 2016, as a Personal Support Worker, or to provide personal support services, regardless of title, has successfully completed a Personal Support Worker Program that meets the requirements listed below and has provided the licensee with proof of graduation issued

by the education provider.

Under O. Reg. 79/10, s. 47 (2) - The personal support worker program, (a) must meet, (i) the Personal Support Worker Program Standard published by the Ministry of Training, Colleges and Universities dated July 2014, or (ii) the Personal Support Worker Training Standard published by the Ministry of Training, Colleges and Universities dated October 2014; and (b) must be a minimum of 600 hours in duration, counting both class time and practical experience time.

Under O. Reg. 79/10, s. 47 (3) - Despite subsection (1), a licensee may hire as a personal support worker or to provide personal support services, (a) a registered nurse or registered practical nurse, (i) who, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a personal support worker, and (ii) who has the appropriate current certificate of registration with the College of Nurses of Ontario; (b) a person who was working or employed at a long-term care home as a personal support worker at any time in the 12-month period preceding July 1, 2011, if, (i) the person was working as a personal support worker on a full-time basis for at least three years during the five years immediately before being hired, or (ii) the person was working as personal support worker on a part-time basis for the equivalent of at least three full-time years during the seven years immediately before being hired; (c) a person who is enrolled in an educational program for registered nurses or registered practical nurses and who, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a personal support worker; (d) a person who is enrolled in a program described in subsection (2) and who is completing the practical experience requirements of the program, but such a person must work under the supervision of a member of the registered nursing staff and an instructor from the program; (e) a person, (i) who has a diploma or certificate granted in another jurisdiction resulting from a program that was a minimum of 600 hours in duration, counting both class time and practical experience time, (ii) who has a set of skills that, in the reasonable opinion of the licensee, is equivalent to those that the licensee would expect of a person who has completed a program referred to in clause (2) (a), and (iii) who has provided the licensee with proof of graduation issued by the education provider; (f) a person who is enrolled in a program that is a minimum of 600 hours in duration, counting both class time and practical experience time, and meets, (i) the vocational standards established by the Ministry of Training, Colleges and Universities, (ii) the standards established by the National Association of Career Colleges, or (iii) the standards established by the Ontario Community Support Association, but such a person must work under the supervision of a member of the

registered nursing staff and an instructor from the program; or (g) a person who, by July 1, 2018, has successfully completed a personal support worker program that meets the requirements set out in clause (f), other than the requirement to work under supervision, and has provided the licensee with proof of graduation issued by the education provider.

Related to Intake #005826-17:

The Nursing Clerk provided Inspector #554 with a list, of names and start dates of nursing personnel hired, by the Director of Care, during a period of approximately three months.

The Director of Care reviewed the list, of nursing personnel hired, with Inspector #554 and provided confirmation of start dates for the identified staff. The DOC indicated that the identified staff had been hired to work in a Personal Support Worker (PSW) role.

The Director of Care indicated that PSW's #146, 147, 148, 149 and 150 started their employment on an identified date. The Director of Care was unable to provide documentation indicating that the identified PSW's had successfully completed a Personal Support Worker (PSW) Program, nor held certification as a PSW. The Director of Care indicated that the identified PSW's did they not meet the requirements identified under subsections (2) and/or (3).

The Director of Care indicated that he/she is aware of the legislation surrounding the hiring of qualified nursing personnel, specifically the qualifications of a Personal Support Worker (PSW).

The Administrator, and the Licensee, both indicated, to Inspector #554, that they were aware that the Director of Care had hired non-qualified workers, to work within a Personal Support Worker role. Both indicated that staff had been hired without the required qualifications as it is difficult to find staff qualified in rural areas. [s. 47 (1)]

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. 245. Non-allowable resident charges
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,
i. 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. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

The licensee failed to comply with O. Reg. 79/10, s. 245 (1) (ii) by charging residents for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from the Minister under section 90 of the Act.

Related to resident #007:

During an interview with resident #007, resident indicated that the licensee was charging him/her an identified sum of money per day to for an identified service. Resident #007 expressed feeling upset.

Inspector #461 reviewed the "Long-Term Care Home Unfunded Services Agreement" between the Pinecrest Nursing Home and resident #007, which showed that the resident agreed to pay an identified sum of money, and had signed the agreement on an identified date.

The Licensee confirmed to Inspector #461 that resident #007 was charged an identified sum of money per day related to an identified service. The Licensee indicated, that in the past, residents had not been charged a fee for the service.

During an interview with resident #007, resident confirmed that he/she had a meeting with the Licensee on an identified date, to review the charges. Resident #007 felt obligated to sign the agreement.

The licensee failed to provide residents goods and services that a licensee is required to provide to a resident using funding that the licensee receives from the Minister. [s. 245 (3)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with 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,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implanted to ensure that the heating, ventilation, and air conditioning systems (HVAC) are kept in a good state of repair, that it is inspected at least every six months by a certified individual, and that documentation is kept of the inspection.

Related to Intake #005826-17:

Pinecrest has sixty-five licensed beds. The long-term care home is heated by baseboard heaters; there are six roof top exhaust units which service the north and south halls, tub room, laundry room, staff room/housekeeping, and the kitchen; there are two roof top make-up air units that service the kitchen and corridors; and the home has approximately seven stand-alone heat-air conditioning units.

Observations, by Inspector #554:

- On an identified date - black discolouration was observed inside the tub-shower room, specifically on the ceiling above on of the two tubs, and along the flooring and walls

inside the shower stall.
- On an identified date - Three of the five ceiling exhaust vents were observed to be non-functioning.

The Maintenance Worker indicated, to Inspector #554, that the ventilation system in the tub-shower room was operational, and further indicated that he/she "was unsure why three of the exhaust vents in the ceiling were not working". During a second interview, that same day, the Maintenance Worker indicated that he/she had closed three of the five ceiling exhaust vents, as it was his/her belief that the tub-shower room did not need all five operational.

The Maintenance Worker, and the Administrator, both indicated that the licensee does not have any policies specific to the HVAC system. Both indicated that the Maintenance Worker, cleans the filter on the Make-Up Air Units twice yearly, and will oil the motor of the unit as needed.

The Administrator indicated being unaware of the qualifications held by the Maintenance Worker.

The Maintenance Worker indicated that he/she does not have any certifications related to HVAC systems.

The Administrator, and the Licensee both indicated that the HVAC system had not been inspected every six months by a certified individual. The Administrator indicated being unaware of when the HVAC system was last inspected, and commented that "the Licensee looks after all service contracts" for the long-term care home, and he/she him/herself is not involved with such. [s. 90. (2) (c)]

2. The licensee failed to ensure that procedures are developed and implemented to ensure that the gas, electric fireplaces and other heat generating equipment (other than the home's HVAC system) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection.

The Administrator and the Licensee indicated that the long-term care home has two dryers, both operated using propane.

The Administrator indicated, to Inspector #554, that the licensee does not have maintenance specific policies, but does have procedures, and schedules for

maintenance staff to follow. Copies of the procedures and/or schedules completed by the Maintenance Worker were provided to Inspector #554 for review.

The procedure/schedule titled, "Seasonal and Occasional Maintenance-Monthly" was reviewed by Inspector #554. The document identifies that during the month, of June, the dryer burners in the laundry room are to be cleaned either by maintenance or an identified contractor. The identified item (dryer burners) had been 'checked off" as completed in June of 2017; there is not documentation as to the specific date that the task was completed and/or who completed the identified task.

The Administrator indicated that the cleaning (identified above) had been completed by the Maintenance Worker.

The Administrator and the Licensee indicated, to Inspector #554, that the propane dryers had not been inspected annually by a qualified individual. The Administrator was unable to provide documentation of any inspections relating to the propane dryers. The Administrator indicated that he/she is not aware of when the propane dryers were last inspected. [s. 90. (2) (e)]

3. The licensee failed to ensure that procedures are developed and implemented to ensure that hot water boilers, and hot water holding tanks are serviced at least annually, and that documentation is kept of the service.

The Administrator and the Licensee indicated that the long-term care home has a hot water holding tank which is operated using propane.

The Administrator and the Licensee indicated, to Inspector #554, that the hot water holding tank had not been serviced annually by a qualified individual. The Administrator was unable to provide documentation of any servicing related to the hot water holding tank. The Administrator was uncertain as to the last time the hot water holding tank was serviced.

The Licensee indicated, to Inspector #554, being aware of the legislation specifically required for the inspections, service and required documentation, in relation to the HVAC system, heat generating equipment, and hot water boilers/hot water holding tanks.

On October 24, 2017, the Administrator indicated, to Inspector #554, that the Licensee has signed a contract with an identified contractor, as of October 18, 2017, for the

inspection of the HVAC, and servicing of the propane dryers and hot water tank, but a time for such has not yet been established. [s. 90. (2) (f)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to interventions are documented.

Related to Resident #036:

Resident #036 was admitted to the long-term care home on an identified date.

Registered Practical Nurse (RPN) #109, Registered Nurse(s) (RN) #106, and #117, the Director of Care, and the Administrator, all indicated, to Inspector #554, that resident #036 is known to exhibit identified responsive behaviours. All indicated that the identified responsive behaviours are directed towards both residents and staff.
Registered Nurse #117, the Director of Care, and the Administrator indicated that

resident #036, shares a room with other residents. RN #117, the Director of Care and the Administrator, all indicated that resident #036 exhibits identified responsive behaviours towards his/her roommates.

The clinical health record, specifically progress notes, for resident #036 were reviewed, by Inspector #554, for the period of approximately four months. There were approximately forty documented incidents of exhibited responsive behaviours. Documentation indicated that interventions, such as explanation of tasks being performed by staff, rationale for care of co-residents, apologies, medication reviews, and as needed medications, were of limited effect, or rarely effective, and thus the exhibited responsive behaviour continued to be exhibited by resident #036.

Resident #035 indicated, to Inspector #554, that he/she has been yelled at by resident #036.

On October 13, 2017, Inspector #554 heard a voice yelling profanities in the hallway. Inspector #554 observed RN #106 come down the hallway with a medication cart; RN #106 indicated to staff and Inspector #554 that was resident #036, was upset with him/her. RN #106 was not observed taking any action to address resident #036's behaviour. Registered Nurse #106 entered the medication room, and closed the door. Resident #036 was then observed, by Inspector #554, coming down the hallway, and entering the Director of Care's office, resident #036 continued to exhibit responsive behaviours directed at the Director of Care. Staff and/or the Director of Care did not intervene. These incidents were observed by fifteen (approximate) residents, who were seated in the main foyer lounge.

On October 18, 2017, resident #036 was observed in the front entrance of the long-term care home, exhibiting identified responsive behaviours. Registered Nurse #106 was observed upset as resident #036 exhibited responsive behaviours directed towards him/her. Registered Nurse #106 walked away from resident #036, while resident continued to exhibit the responsive behaviour. Resident #018 and #042 were heard voicing concern to registered nursing staff about resident #036's responsive behaviours. This incident was observed by other staff, and approximately ten to fifteen residents who were in the lounge.

The Director of Care indicated that the physician, for resident #036, had in the past ordered a referral to a community resource consultant, but DOC indicated that the referral was declined, as resident #036 did not meet the required criteria for the ordered

assessment. The Director of Care indicated that no other arrangements, specific to resident #036's responsive behaviours, had been made, and indicated that resident's (responsive) behaviours continue to escalate.

Registered Nurse(s) #106, and #117, the Director of Care, and the Administrator all indicated that resident #036's exhibited responsive behaviours are a challenge, and that the interventions taken by the staff are usually ineffective. All indicated that resident #036's responsive behaviours are upsetting to residents living in the home, especially those residing with him/her in the shared room, and are disruptive to the care being provided to others. [s. 53 (4) (c)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 78. Food service workers, training and qualificationsTraining and qualifications

Specifically failed to comply with the following:

78. (1) Every licensee of a long-term care home shall ensure that food service workers hired on or after July 1, 2010, other than cooks to whom section 76 applies,
(a) have successfully completed or are enrolled in a Food Service Worker program at a college established under the Ontario Colleges of Applied Arts and Technology Act, 2002 or a Food Service Worker program provided by a registered private career college and approved by the Superintendent of Private Career Colleges under the Private Career Colleges Act, 2005;
(b) have successfully completed an apprenticeship program in the trade of Cook, Institutional Cook or Assistant Cook under the Apprenticeship and Certification Act, 1998 or the Ontario College of Trades and Apprenticeship Act, 2009; or
(c) have entered into a registered training agreement in the trade of Cook, Institutional Cook or Assistant Cook under the Apprenticeship and Certification Act, 1998 or the Ontario College of Trades and Apprenticeship Act, 2009.

Findings/Faits saillants :

1. The licensee failed to ensure that Food Service Workers hired, on or after July 01, 2010, had successfully completed or were enrolled in a Food Service Worker Program, had successfully completed an apprenticeship program in the trade as a Cook, and or had entered into a registered training agreement in the trade as a Cook.

Related to Intake #005826-17:

Dietary Aid #134 began his/her employment at the long-term care home on an identified date, in 2017.

The Administrator indicated, to Inspector #554, that the personnel file, for Dietary Aid #134, does not contain documentation that the Dietary Aid holds certification as a Food Service Worker, nor is there documentation to support that Dietary Aid #134 is enrolled in any associated program. The Administrator referred Inspector #554 to the Food Service Supervisor who hired Dietary Aid #134.

Food Service Supervisor indicated, to Inspector #554, that he/she hired Dietary Aid #134. The Food Service Supervisor indicated that Dietary Aid #134 did not have a Food Service Worker Certificate upon hire, nor was he/she enrolled in a program as indicated by the legislation.

The Food Service Supervisor, and the Administrator, both indicated being aware of the legislation, specifically related to hiring of Food Service Workers on or after July 01, 2010, and the required qualifications for employment.

At the time of this inspection, Food Service Supervisor provided, Inspector #554 with documentation that indicates that Dietary Aid #134 has enrolled in the Food Service Worker Program as of October 17, 2017, but has not yet started the program. [s. 78. (1)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(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 has failed to ensure that each resident who was unable to toilet independently some or all of the time, received assistance from staff to manage and maintain continence, related to resident #008.

Related to Resident #008:

Resident #008 was admitted to the long-term care home on an identified date. Resident #008 requires the use of a mobility aid and requires assistance with transfers.

During an interview, with Inspector #672, resident #008 indicated being displeased with the continence care that he/she was currently receiving. Resident #008 indicated being unable to use the washroom, as the transfer device, he/she required, could not fit through the washroom door, and was unsafe to use with a commode. Resident #008 indicated being told that he/she was to use a continence product. Resident #008 indicated that using a continence product was undignified.

Personal Support Worker #135 indicated, to Inspector #672, that resident #008 was continent, but was unable to be toileted as the transfer device required would not fit into the washroom, and that the commode was unsafe when paired with the identified transfer device. Personal Support Worker #135 indicated resident #008 used a

continence product for management of continence care.

The current written plan of care, for resident #008, was reviewed by Inspector #672, the following interventions are documented, specific to toileting, requires two staff and an identified transferring device, ensure safety, provide hygiene and continence care product, adjust clothing, and wash hands. The written plan of care states resident does not utilize the washroom, as resident #008 has an identified treatment device in place.

The identified treatment device (mentioned above), for resident #008, was discontinued on an identified date, during this inspection.

During an interview, the Director of Care indicated that the expectation was that the written plan of care should be reflective of every resident's assessed level of assistance, and that such should provide direction to staff. The DOC indicated that it was the responsibility of the registered staff member assigned to the resident to ensure that the written plan of care was reflective of the resident's care needs.

The licensee has failed to ensure that resident #008, who was unable to toilet independently, received assistance from staff to manage and maintain continence. [s. 51. (2) (c)]

2. The licensee failed to ensure that 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.

Resident #006's Substitute Decision Maker (SDM) indicated that resident was using an identified continence product prior to his/her admission to the long-term care home. Substitute Decision Maker indicating asking that the identified continence product be used, for resident #006, while residing in the long-term care home to maintain resident's independence. The SDM indicated that he/she had asked the DOC if the home could provide the identified continence product; SDM indicated he/she was advised that the licensee did not provide the identified continence product, and it SDM/resident choose to use the identified continence product, it would be the SDM/resident's responsibility to pay for it. The DOC indicated to the SDM that the long-term care home (licensee) only purchased specific continence products, and that families had to purchase other continence products, if they chose to use them.

Inspector #461 reviewed the licensee's product list located on the linen/product carts,

which listed twelve residents that were currently using continence products supplied by their families. Residents #006, #024, #012, #023, #051, #032, #052, #034, #044, #010, and #038 were included on the list.

Personal Support Workers #102 and #133 were interviewed by Inspector #461, PSW #133 indicated that resident #024 used an identified continence product brought in by family. PSW #102 reported that resident #024 used the identified continence product supplied by family. Both PSWs #133 and #102 indicated the long-term care home only had certain continence products available, not the identified continence product used by resident #024.

Registered Nurse (RN) #106 and the DOC were interviewed by Inspector #461. Registered Nurse #106 reported the long-term care home (the licensee) had assessed and identified continence products available for residents. RN #106 indicated that whether a resident was assessed and identified by staff to need a specific continence product or was a SDM preference, the family always had to purchase the continence product, if the home did not supply the identified continence product. The DOC confirmed that all the residents listed on the continence product list attached to the care carts were using identified continence products provided by their SDM not provided by the licensee.

The DOC further indicated that the identified continence products, being used by the above identified residents, were costly, and indicated that SDM, for identified residents, were given the list of products offered in the long-term care home, but they preferred to use an alternate continence product for their loved ones, the long-term care home did not have the identified continence product available among the products offered to the residents.

The licensee failed to ensure there a range of continence care products available and accessible to residents, specifically the identified continence product.
[r. 51. (2) (h) (i)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring each resident who was unable to toilet independently some or all of the time, receive assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #8: 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. (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 the plan of care sets out clear directions to staff and others who provide direct care to residents, specifically related to the use of an identified medication.

Resident #021 was admitted to the long-term care home on an identified date.

The clinical health record, specifically progress notes for resident #021 were reviewed for a period encompassing one month. Registered Nurse (RN) #117 documented, on an identified date, resident #021's vitals, a specific assessment and positioning. RN #117 indicated that an identified treatment was initiated, a physician was contacted and physician's orders were received. Resident #021 was transferred to hospital for

assessment and admitted.

Documentation, by registered nursing staff, indicates that six days later resident returned to the long-term care home, from the hospital. Documentation indicates that resident did not require an identified treatment upon his/her return from hospital.

Registered Practical Nurse (RPN) #119 documented, in progress notes that resident #021 from hospital on the above identified date. Registered Practical Nurse documented taking an assessment and initiating an identified treatment.

Documentation indicated that resident #021 was administered the identified treatment from his/her readmission, from hospital, and for six days following. There is no mention of the identified treatment in written documentation by registered nursing staff following the sixth day, and there is no assessment to indicate that the identified treatment was no longer required by resident #021. Resident #021 received the identified treatment for seven days after return from hospital.

The clinical health record, for resident #021, was reviewed for a period of three months. The clinical health record reviewed fails to identify a specific diagnosis, and or the administration or use of an identified treatment for this resident.

During an interview Registered Nurse (RN) #106 indicated that when a resident requires the use of an identified treatment, there is a standing medical directive (for the treatment). RN #106 indicated that the RN or RPN can initiate the identified treatment in an emergency at an identified rate. RN #106 indicated that the registered nursing staff who initiates the treatment should do an assessment, write an order for the treatment and place a note on the doctor’s board for the next time that they (the doctor) are in so they can write the order. RN #106 indicated that the RAI Coordinator will put the treatment in the 'tasks' in electronic flow record so that the PSW’s can sign for it and also so they know to clean the equipment.

The Director of Care (DOC) indicated that the written plan of care should indicate when a resident requires the use of the identified treatment, and that the use of treatment should also be placed onto the tasks in the electronic flow record for the PSW's to sign that the resident is receiving the identified treatment.

The licensee failed to ensure that the plan of care for resident #021 set out clear directions to staff and others who provide direct care to the resident related to the use of

the identified treatment.

Resident #021 is currently not being administered the identified treatment. [s. 6. (1) (c)]

2. The licensee failed to ensure the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Related to Resident #008:

Resident #008 was admitted to the long-term care home on an identified date. Resident #008 requires the use of a mobility aide, and requires an identified transfer device for all transfers.

Resident #008 indicated being continent, but indicated he/she is unable to use the washroom, as the transfer device, he/she required, could not fit through the washroom door, and that staff have indicated that it was unsafe to use, the transfer device, with a commode. Resident #008 indicated that he/she required assistance from staff to position a toileting aid, and when he/she rang for assistance staff told him/her to go in his/her continence product. Resident #008 indicated that using a continence product was undignified.

Personal Support Worker #135 indicated, to Inspector #672, that resident #008 was continent, but was unable to be toileted as the transfer device required would not fit into the washroom, and that the commode was unsafe when paired with the identified transfer device. Personal Support Worker #135 indicated resident #008 used a continence product for management of continence care.

The Director of Care (DOC) indicated that it was an expectation that staff were to offer a resident a toileting aid if the resident was continent. The DOC indicated that it was not appropriate for staff to inform a resident that they should use their continence product versus toileting.

The licensee failed to ensure that the plan of care for resident #008 was based on an assessment of the resident and the resident's needs and preferences, related to continence care. [s. 6. (2)]

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

During this inspection, on October 05, 2017, resident #042 received tray service during an identified meal service. Resident #042's written plan of care did not specify the need for this intervention. On October 06, and October 16, 2017, it was identified that residents #004, #022, #042 received tray service, the written plan of care did not indicate the need or choice for tray service.

On October 13, and 20, 2017, resident #020 was observed eating an identified meal in his/her room. Resident #020 received tray service instead of attending the dining room. Inspector #461 reviewed the health records of residents #004, #020, #022, and #042. The written plan of care indicated the identified residents ate meals in the dining room, and made no mention of the identified residents requesting or needing tray service at meals.

During interviews, residents #022 and #042 indicated, to Inspector #461, that it was their choice to have meals in their rooms. Residents #020 and #004 were not able to indicate their preference due to cognitive impairment.

Personal Support Workers (PSW) #111, #125, and #152 were interviewed by Inspector #461. PSW #111 indicated that resident #043 had chosen to eat meals in bed, except on bath days when resident was out of bed. PSW #111 indicated that resident #022 had, recently, been choosing to stay in bed for meals. PSW #125 indicated that resident #004 used to go to the dining room, but started to feel tired towards the end of the meal, so staff decided to provide a tray service and let resident rest after lunch. PSW #152 indicated that resident #020 receives a tray on bath days to allow resident rest after his/her bath.

During an interview, the Director of Care (DOC) indicated that staff are to encourage residents to come to the dining room, and indicated that tray service was only offered to residents who were ill or chose to stay in their room. The DOC further indicated being aware that residents #004, #020, #022, and #042 receive tray service, but was unaware the residents were not assessed for the service. Director of Care indicated it is the expectation that staff assess the need for a tray service and add 'tray service' as an intervention in the residents' written plan of care.

On October 19, 2017, during an interview with the Registered Dietitian (RD), the RD indicated that on while completing nutritional assessments, he/she has come across a few residents who stay in their rooms for meals, but indicated he/she has not looked into

the reason for such. The RD indicated that there should be an assessment to identify the resident's needs or choice to receive tray service.

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, specifically an assessment of residents #004, #020, #022, and #042 to identify the need or preference to receive tray service. [s. 6. (2)]

4. The licensee has failed to ensure that, the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care, and that the effectiveness of the plan of care are documented related to the use of an identified medication.

Resident #021 was admitted to the long-term care home on an identified date.

A review of the progress notes, for resident #021, for the period of one month indicates that resident began receiving an identified treatment on an identified date, and continued to receive this treatment for approximately eight days. After the eighth day, there is no mention in the clinical health record of the resident receiving this treatment, nor was there mention that resident was assessed to not need the treatment.

A review of the plan of care for resident #021 for the identified period fails to identify the provision of care, the outcomes of care and the effectiveness of the plan of care related to a specific diagnosis and the use of the identified treatment. [s. 6. (9) 1.]

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

Related to Resident #006:

Resident #006 was found on the floor on an identified date. Resident had an unwitnessed fall, and sustained injury. The injury required an identified treatment.

A review of the clinical records for resident #006 indicated the following:

The progress notes, for a period of approximately sixteen days indicate resident #006 had only received the above identified treatment, to his/her injury, on four identified dates.

A review of the current plan of care, in the electronic health record, for resident #006 fails to identify a skin care plan (focus or interventions) for the identified injury. There was no documentation of the identified injury in the eTAR (electronic treatment record).

Registered Practical Nurse #109 and Registered Nurse #106 indicated that an injury's like resident #006's are not typically put into the planned care for residents as the injury heals fast, nor are they placed into the eTAR.

During an interview, the Director of Care indicated that all skin and wound issues should be documented in the plan of care, including the type of injury sustained by resident #006.

The written plan of care for resident #021 was not revised when the resident's care needs changed. [s. 6. (10) (b)]

6. Related to Resident #008:

Resident #008 was admitted to the long-term care home on an identified date. Resident was admitted to the home, with a specific treatment in place.

During an interview, Physician (#136) indicated that the identified treatment, for resident #008, had not been discontinued after resident's admission, due to resident having an identified diagnosis. The Physician indicated that shortly after resident's admission to the home, the resident began to have the identified treatment discontinued; Physician indicated that the treatment was discontinued on an identified date.

Inspector #672 reviewed resident #008's progress notes, registered nursing staff documented that on an identified date, the treatment was discontinued.
Inspector #672 reviewed the most recent written plan of care (dated ten days post treatment discontinuation), which indicated that resident #008 continued to have the identified treatment in place. There was no other mention of continence care and management in the written plan of care for resident #008.

The Director of Care indicated that it is the responsibility of the registered nursing staff on duty, and who is assigned to the resident, to update the written plan of care immediately following a change in the resident's condition or treatment, and the expectation was that the written plan of care should have been updated during the shift that the identified

treatment was discontinued.

The licensee failed to ensure that resident #008's plan of care was reviewed and revised when the resident's care needs changed, related to continence care and management. (672) [s. 6. (10) (b)]

7. Related to Resident #024:

Personal Support Worker (PSW) #133 was interviewed by Inspector #461. PSW #133 indicated that resident #024's continence care needs had significantly changed in the last three months. Resident #024's Substitute Decision Maker (SDM) provided an identified continence product for resident, to allow resident #024 to have some independence in the day time. PSW indicated that the identified continence product was not likely effective as resident was requiring more extensive assistance with toileting. PSW #133 indicated that resident's continence level had declined and the assessed continence product was not adequate for resident #024. PSW #133 indicated that the PSW's had begun to use an alternate product for resident #024's comfort.

Inspector #461 reviewed the continence product list, and noted that resident #024 had been assessed for the use of an identified continence product, and had not been assessed for the alternate product being used by staff during the identified shift.

Inspector #461 reviewed resident #024's health records and written plan of care related to continence care. Resident was identified as being assessed to use the identified continence product supplied by his/her SDM. Review of resident #024's progress notes, for a period of twenty-five days, indicated that resident's health had declined, and that resident #024 was requiring extensive to total assistance with his/her activities of daily living (ADLs). It was identified that resident's continence had not been assessed despite the physical changes documented in the health record, nor the need for a change in continence products.

During an interview, the Director of Care indicated that he/she was aware of resident #024's health decline over the past few months. The DOC indicated that nursing staff were expected to communicate any changes of residents' care needs, including continence to the charge nurse or to the DOC. The DOC indicated that registered nursing staff should update the plan of care when there is a change in residents' condition including changes with continence care. The DOC further indicated that a formal continence assessment was not available or used in the home.

The licensee failed to ensure that resident #024 was assessed and the plan of care reviewed when the resident's care needs change or care set out in the plan of care is no longer necessary, specifically related to continence care. [s. 6. (10) (b)]

8. Related to Resident #019:

Resident #019 was admitted to the long-term care home on an identified date. Resident #019 is cognitively well. Resident #019 requires a mobility aide, and is known to have allergies and sensitivities.

Resident #019 indicated that when he/she was admitted to the home, he/she used a specific disposable product for continence care and management, as he/she was unable to be toileted. Resident #019 indicated he/she was able to be independent with continence care while using the identified product, and indicated he/she would ring for assistance as needed. Resident #019 indicated that a "few months ago", he/she was informed by staff that he/she could no longer use the identified product as a continence care product, as the product was not intended for continence care, but for wound care. Resident #019 indicated that she tried using the continence product which he/she was now told to use, but indicated he/she was unable to position him/herself, and now needed to ring for staff assistance with continence care, which has resulted in episodes of incontinence while waiting for staff to assist him/her. Resident #019 indicated that the change in continence product had decreased his/her independence, and that episodes of incontinence are embarrassing.

Resident #019 further indicated that since he/she can no longer use the other product, which he/she use to use for continence care, his/her skin had become sore. Resident #019 indicated he/she has informed nursing staff of his/her sensitivity to the now used continence product, and staff indicated he/she had to continue to use the product, or purchase his/her own. Resident #019 indicated he/she was given no alternatives nor were other interventions discussed or trialed.

Registered Nurse (RN) #106 indicated being aware that resident #019 had been complaining of skin irritation since that change in continence product, but was not aware that other alternatives or interventions had not been discussed with the resident.

The Director of Care indicated that the product originally being used by resident #019 was not to be used for continence care, as the product was too expensive, and was only

to be used for wound care purposes. The DOC indicated that if skin sensitivities were noted, then other interventions, such as barrier creams, could be trialled, but the continence product would be continued to be used. The DOC indicated that an assessment for resident #019's sensitivities should have been completed and other interventions trialed noting resident's concern regarding sensitivity.

The licensee has failed to ensure that resident #019 was reassessed, and the plan of care reviewed and revised when the resident's care needs changed, related to continence care and skin care. [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 there is a process in place and monitored, ensuring that the plan of care sets out clear directions to staff and others who provide direct care to residents; to ensure that the plan of care is based on the resident's assessed needs; to ensure that the provision of the care set out in the plan of care is documented, along with the outcomes and the effectiveness of the planned care; and to ensure that the resident is reassessed and that the plan of care is reviewed, and revised at least every six months, and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Under O. Reg. 79/10 s. 68 (2) (a) every licensee of a long-term care home shall ensure that the program include the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

Review of the licensee's policy for Dietary Nourishment Service, (revised on an identified date), indicated the following:

- Nourishment's are served daily at 1015, 1415, and 2000 hours.
- Two carts are set up: one for the north wing and one for the south wing. Trays are placed in a cooler until time of service.
- Delivery of nourishment: nursing staff are responsible for delivering and serving beverages and snacks. Staff will assist and encourage residents to ensure they can safely eat and drink as comfortably and independently as possible.

On October 20, 2017, Inspector #461 observed Housekeeper #127 delivering and serving snacks from the nourishment carts for the residents on an identified area of the long-term care home. Housekeeper #127 indicated to Inspector #461 that the nursing staff asked him/her to help serve and assist residents with the afternoon snacks because the home was short staffed.

Housekeeper #127 indicated to Inspector #461 that the Personal Support Workers (PSWs) had provided advice on how to feed residents in the past, but that he/she have not received training by a registered nursing staff or the RD. Housekeeper #127 further indicated there was a diet list with the residents' diets and preferences on the snack cart, but he/she rarely used it because he/she could not differentiate the various texture modified diets. Housekeeper #127 indicated he/she relied on the PSWs for direction on the type of diet and feeding assistance required for each resident.

Inspector #461 reported the observation to the DOC and Administrator. The DOC indicated that housekeeper #127 had helped with the snacks and feeding in the past. The DOC confirmed that the nursing staff should be delivering and serving the snacks, not a housekeeping staff.

Following discussion with the DOC, Inspector #461 observed that Housekeeper #127 had returned to perform his/her housekeeping duties and had left the snack cart in the dining room.

At an identified time, Inspector #461 observed the snack cart was still left unattended in the dining room, the snack service for residents living on an identified wing had not yet started. Inspector #461 reported the observation to the Administrative Assistant #154 who found a PSW to assist with the snack cart.

On October 25, 2017, during separate interviews with the Food Service Supervisor (FSS) and the Administrator, the FSS indicated that the dietary staff were responsible for assembling the snack carts and keeping the cold beverages in a cooler until the nursing staff picked up the cart from the kitchen, then the nursing staff were responsible for delivering the snacks and assisting the residents. The Administrator confirmed that it was the expectation that nursing staff deliver the snacks and assist residents during snack times.

The licensee failed to comply with the policy for Dietary Nourishment Service as it was identified during the afternoon snack service that the trays with cold beverages were not placed in a cooler until and during the snack serving. The snack service was initiated 30 minutes later than indicated by the home's policy, and a housekeeper (non-nursing staff) was observed delivering the snacks to the residents.

2. Review of the licensee's policy for Referrals to Dietitian, (identified revision date), indicated the following:

- When a risk factor has been identified for a resident, the charge nurse shall write a "Dietary Referral" progress note on Point Click Care (PCC) which should specify the reason for the referral.
- The charge nurse may initiate on a trial basis only, a change in diet (e.g. from regular to minced texture when such a change is indicated). Generate a Dietary Referral for the Registered Dietitian (RD)
- Any changes to a resident's dietary plan of care initiated on a trial basis by the charge nurse shall be communicated to the dietary department by the Registered Nurse (RN) who will write the change in the Dietary Communication Book, and make a referral to the RD (Dietary Referral Progress Note).

On October 20, 2017, Inspector #461 observed resident #024 in the dining room for an identified meal service. Resident #024 was sitting on a chair slightly away from the dining table with his/her body leaning forward and his/her head resting on the dining table. Resident #024 was served a pureed meal, no staff were observed in attendance, to assist the resident.

PSW #153 indicated to Inspector #024 that resident was able to feed him/herself, but that the resident had been requiring more assistance with meals in the last few days. PSW #153 proceeded to feed resident for approximately 10 minutes, when resident asked PSW to stop.

Resident #024's written plan of care was reviewed. The written plan of care identified that resident #024 needed supervision with eating and received a regular diet with regular texture. Review of the progress notes, for a period of twenty-five days, identified that resident #024 had been experiencing a rapid cognitive and physical decline, and a RAI-MDS assessment for a significant change in status had been initiated on an identified date. Inspector #461 did not identify progress notes related to the nursing staff initiating a trial of pureed meal or placing a referral to the Registered Dietitian (RD) during this review period.

On October 25, 2017, during separate interviews with the FSS and the DOC by Inspector #461, the FSS indicated that when a nurse initiates a diet trial for a resident, the registered staff must send a referral to the RD on the same day. The FSS showed Inspector #461 the dietary request filled out by the charge nurse on an identified date, to initiate a trial of pureed diet for resident #024, but the referral to the RD was not placed.

The DOC indicated to Inspector #461 that when a registered nursing staff initiates a diet trial for a resident, they were expected to simultaneously create a Dietitian referral progress note in the electronic health record. The DOC confirmed that a Dietitian referral should had been generated for resident #024 when a diet trial was initiated on an identified date.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, particularly, the policies for Dietary Nourishment Service and Referrals to Dietitian. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in

accordance with all applicable requirements under the Act.

Under O.Reg. 79/10, s. 114. (2) - The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

Related to Intake #020103-17 :

An identified pharmacy is the contracted service provider for Pinecrest Nursing Home. The identified contracted pharmacy provider's policy, #10-11 (revised date identified), is used by the licensee.

Policy, #10-11, directs that the licensee and the staff to follow the procedures as outlined in the policy.

Resident #036 was admitted to the long-term care home on an identified date.

During an interview resident #036 indicated that he/she uses a identified medication for an identified diagnosis. Resident #036 indicated that he/she self-administers the identified medication and keeps such on his/her person.

During an interview RN #106, and the Director of Care, both indicated that policy #10-11, specifically procedures #1, #4, #7, and #8 were not complied with.

The licensee failed to ensure that policy, #10-11 was complied with. [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 to ensure there is a process in place and monitored, ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specifically as such relates to medication management and nutritional care, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system is available in every area accessible by resident.

During the initial tour of the long-term care home it was identified, by Inspector #554, that there was no resident-staff communication and response system available in the resident lounge, located in an identified area of the long-term care home. Approximately fifteen residents were observed sitting in lounge chairs and or wheelchairs in this lounge.

Registered Practical Nurse (RPN) #109 indicated that the lounge is a resident accessible area, and is an area used daily by residents.

Upon further inspection, it was observed that there is no resident-staff communication and response system available in the secured courtyard, and/or the patio area, which is located at the front entrance of the long-term care home. Residents were observed daily, during this inspection, sitting outside on the patio at the front of the home.

Activity Aid (AA) #105, and Personal Support Worker #116 indicated, to Inspector #554, that residents utilize both the secured courtyard and the front patio.

Resident #054 and a visitor indicated, to Inspector #554, that he/she regularly sits outside. Resident #054 indicated that there is no resident-staff communication and response system, and if he/she needed assistance when outside that he/she would yell out, and hope that staff inside could hear him/her.

The Director of Care, and the Licensee, both indicated, to Inspector #554, that the lounge does not have a resident-staff communication and response system available. Both indicated that the lounge is used by residents daily, and both indicated that the long-term care home is small, and if needed residents could call out for assistance from staff.

The Director of Care confirmed that there was no resident-staff communication and response system available outside in the secured courtyard and or the front patio area of the home.

The licensee failed to ensure that there is a resident-staff communication and response system available in every area accessible to residents. [s. 17. (1) (e)]

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 there is a process in place and monitored, ensuring there is a resident-staff communication and response system is available in every area accessible by residents, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The licensee's policy, Prevention of Abuse and Neglect (dated 2017) indicates that Pinecrest is committed to providing a safe home for residents, ensuring care, safety, security and rights of residents is not compromised. The policy directs that staff must report all alleged, suspected or witnessed incidents of abuse of a resident by anyone, and neglect of a resident by a staff member. Staff are to report abuse and or neglect to their supervisor, Charge Nurse, Director of Care or Administrator.

The licensee's policy, Prevention of Abuse and Neglect does reference to Section 24, of the Long Term Care Home's Act, and speaks to immediate reporting of abuse and or neglect to the Director, under the Ministry of Health and Long Term Care.

Related to Intake #005826-17:

Personal Support Worker (PSW) #130 indicated, to Inspector #554, that he/she had

witnessed, nursing staff, yelling at residents and telling residents to go in their briefs. PSW #130 indicated the following:

- PSW #101 was heard yelling at resident #053. PSW #130 indicated he/she was in another resident’s room when he/she heard the yelling, and went to see what was happening. PSW #130 indicated that he/she entered resident #053’s room, and witnessed PSW #101 yelling at resident, to lift his/her legs. PSW #130 indicated telling PSW #101 that yelling at a resident was not appropriate. PSW #130 indicated that PSW #101 stated that the resident is hard of hearing. PSW #130 indicated that he/she told PSW #101 again that his/her actions were inappropriate, and that PSW was not to be yelling at residents. PSW #130 indicated, to Inspector #554, that the witnessed incident occurred last week, but that he/she could not recall the exact date of the incident.

- PSW #130 indicated witnessing nursing staff telling resident #047 to 'go in his/her pad'. PSW #130 indicated 'go in the pad' meant for the resident to urinate or defecate in the continence product. PSW #130 indicated that resident #047 is to be toileted or placed onto the commode, but often staff would tell resident #047 to go in his/her pad, as staff had difficultly standing resident and transferring resident onto the toilet/commode. PSW #130 indicated resident #047 was to be toileted. PSW #130 indicated resident #047 would get upset with staff when they told resident to go that. PSW indicated being unable to recall dates of incidents, stating 'it happens frequently'. PSW #130 refused to name staff involved, and only stated, to Inspector #554, 'it was PSW’s who told the resident to go in the product'.

- PSW #130 indicated witnessing nursing staff telling resident #022 to 'go in his/her brief'. PSW #130 indicated resident use to be toileted or given a toileting aid, but indicated resident is no longer toileted or given the toileting aid. PSW #130 indicated that resident #022 is now incontinent. PSW #130 indicated that resident #022 will still ask to use the toilet. PSW #130 indicated resident #022 gets upset when staff won’t toilet him/her. PSW indicated being unable to recall dates when resident #022 was refused toileting by staff, but stated 'it happens frequently'.

Personal Support Worker #130 indicated that yelling at a resident is abusive, and that refusing to toilet at resident would be viewed as neglect of care. Personal Support Worker #130 indicated that he/she is aware that abuse and or neglect is to be reported to registered nursing staff and or the Director of Care. Personal Support Worker #130 indicated that he/she did not report the witnessed abuse-neglect incidents to anyone.

The Director of Care and that Administrator, both indicated, to Inspector #554, that Personal Support Worker #130 has received training and is aware of the licensee's policy regarding zero tolerance of abuse and neglect. Both indicated that PSW #130, as well as other staff are expected to report any alleged, suspected or witnessed incident of abuse and or neglect. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.

Resident #008 was admitted to the long-term care home on an identified date. Review of the clinical records indicated that resident #008 experienced impaired skin integrity, beginning on an identified date, that require dressings and had further impairment in skin integrity on a subsequent date, which required treatment.

Review of the current plan of care identifies the following;
- Skin Care impaired, with the goal to comply with therapeutic regime. Interventions include a drawsheet under resident instead of square as he/she finds it uncomfortable,

cleanse identified area well with each incontinence episode, ensure special mattress is in place (identified surface), provide identified fluids daily, turn and reposition with skin care every two hours.

The plan of care does not identify the specific skin impairment for resident #008 or any interventions required. The Nutrition care plan identifies the presence of altered skin integrity for resident #008, but there are no goal or interventions in place to promote healing.

Review of the progress notes for a period of approximately four months fails to identify that a referral was made to the Dietitian regarding the altered skin integrity for resident #008.

During an interview RPN #109 indicated that the skin and wound assessment form is to be completed weekly for identified skin impairment. RPN #109 indicated that for resident #008 this assessment form was only completed twice during the time that resident had altered skin integrity (period of four months). RPN indicated that staff get busy and often only sign the treatment sheet or write a progress note about the altered skin integrity and do not complete the skin and wound assessment. RPN indicated that there is no official wound care committee in the home and there is no designated skin and wound care lead. RPN indicated that him/herself, RN #106 and the DOC are all trained for assessing wounds and the recommendation of treatments based on best practice guidelines. RPN #109 indicated that if there was a skin and or wound issue that was not healing, he/she is not aware of an external resource that is available to assess a skin and wound such as an ET Nurse. RPN #109 indicated that when a resident has a new or worsening wound, a referral is supposed to be made to the Dietitian but it doesn't always happen.

The DOC indicated that all residents who have a wound should have a referral sent to the Dietitian. The DOC indicated that he/she reminds staff this documentation is required and he/she is aware that it is not always done. The DOC indicated that wounds are discussed at the monthly multidisciplinary CQI meetings, minutes of these meetings are kept. Meeting minutes were reviewed for a three month period, resident #008's altered skin impairment is only identified in one of the three meetings that was attended by the DOC, Administrator and RPN #122.

The licensee has failed to ensure that the plan of care for resident #008 is based on an interdisciplinary assessment with respect to the resident's skin condition, and altered skin integrity. [s. 26. (3) 15.]

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 there is a process in place and monitored, ensuring that the plan of care is based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions, to be implemented voluntarily.

WN #13: 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).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan, provides 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; promotes continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; includes 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 is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Related to Intake ##020103-17:

The Director of Care, who oversees the operations of the Nursing department, indicated, to Inspector #554, that he/she is not aware of any written staffing plans for the Nursing and Personal Support Services Programs. The Director of Care asked that the Inspector speak with the Administrator, and or the Licensee with regards to the existence if any of a written staffing plan.

The Director of Care indicated that he/she does have a back-up plan for nursing and personal care staff to address situations when staff cannot come to work. The Director of Care provided a document titled, 'PSW Short Staff Routine' (dated review for an identified date), to Inspector #554. The Director of Care indicated that there is a back-up plan for Personal Support Workers (PSW), but there is no back-up plan to address situations when staff, specifically a Registered Nurse or a Registered Practical Nurse cannot come to work.

The Nursing Clerk provided Inspector #554 with a document identified as, 'On Site Hours'. The document was provided to the Nursing Clerk by the Licensee.

The Administrator indicated, to Inspector #554, that the document titled 'On Site Hours' would be considered the licensee's written staffing plan.

The written staffing plan provided, was reviewed with the Administrator (and Inspector #554). The written staffing plan, provided by the licensee, fails to identify and/or include, 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; and doesn't identify how it

promotes continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident.

The Administrator indicated, to Inspector #554, that there is a back-up plan to address situations when Personal Support Workers cannot come to work, but confirmed that the Director of Care was correct, and indicated that the back-up plan does not identify a back-up plan for situations when registered nursing staff cannot come to work, nor does it include staff who must provide the nursing coverage required under subsection 8 (3) of the Act.

The Administrator indicated being unaware of when the written staffing plan was last evaluated and/or updated; the Administrator further indicated being unsure if the document (On Site Hours) is evaluated annually in accordance with evidence-based practices, as she nor the Director of Care have been involved with the development of the document. [s. 31. (3)]

2. The licensee failed to ensure that there is a written record of each annual evaluation of the staffing plan, including the date of the evaluation, the names of persons who participated in the evaluation, a summary of the changes made and the date of changes were implemented.

Related to Intake #020103-17:

The Director of Care, who oversees the operations of the Nursing department, indicated, to Inspector #554, that he/she is not aware of any written staffing plans for the Nursing and Personal Support Services Programs, nor has she been involved with any evaluation of a staffing plan.

The Nursing Clerk provided Inspector #554 with a document identified as, 'On Site Hours'.

The Administrator indicated, to Inspector #554, that the document titled 'On Site Hours' would be considered the licensee's written staffing plan. The Administrator indicated being unaware of when the written staffing plan was last evaluated, and indicated that he/she him/herself has not been involved with any evaluations related to a written staffing plan.

The Licensee could not identify, to the Inspector #554, when the written staffing plan

(document titled 'On Site Hours') was last evaluated, the names of person who participated in the evaluation nor could he identify a summary of changes or dates of any changes implemented. [s. 31. (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 there is a process in place and monitored, ensuring that the staffing plan, provides 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; promotes continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; includes 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 is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and to ensure that there is a written record of each annual evaluation of the staffing plan, including the date of the evaluation, the names of persons who participated in the evaluation, a summary of the changes made and the date of changes were implemented, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents have their personal items labelled within 48 hours of admission and in the case of new items, of acquiring.

During the initial tour (on October 05, 2017) of the long-term care home, Inspector #554 observed the following in the tub-shower room:

- A black brush, and a grey brush were observed in a care caddy, sitting adjacent to the tub; items were unlabelled. Both brushes contained gray hair.
- A blue razor was observed sitting on a shelf. The razor was covered in a white film, and the blades of the razor contained small black hair. The razor was unlabelled.

Personal Support Worker (PSW) #111, who was the assigned bath aid, on an identified date, indicated to Inspector #554, that all resident personal (care) items are to be labelled for individual use, both on admission and as residents acquire new ones. PSW #111 indicated that the identified brushes, observed in the care caddy, are being used on more than one resident, by him/herself. PSW #111 indicated being unaware of any cleaning procedure for communal use brushes.

Subsequent observations, by Inspector #554 during the dates of October 05, to October 11, 2017, identified the following:

- Identified resident room – a blue brush, a black comb and a purple-white toothbrush, were observed sitting on the counter-top vanity in a shared ward (4 residents) bathroom; all items had been used and were unlabelled. Resident #017 and #018, who reside in the room, did not know who the personal items belonged to.
- Identified resident room – a toothbrush was observed in a toothbrush holder in a shared resident bathroom; the item had been used and unlabelled. Resident #024 who resides in the room, did not know who the toothbrush belonged to.
- Identified resident room – two toothbrushes were observed in a toothbrush holder in a shared ward bathroom; the items had been used, and were unlabelled. Resident #025 who resides in the room, did not know who the toothbrushes belonged to.
- Identified resident room – a brown brush observed sitting on the counter-top vanity in a shared semi-private bathroom; the brush contained hair in its bristles, the brush was unlabelled. Resident #001, who resides in the room, did not know who the brush belonged to.
- Identified resident room – a red toothbrush was observed in a toothbrush holder in a shared resident bathroom; the item had been used, and was unlabelled. Resident #022 who resides in the room, did not know who the toothbrush belonged to.

Inspectors #461 and #623 observed unlabelled resident personal items (brushes, combs, toothbrushes and denture cups) in another four shared resident washrooms, during dates of October 06, to October 11, 2017. It was not verified by Inspector #461 and #623, if resident's in these four (identified) resident rooms knew who the unlabelled personal items belonged too.

Registered Nurse (RN) #106 and the Director of Care indicated that resident personal items are to be labelled, by nursing staff (Personal Support Workers) on admission, and as residents acquire new ones. The Director of Care indicated that personal items are intended for use by an individual resident, and are not to be shared.

The licensee failed to ensure that all personal care items are labelled. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that residents have their personal items labelled within 48 hours of admission and in the case of new items, of acquiring, to be implemented voluntarily.

WN #15: 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #008 was admitted to the long-term care home on an identified date.

Review of the progress notes for identified dates identified that resident was admitted with altered skin integrity. The identified area began to worsen shortly after admission. Resident #008 began to experience other areas of altered skin integrity as indicated in the progress notes reviewed.

Review of the clinical records for resident #008 indicate that the treatment for the altered skin integrity, specifically two identified areas do not appear on the eTAR until an identified date. Weekly skin and wound assessments are indicated on the treatment records beginning on a different dates. A review of the Wound Assessment Form identifies that assessments were completed weeks to months later, depending on the area being identified.

During an interview RPN #109 indicated that the wound assessment form is to be

completed weekly for any wound. RPN #109 indicated that for resident #008 this assessment form was only completed twice during the time that the altered skin integrity was present, and/or treatment was completed. The RPN indicated that staff get busy and often only sign off on the treatment record or write a progress note and do not complete the wound assessment.

During an interview the DOC indicated it is the expectation that registered nursing staff will complete the wound assessment form when altered skin integrity is initially discovered and then weekly as indicated in the policy. The DOC indicated that the eTAR should alert the nurse that a weekly assessment is required. The weekly assessment would include a measurement of the wound, location, type, stage is applicable, a description, and any drainage. The DOC indicated that he/she reminds staff this documentation is required and he/she is aware that it is not always done.

The licensee failed to ensure that a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment was completed for resident #008. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment related to altered skin integrity for resident #006.

Review of the clinical records for resident #006 indicated the following;

A progress note indicated that Resident #006 was discovered on an identified date, sitting on the floor of his/her room. As a result of the un-witnessed fall resident sustained injury to an identified area, and a treatment was initiated.

Progress notes were written on three identified dates and indicated a treatment to resident's injury was changed by RPN #109 and RN #100 and #114. On an identified date, a progress note written by RN #106 indicated that the injury was now healed and a dressing was no longer required.

Review of the skin and wound assessment's for resident #006 indicated that there is no record of a Skin and Wound Assessment being completed for the altered skin integrity

that resident #006 received as a result of an un-witnessed fall.

During separate interviews RPN #109 and RN#106 indicated that the identified skin issue were not documented on the Skin and Wound Assessment Form. Both indicated that the identified skin issue was usually only documented in the progress notes when such occur.

The DOC indicated that the identified skin issue (of resident #006) are not documented on the Wound Assessment Form, the form is used for wounds such as pressure ulcers, and surgical wounds. The DOC indicated that the form; Pinecrest - Wound Assessment Form does identify the identified skin issue as a wound type to be documented on by using the form however, the form is not used for the identified skin issue. The DOC indicated that there is no clinically appropriate assessment tool, specifically designed for skin and wound assessment that is used to assess that injury specifically.

The licensee failed to ensure that resident #006 has received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, when resident #006 sustained injury. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff.

Resident #019 was admitted to the long-term care home on an identified date.

Resident #019 is identified on admission as having altered skin integrity, two specific areas were identified and measurements were recorded by registered nursing staff.

The clinical health record, documents that resident #019 has two areas of altered skin integrity, and notes that one area, originally, identified on admission had healed.

Review of the licensee's Wound Assessment Forms for resident #019 from a period for approximately six months indicates that identified assessments were documented on identified dates during this period.

Review of the treatment administration records (TAR) for a three month period identifies that weekly assessment are to be completed on Friday. Documentation indicates that

during this review, there were six dates where registered nursing staff did no complete skin and wound assessments.

During an interview RPN #109 indicated that the wound assessment form is to be completed weekly for any identified skin impairment. RPN #109 indicated that resident #019 had identified been identified as having altered skin integrity. RPN indicated that skin and wound assessments are not always completed weekly. RPN indicated that staff get busy and often only sign the treatment sheet or write a progress note about the identified issue and do not complete the skin and wound assessment.

The DOC indicated it is the expectation that registered nursing staff will complete the skin and wound assessment form weekly as indicated in the skin and wound care policy. The DOC indicated that the eTAR should alert the nurse that a weekly assessment is required. The weekly assessment is completed on the paper form and would include a measurement of the wound, location, type, stage, a description, and any drainage. The DOC indicated that he/she reminds staff this documentation is required and she/he is aware that it is not always done.

The licensee has failed to ensure that resident #019 who is exhibiting altered skin integrity has been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

4. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff.

A progress note indicated that Resident #006 was discovered on an identified date sitting on the floor of his/her room. As a result of the un-witnessed fall resident #006 sustained injury to an identified area. The progress notes indicated that RN #121 assessed the injury, applied a dressing and initiated treatment.

Progress notes were documented following the incident registered staff (RPN #109, RN #100, and #114) changed the dressing five days post incident, and then on two other documented dates. There is no written assessment of the altered skin integrity. On an identified date (fifteen days post incident), a progress note written by RN #106 indicates that identified skin issue had healed and the treatment was no longer required.

Review of the skin and wound assessment's for resident #006 indicated that there is no

record of a Skin and Wound Assessment being completed weekly for resident #006, specific to the above identified skin issue.

During separate interviews RPN #109 and RN#106 indicated that the identified skin issue (for resident #006) are not documented on the Wound Assessment Form, and such is usually only documented in the progress notes when they occur and they should be documented on weekly if they are still present after a week. RPN#109 indicated that he/she often leaves a treatment on the eMAR for a few weeks after the identified issue is healed just so it reminds him/her to look at it. RPN #109 indicated that he/she documents treatments for the identified issue in Point Click Care (PCC) but will not include a complete assessment of the wound that includes measurements, discharge, colour, location, the note usually just indicates that the dressing (treatment) was changed. RPN #109 indicated that because the identified skin issue usually heals fast, he/she just documents in the progress notes when the treatment was completed.

The DOC indicated that the above identified skin issue are not documented on the Wound Assessment Form, the form is used for wounds such as pressure ulcers, and surgical wounds. The DOC indicated that the Wound Assessment Form does identify the particular skin issue as a wound type to be documented on by using the form however, the form is not used for this purpose. The DOC indicated that there is no clinically appropriate assessment tool, specifically designed for skin and wound assessment that is used to assess resident #006's identified skin issue. The DOC indicated that all wounds are to be assessed weekly including the type of injury resident #006 had.

The licensee failed to ensure that resident #006 received weekly skin assessments by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

5. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #008 was admitted to the long-term care home on an identified date.

Review of the progress notes from an identified date to present identifies that resident was admitted with altered skin integrity to an identified area. The area began to worsen following admission, and resident developed a second area of impaired skin integrity, on an identified date.

Review of the clinical health records, for resident #008, during an identified period fails to provide support the weekly skin and wound assessments were completed.

Registered Practical Nurse (RPN) #109 indicated that the wound assessment form is to be completed weekly for identified skin and wound issues. RPN #109 indicated that for resident #008 this assessment form was only completed twice during the time that the identified skin issue was present for an identified area, during a three month period. RPN #109 indicated that staff get busy and often only sign off on the treatment record or write a progress note about the skin and wound issue, and do not complete the actual wound assessment.

The DOC indicated it is the expectation that registered nursing staff will complete the skin and wound assessment form when altered skin integrity is initially discovered and then weekly as indicated in the policy. The DOC indicated that the eTAR should alert the nurse that a weekly assessment is required. The weekly assessment would include a measurement of the wound, location, type, stage, a description, and any drainage. The DOC indicated that she reminds staff this documentation is required and he/she is aware that it is not always done.

The licensee failed to ensure that resident #008 who had altered skin integrity receives a weekly assessment by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment; and ensuring that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle is reviewed by the Resident's Council.

During an interview with the President of the Resident's Council, the president indicated that the home's menus were not reviewed by the Council's members. The home's management team had directed the residents to discuss any food concerns, including the review of the menu cycles, at the food committee that is run by the Activity Aide (AA) #129 on a monthly basis.

Review of the Food Committee minutes from September 2017, by Inspector #461 indicated that the Fall and Winter Menu was reviewed and approved by the residents attending the Food Committee. The results of this discussion was not communicated back to the Resident's Council meeting that occurred in October 2017. Inspector #461 also noted that residents who participated in the Resident's Council meetings did not consistently attend the Food Committee meetings.

During an interview with the AA #129, the AA indicated that the menu cycles were not reviewed by the Resident's Council, the menus were reviewed at the Food Committee instead. The AA #129 considered that most residents participating in the Food Committee were also members of the Resident's Council, therefore the AA #129 considered the menu was approved. The AA further indicated the president of the Resident's Council rarely participated in the Food Committee meetings.

The Administrator indicated to Inspector #461 that the menu cycles were reviewed by the food committee, and not by the Resident's Council.

The licensee failed to ensure that the Fall and Winter Menu Cycle was reviewed by the Resident's Council. [s. 71. (1) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, to ensure that the menu cycle is reviewed by the Resident's Council, to be implemented voluntarily.

WN #17: 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: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are monitored during meals.

Registered Nurse (RN) #106 indicated to Inspector #461 that there were ten residents receiving tray service for an identified meal. It was established that the trays were distributed between the North and the South Wings where two PSWs delivered and assisted residents with during meal time. PSW #107 indicated to Inspector #461 that monitoring of the residents on tray service consisted of going back and forth into residents' rooms, it was not possible to monitor all the residents at the same time.

On an identified date, during an identified meal service, Inspector #461 observed a PSW setting up a tray for resident #009 and left the room. Inspector #461 stayed in the room and observed that resident #009 was feeding him/herself, resident #009 presented with intermittent coughing throughout the meal, but was able to clear out his/her own throat.

At an identified time, the PSW had not yet come back to resident's room to check on him/her. It was noted that there was no monitoring for resident #009 during the identified meal for approximately 25 minutes.

Review of resident #009's health record revealed that resident was a high nutritional risk due to poor intake and swallowing problems. Staff were directed to provide encouragement and light physical touch during meals, which was not observed being done for resident #009 on the identified date.

During a subsequent date and during an identified meal, Inspector #461 observed that PSW #111 was responsible for monitoring the residents receiving tray service on the South Wing. PSW #111 set up a tray for resident #042 in his/her bed and left the room. Review of resident #042's health records revealed that he/she was a high nutritional risk due to an identified risk,and had impaired eating ability related to chewing difficulties. Staff were directed to provide encouragement to resident with light physical touch, which was not observed being done during this meal for approximately 15 minutes.

PSW #111 indicated to Inspector #461 that resident #042 has been identified to have an identified risk, and would require more frequent monitoring, but it was not possible as PSW #111 needed to monitor other residents receiving tray service.

On the same day, PSW #125 was responsible for monitoring the residents receiving tray service on the North Wing. PSW #125 indicated to Inspector #461 that residents #044 and #046 were eating lunch in their room without monitoring because they were able to feed themselves and did not need constant monitoring. For approximately 15 minutes, Inspector #461 observed that resident #046 had the tray set up in front of him/her, but he/she did not attempt to feed him/herself.

Review of resident #046's health record review revealed that resident was a high nutritional risk due to cognitive deficit, had a history of chewing and swallowing difficulty, and visual impairment. The written plan of care indicated that resident #046 was to receive tray service at an identified meal (except on bath days) and another meal as per resident's preference. Staff were directed to provide extensive assistance, in which staff fed part of the meal and resident helped. Inspector #461 observed that resident #046 did not receive the assistance outlined in the plan of care during this meal for approximately 15 minutes.

The licensee's policy, 'Mealtime Room Service' was reviewed. The policy directs the

Registered Nursing Staff to determine the need for tray service for a resident. Registered staff are to ensure that residents requiring tray service do not receive their meals until someone is available to provide the assistance they need.

The Director of Care (DOC) indicated to Inspector #461 that the nursing staff were expected to encourage all residents to come to the dining room. Tray service was only offered to residents who were ill or chose to stay in bed for meals. For the tray service, two or three staff members are assigned depending on the number of trays being served. The DOC confirmed that the monitoring system for residents at high risk of choking during meal times needs to be reviewed with the interdisciplinary team.

The licensee failed to ensure that the home has a dining and snack service that includes monitoring of all residents during meals, specifically for resident #009, #042 and #046. [s. 73. (1) 4.]

2. The licensee failed to ensure that foods and fluids being served at a temperature that is both safe and palatable for residents.

On October 11, 2017, residents #007 and #019 reported to Inspector #461 that the food in the home was frequently served cold. On October 16, 2017, resident #042 indicated to Inspector #461 in his/her room that he/she did not like the taste of the food brought to his/her room, and the food was often served cold.

Resident #007 indicated that as President of the Resident’s Council, he/she received complaints from residents outside the Resident's Council meetings about the food being served cold. Resident #007 confirmed the complaints were not logged in the Resident’s Council meeting minutes because the residents felt their complaints about food were not being taken seriously.

During an interview with Dietary Aide (DA) #104, the DA indicated that the meal temperatures are taken in the kitchen before serving the meals in the dining room and preparing the trays. PSWs were expected to check the temperatures of one tray meal per diet type (i.e. pureed, minced, regular), including the soup, prior to serving the meals to the residents in their room.

Inspector #461 reviewed the "Room Service Food Temperatures Audits", which were used by the PSWs to record the trays temperatures prior to serving the meal. The audit directed staff that foods and beverages were to be served at a temperature that was both

safe and palatable to the residents.

Recommended Serving Temperatures (Celsius degrees (C) and Fahrenheit degrees (F)):

Soups, Hot beverages (82 – 88 C or 170 – 190 F)
Cream soup, sauces, casseroles (65 – 75 C or 149 – 167 F)
Meat (60 – 71 C or 140 – 160 F)
Potatoes/vegetables (60 – 65 C or 140 – 149 F)
Chilled food and beverages (4 – 12 C or 39 – 54 F)
- If hot food temperature is too hot: allow to sit for five minutes, retake temperature until within serving guidelines
- If hot food temperature is too cold: return to dietary for reheating

Review of the "Room Service Food Temperatures Audits" for a period of approximately one month, indicated that during eight days during this review period, the temperatures for the main entrée and alternate entrée ranged from 50 – 63 C, which was below the recommended temperature range for this item (65 – 75 C). The audit did not contain details on the type of meal (i.e. hot or cold) as well as corrective actions taken when a temperature was below the recommended safe temperature ranges.

Inspector #461 reviewed the home's Recommended Serving Temperatures Policy, which had an unidentified approval and revision date. The policy listed the recommended serving temperatures for meals in the kitchen, but did not provide direction to the staff on how to take action when a temperature was found to be outside the recommended safe temperature ranges during tray service.

On October 16, 2017, during separate interviews with Dietary Aide (DA) #104, DA #154, and Food Service Supervisor (FSS) by Inspector #461, DA #154 indicated that there were normally 10-11 trays prepared for breakfast, 13 to 14 trays set up for lunch and dinner. DA #154 indicated that setting up that many trays could affect the meals temperatures by the time the food was delivered to the residents in their room. DA #154 further indicated the food had rarely come back to the kitchen to be reheated. Dietary Aide #154 indicated that had seen the nursing staff bringing back food to be reheated perhaps two or three times a week.

The FSS indicated to Inspector #461 that the cook was responsible for taking the temperatures in the kitchen before serving the residents in the dining room and residents

with trays. Once the trays were prepared in the kitchen, a PSW picked the tray cart, took temperatures, and delivered the trays to the residents' room. The PSW was responsible of taking the temperature of a regular meal, a minced meal, and a pureed meal. If the temperatures were below the recommended serving temperatures outlined in the temperature audit form, the PSW had to return the meal item to the kitchen to be reheated. The FSS confirmed that the temperatures were not maintained within a safe range before serving the meals receiving trays and audits of the temperature forms should be completed.

On October 17, 2017, during an interview with PSW #102, PSW #102 indicated that PSWs were responsible of taking the temperatures of the trays prior to serving the residents in their rooms. PSW #102 indicated that had only brought meals back to the kitchen to be reheated when the temperature was really low. For instance, the soup was supposed to be around 80 C, PSW only returned the soup to the kitchen when the temperature was 60 C or less.

On October 19, 2017, the RD indicated to Inspector #461 that had seen the staff taking temperatures of the trays, but RD had not looked into the temperature audits.

The licensee failed to ensure that the home has a dining and snack service that includes food and fluids being served at temperature that is palatable for residents, particularly the residents receiving a tray service. [s. 73. (1) 6.]

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 there is a process in place and monitored, ensuring that residents are monitored during meals; and that foods and fluids being served at a temperature that is both safe and palatable for residents, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that screening measures shall include criminal reference checks, unless the person screened is under 18 years of age.

Under LTCHA, 2007, s. 75 (1) - Every licensee of a long-term care home shall ensure that screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteer.

Related to Intake #005826-17:

The Director of Care indicated, to Inspector #554, that his/her role includes hiring of Personal Support Workers (PSW), Registered Practical Nurses (RPN) and Registered Nurses (RN).

The Director of Care indicated that he/she hires basically all applicants interviewed. The Director of Care indicated that those hired are given a letter following their interview, and that the letter identifies, that employment has being offered, the role the individual is being hired into, and requests that the identified individual obtain a Criminal Reference Check with Vulnerable Sector Screen. The Director of Care indicated 'it is ideal if a criminal reference check is provided at the time of hire', but indicated 'we hire, and start the staff, in their hired roles, without it, and hope that the personnel hired gets the criminal reference check within a couple of weeks of starting their employment'.

The Nursing Clerk provided, an inclusive list, of names and start dates of personnel hired, by the Director of Care within the last six months. The Director of Care reviewed the list, of personnel hired, confirmed start dates and indicated if a Criminal Reference Check was on file for each hired staff and the associated date of the document.

Staff #153, #154, and #155 had been hired, to work as a Personal Support Worker during an identified period, and all were hired and began their roles, without a Criminal Reference Check. Staff #153 and #154 worked during a period of two to three months without providing the licensee with a Criminal Reference Check.

The Director of Care indicated that the Administrator, as well as the Licensee are aware that staff have been hired and have begun their roles and responsibilities without having a Criminal Reference Check.

The list of hired personnel, provided to Inspector #554, by the Nursing Clerk, further identified that Staff #134 was also hired during the past six months, this staff is not part of the nursing deployment, but works for the licensee in the dietary department.

The Administrator indicated, to Inspector #554, 'that in an ideal world, criminal reference checks are to reviewed and placed in the staff's personnel file prior to hiring', but further indicated, that he/she was aware that staff were being hired, and did start their role and responsibilities without having a Criminal Reference Check.

The Licensee indicated to Inspector #554 being aware that staff had being hired and started their role and responsibilities without a Criminal Reference Check.

The Food Service Supervisor, the Director of Care, the Administrator and the Licensee all indicated awareness that screening measures are to be conducted in accordance with the regulations before hiring staff and accepting volunteer, specifically as such related to Criminal Reference Check.

The Licensee failed to ensure that screening measures, are conducted in accordance with the regulations, before hiring staff, specifically Criminal Reference Checks. [s. 75. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that screening measures shall include criminal reference checks, unless the person screened is under 18 years of age, to be implemented voluntarily.

WN #19: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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).

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, related to the use of an identified medication.

Resident #021 was admitted to the long-term care home on an identified date.

Review of the progress notes, for a period of one month, indicated that on an identified date Registered Nurse (RN) #117 documented resident #021's vitals, an assessment and positioning; resident #021 was started on an identified treatment. The physician was contacted and orders were received. Resident #021 was transferred to the hospital and admitted for treatment. Six days later, resident #021 was readmitted to the home. Registered Practical Nurse (RPN) #118 received report from the hospital regarding resident #021's condition, and was informed that resident had no orders for an identified treatment.

Upon readmission, to the long-term care home, resident's vitals were assessed, and assessment was completed and documented by RPN #119. Resident #021 was

administered an identified treatment. Documentation on readmission and for seven days later indicates that resident #021 received the identified treatment; after the seventh day, there is no mention that resident #021 was receiving the identified treatment, nor was there any assessments indicating resident #021 no longer required the treatment.

A review of the clinical health record fails to provide support that the identified treatment was ordered by a physician. The health record further fails to provide documentation that an assessment was completed, for resident #021, by the service provider.

During an interview, RN #106 indicated that when a resident requires the use of the identified treatment, there is a standing order for use of a medical directive that the RN or RPN can initiate in an emergency to administer the identified treatment as an identified rate. The person who initiates the treatment should do an assessment, write an order for the treatment and place a note on the doctor's board for the next time that they are in so they can order the treatment. RN #106 indicated that treatment should be put on the eMAR and signed for. The night shift RN will usually complete, assess and document this in a progress note for the residents who receives the identified treatment as a way to monitor the use.

The Director of Care indicated that there is a policy for the identified treatment. The policy indicates that if a resident's is assessed by registered nursing staff, and is assessed as needing an identified treatment, then the treatment may be administered at an identified rate without an order. The order for the treatment is to be obtained from the physician at the earliest convenience. The DOC indicated that "earliest convenience" should be interpreted as the next time the doctor is in the building, an order should be obtained. The DOC indicated that treatment is considered a medication but it is not tracked or monitored in the eMAR or eTAR for any residents.

Resident #021 was administered an identified treatment during an identified seven day period, without a Physicians order. [s. 131. (1)]

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

Review of the licensee's medication incident reports for a three month period in 2017, identified that resident's #049, #42, #036, #041, #019, #004, #026, #024, and #056 did not receive their medication as prescribed by the physician.

The medication incidents, related to the nine identified residents, documented that drugs were not administered by registered nursing staff, on identified dates as prescribed by their physician.

The nine identified residents had no ill effect as a result of the medication incidents.

Drugs were not administered to residents #049, #42, #036, #041, #019, #004, #026, #024, and #056 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

3. The licensee failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

Related to Resident #036:

Resident #036 is cognitively well.

Resident #036 indicated, to the Inspector, that Personal Support Worker (PSW) #128 had administer medications to him/her, when RN #117 was working. Resident #036 could not provide exact dates of when PSW #128 administered his/her medications, but indicated medications were administered to him/her by PSW #128 during an approximate period of one month.

The clinical health record, for resident #036, was reviewed, for an identified two month period. Physician's orders, and the electronic medication administration record provide support that resident #036 received medications during the an identified shift, and routinely at an identified hour.

Registered Nurse (RN) #117 indicated that PSW #128 did administer medications to resident #036 on occasions. RN #117 indicated that the Director of Care had approved that medications, prescribed for resident #036, could be given to PSW #128 to administer to resident #036.

The nursing schedule, for the period identified, was provided to Inspector #554. The schedule provides documentation that Personal Support Worker #128 and Registered Nurse #117 worked together during this period on twelve separate dates.

The Director of Care indicated, to Inspector #554, that he/she had approved Registered Nurse #117 give medications to Personal Support Worker #128 for administer to resident #036. The Director of Care indicated 'PSW #128 is a senior staff, and was instructed to only administer the medications to resident #036'.

Registered Nurse #117, and the Director of Care, both indicated being aware that only physicians, a dentist or registered nursing staff could administer medications in long-term care homes.

The licensee failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. [s. 131. (3)]

4. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Related to Intake #020103-17:

Resident #036 was admitted to the long-term care home on an identified date.

A review of the physician orders for resident #036 indicated that a prescription for the use of an identified drug was discontinued on an identified date.

During an interview resident #036 indicated that he/she uses the identified drug for an identified diagnosis.

During an interview RN #106 indicated that resident #036 uses the identified drug. RN #106 indicated that resident #036 does not have a physician’s order for the identified drug.

The DOC indicated that resident #036 does not have a physician’s order for the use of the identified medication.

The licensee has failed to ensure that no drug is used or administered to a resident in the home unless the drug has been prescribed for the resident specifically for resident #036. [s. 131. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance To ensure there is a process in place and monitored, ensuring that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident; to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber; ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse; and to ensure that no resident administers a drug to himself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM (substitute decision maker), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the

pharmacy service provider.

The licensee's medication incident reports, were reviewed, for an identified three month period in 2017, there were nine medication incidents during this period. Medications incident reports identified resident's #042, #036, #041, #019, #004, #026, #024, and #056 as being involved in the incidents.

Inspector #623 reviewed the nine medication incidents, which involved resident's #042, #036, #041, #019, #004, #026, #024, and #056. There was no documentation to support that registered nursing staff took immediate action when the medication incidents were discovered, and/or that the identified residents were monitored. There is no documentation to indicate that the physician or resident's SDM were notified in identified medication incidents.

During an interview, RN #106 indicated that when a medication incident is discovered nursing staff use the online medication incident reporting system. RN indicated that depending on the medication that was involved, he/she may or may not complete an assessment of the resident. The RN indicated that this assessment would not be documented in the progress notes. RN #106 indicated that he/she would not always be aware that a medication incident has occurred because it is not documented in the progress notes, staff would rely on this information being passed on from shift to shift. RN #106 indicated that he/she has received training from the contracted pharmacy service provider related to medication administration.

During an interview, the Director of Care (DOC) indicated that it is the expectation that registered nursing staff will report a medication incident when they discover it, and that this will be done by using the Medication Incident Reporting system online through the pharmacy service provider. The DOC indicated that this report is not part of the clinical records for each resident. The DOC indicated that registered nursing staff do not usually document medication incidents in the clinical records for the resident. The DOC indicated that the physician is usually notified when an incident occurs, but the SDM is not always notified. This information would be documented within the Medication Incident Reporting system online and not in the resident's individual clinical records. The DOC indicated that all registered nursing staff receive education on the contracted pharmacies medication policies upon hire and as needed.

Medication incidents involving residents #042, #036, #041, #019, #004, #026, #024, and #056, were not documented, together with a record of the immediate actions taken to

assess and maintain the resident's health and were not reported to the SDM or physician. [s. 135 (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that every medication incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM (substitute decision maker), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

The licensee failed to ensure that all staff had received annual retraining, specifically, the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and whistle-blowing protections.

Related to Intake #005826-17:

The Director of Care indicated, to Inspector #554, that all staff are provided annual retraining related to, the Residents' Bill of Rights, the licensee's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and whistle-blowing protections. The Director of Care provided Inspector #554 with the 2016 retraining statistics, which included staff names, and dates of the identified annual retraining.

Documentation, of the 2016 retraining statistics, provided, to Inspector #554 by the Director of Care, failed to support that all staff had received annual retraining. Retraining statistics, provided, identified that Registered Practical Nurse #137 and #138, as well as the Maintenance Worker had not received retraining in 2016.

The Director of Care (DOC) and the Administrator confirmed that the identified staff had not received retraining in 2016.

The Administrator indicated that it is an expectation that all staff complete the required annual retraining, and further indicated that all department managers and or supervisors are responsible to ensure that their departmental staff have completed it. [s. 76 (4)]

Issued on this 6th day of February, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY BURNS (554), CRISTINA MONTOYA (461), JENNIFER BATTEN (672), SARAH GILLIS (623)
Inspection No. / No de l'inspection :	2017_673554_0023
Log No. / No de registre :	014854-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 5, 2017
Licensee / Titulaire de permis :	MEDLAW CORPORATION LIMITED 42 Elgin Street, Thornhill, ON, L3T-1W4
LTC Home / Foyer de SLD :	PINECREST NURSING HOME (2731) 3418 County Road 36, R.R. #2, BOBCAYGEON, ON, K0M-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mary Carr

To MEDLAW CORPORATION 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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

The licensee shall do the following:

Issue #1 - Water Infiltration or Leaking:

- Develop and implement a systematic maintenance procedure that will ensure that any indications of water infiltration or leaking are detected, immediately assessed, and rectified without delay in order to prevent or mitigate microbial growth, and to ensure residents safety. The procedure shall include the processes to be followed should there be any visual evidence of microbial growth as a result of the infiltration or leaking. The procedure shall be detailed in writing.
- Specifically, related to the water damaged ceiling in the tub-shower room, the licensee will ensure that the wall(s) beneath the area are subject to further invasive investigation, by an organization with experience in microbial growth abatement, in order to determine if there has been water damage. The licensee shall ensure that a document is produced by the organization that does the work, that describes the invasive investigation and the results.
- Should evidence be found of microbial growth, abatement should be done in accordance with evidence-based practices, by an organization with experience in abatement. The licensee shall ensure that a document is produced, by the organization that does the abatement, which describes the abatement procedure and references the evidenced based practice(s) that guided the work.

Issue #2 - Non-Operational Exhaust Fans:

- Develop and implement a systematic maintenance procedure that will ensure that any indications that the exhaust fans are not operational, or any other aspect of the HVAC system is non-operational are detected, immediately assessed, and rectified without delay in order to prevent or mitigate risk associated with the heating, ventilation and air conditioning units, and to ensure residents safety. The procedure shall include the processes to be followed should exhaust fans or associated HVAC be determined non-operational, and who is to be contacted e.g. certified individual to rectify the situation. The procedure shall be detailed in writing.

Issue #3 - Other Maintenance Issues:

- Develop and implement a systematic maintenance procedure that will ensure that the home, furnishings, windows, and equipment are maintained in a safe condition, and in a good state of repair. The procedure shall include routine inspections of the home, furnishings, windows, and equipment, and what action is to be done and by whom. Should the home, furnishings, windows or equipment be assessed and or identified as needing repair or replacement, there should be a process in place to immediately address concerns, and rectify such without delay. The procedure shall be detailed in writing.

Grounds / Motifs :

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

Related to Intake #005826-17:

During the initial tour of the long-term care home, Inspector #554 observed the following:

- Tub-Shower Room – The ceiling area in the room was observed to have discolouration on two of its ceiling tiles. A third ceiling tile, adjacent to the discoloured ceiling tiles, was observed wet. The discoloured ceiling tiles were indicative of microbial growth.
- The shower stall, also located in the tub-shower room, was observed to have areas of discolouration along the ceramic tile walls, and flooring of the shower stall.

- Ceramic Wall Tile, in the tub-shower room, was observed to have discolouration, along the edging of one of the wall tiles.
- Ceiling Tiles were observed to be missing in an area within the service hallway; pipes in the same area were visible.

There was noticeable 'stale' odour in the tub-shower room.

Personal Support Worker #111, and #113 indicated, to Inspector #554, that there has been issues with pipes leaking in the tub-shower room, and indicated that the room also is known to have a 'strange odour'. Personal Support Worker #111 and #113 indicated that the Maintenance Worker, and management, specifically the Director of Care are aware of the pipes leaking, and the odour in the tub-shower room.

The affected ceiling area, described above, was brought to the attention of the Director of Care (DOC), by Inspector #554. The Director of Care indicated that the discoloured ceiling tiles were caused by a roof leak, approximately a year ago, and indicated it was his/her belief that the leak had been repaired. The DOC indicated being uncertain as to why the ceiling tiles were still discoloured, and directed Inspector #554 to speak with the Maintenance Worker or the Administrator. The DOC indicated that staff had complained about odours in the tub room, and that one particular staff had voiced concern about another identified issue in the tub-shower room. The Director indicated that he/she had placed a request in the Maintenance Request binder for the Maintenance Worker to follow up, with the staff's concern. The Director of Care indicated that a dehumidifier and a fan had been placed into the tub-shower room to help with air circulation, in hopes such would help with odours in the tub-shower room.

The Maintenance Request binder was reviewed, by Inspector #554, with the following documented:
- On an identified date – there were two separate entries, written by the Director of Care, which indicated that an identified observation by staff had been brought to his/her attention. The identified issue, of the concern, relates to the tub-shower room.

The Maintenance Worker indicated, to Inspector #554, being unaware of the discoloured ceiling tiles in the tub-shower room, but indicated being aware that the pipes in the ceiling, of the room, had been leaking on and off. The Maintenance Worker indicated that the leaking pipe was from a drainage pipe on

the roof. The Maintenance Worker indicated that he/she did not routinely check the pipes in the tub-shower room for leaks, and indicated he/she relies on staff to advise him/her if the pipe (in the tub-shower room) is leaking; Maintenance Worker was unable to recall the last date he/she had checked the pipes in the identified room, for leaks.

The Maintenance Worker indicated that the Licensee was aware of the drainage pipe leaking, into the ceiling, above the tub-shower room. The Maintenance Manager indicated that there is second leak in the ceiling above the service hallway, indicating that the leak is also from a draining pipe, but not the same pipe as the one leaking into the tub-shower room. The Maintenance Worker indicated that he/she was not aware of any plans in place to fix the leaking drainage pipes and directed the Inspector to speak with the Licensee. The Maintenance Worker indicated he/she was unsure if the Administrator was aware of the leaking pipes, as he/she reports directly to the Licensee for issues related to maintenance.

The Administrator indicated, to Inspector #554, being unaware that the drainage pipe in the ceiling above the tub-shower room leaked, and further indicated being unaware of any other leaks in the long-term care home. The Administrator indicated that he/she was not aware that there were discoloured ceiling tiles in the tub-shower room.

The Licensee indicated, to Inspector #554, that he/she was not aware of any issues in the tub-shower room, specifically leaking pipes and or discoloured ceiling tiles.

The licensee failed to ensure that the home, furnishings, and equipment are maintained in a safe condition and in a good state of repair, specifically as such relates to the tub-shower room.

2) On an identified date, Inspector #554 observed that three (of the five) exhaust fans in the tub-shower room were non-operational. The following day, Inspector #554, met with the Maintenance Worker, and the Licensee regarding the observed exhaust fans, in the tub-shower room. The Maintenance Worker indicated initially that all exhaust fans were 'in a good state of repair and that all were working', and indicated he/she was unsure as to why three of the five exhaust fans were not operational during observations by the Inspector. During a subsequent interview, with the Maintenance Worker, it was determined that

the three exhaust fans, observed non-operational, had been blocked off by the Maintenance Worker. The Maintenance Worker indicated that it was his/her belief that the tub-shower room did not need all five exhaust fans circulating. The Maintenance Worker indicated having no qualifications specific to the HVAC system.

The Administrator, and the Licensee indicated being unaware that the Maintenance Worker had blocked off sections of the exhaust fans.

The licensee failed to ensure that the home, furnishings, and equipment are maintained in a safe condition and in a good state of repair, specifically, non-operating exhaust fans, in the tub-shower room.

3) Subsequent Observations were as follows:

- Ceiling Tiles – observed to have discolouration in the staff lounge-locker room, and in an identified resident room.
- Windows – windows in four identified resident rooms, were observed open, the windows would not close. Inspector #554 observed the resident rooms to be cool. Paint on wooden window encasement (frames) in nine resident rooms were observed to be cracked and/or chipped.
- Counter-Top Vanity – one resident washroom was observed to have corrosion on the metal frame supporting the vanity; the corrosion ran the entire length of the metal frame.
- Clothing Wardrobe – laminate, on the wardrobe, was observed chipped, and or non-existent in two identified resident rooms.

Personal Support Workers #111, Registered Practical Nurse #109 and Housekeeping Aid #127, all indicated, to Inspector #554, that issues needing repair are placed into the Maintenance Request binder, for follow up by the maintenance worker.

Housekeeping Aid #127 indicated, to Inspector #554, that there has been ongoing issues with windows in the home not closing from the inside, and indicated that often staff have to go outside to close the resident windows.

The Maintenance Request binder was reviewed, by Inspector #554, for the period of approximately two months. The above identified areas needing repair were not indicated in the maintenance request binder.

The Maintenance Worker, and the Administrator indicated, to Inspector #554, that they were unaware of the identified issues. The Maintenance Worker indicated he/she relies on staff to place concerns into the maintenance request binder so that he/she can fix items needing repair.

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

The licensee has a history on non-compliance with LTCHA, s. 15 (2) (c). As a result of the 2015 Resident Quality Inspection conducted August 2015, a written notification (WN) was issued with the additional required action of a voluntary plan of correction (VPC). The scope of the non-compliance would be considered 'widespread', although isolated to the tub-shower room, which the long-term care home has only one of, is utilized by all sixty-five residents residing in the home. The non-compliance presents a potential risk to residents, as water damage building materials may support microbial growth, and non-operational ceiling exhaust fans may support poor ventilation, and additionally odours within the identified area (tub-shower room). In light of these three factors, a compliance order will be served to the licensee. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 47. (1) Every licensee of a long-term care home shall ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 399/15, s. 1.

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 47.

The licensee's plan shall include:

- Review personnel files, ensuring that all personnel hired on or after January 01, 2016, as a Personal Support Worker, or to provide personal support services, regardless of title, has successfully completed a Personal Support Worker Program, and has provided the licensee with proof of graduation issued by the education provider; and/or has met the requirements listed in subsection (2) and (3).
- Develop and implement a plan to closely supervise and monitor any 'current' staff, hired after January 01, 2016, that have been identified, by the licensee, as working a Personal Support Worker, or providing personal support services without the requirements identified in subsection (1), (2), and (3). This supervision and monitoring, by the licensee or designated, is to continue until such time that the identified staff have successfully completed the required education/training. The monitoring and supervision must be documented, including dates, persons involved, and description of what was entailed in the monitoring/supervision of the Personal Support Worker(s).
- Refrain from employing a person hired by the licensee as a Personal Support Worker, or to provide personal support service, unless and until the identified person has successfully completed a Personal Support Worker Program, and/or has met the requirements in
O. Reg. 79/10, s. 47(1), as well as the requirements listed in subsection (2) and (3).

The plan shall identify who will be responsible for each items and expected completion dates.

The plan must be submitted in writing to the Attention of: Kelly Burns, LTC Homes Inspector-Nursing, and faxed to (613) 569-9670, on or before December 12, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that all personnel hired on or after January 01, 2016, as a Personal Support Worker, or to provide personal support services, regardless of title, has successfully completed a Personal Support Worker Program that meets the requirements listed below and has provided the

licensee with proof of graduation issued by the education provider.

Under O. Reg. 79/10, s. 47 (2) - The personal support worker program, (a) must meet, (i) the Personal Support Worker Program Standard published by the Ministry of Training, Colleges and Universities dated July 2014, or (ii) the Personal Support Worker Training Standard published by the Ministry of Training, Colleges and Universities dated October 2014; and (b) must be a minimum of 600 hours in duration, counting both class time and practical experience time.

Under O. Reg. 79/10, s. 47 (3) - Despite subsection (1), a licensee may hire as a personal support worker or to provide personal support services, (a) a registered nurse or registered practical nurse, (i) who, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a personal support worker, and (ii) who has the appropriate current certificate of registration with the College of Nurses of Ontario; (b) a person who was working or employed at a long-term care home as a personal support worker at any time in the 12-month period preceding July 1, 2011, if, (i) the person was working as a personal support worker on a full-time basis for at least three years during the five years immediately before being hired, or (ii) the person was working as personal support worker on a part-time basis for the equivalent of at least three full-time years during the seven years immediately before being hired; (c) a person who is enrolled in an educational program for registered nurses or registered practical nurses and who, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a personal support worker; (d) a person who is enrolled in a program described in subsection (2) and who is completing the practical experience requirements of the program, but such a person must work under the supervision of a member of the registered nursing staff and an instructor from the program; (e) a person, (i) who has a diploma or certificate granted in another jurisdiction resulting from a program that was a minimum of 600 hours in duration, counting both class time and practical experience time, (ii) who has a set of skills that, in the reasonable opinion of the licensee, is equivalent to those that the licensee would expect of a person who has completed a program referred to in clause (2) (a), and (iii) who has provided the licensee with proof of graduation issued by the education provider; (f) a person who is enrolled in a program that is a minimum of 600 hours in duration, counting both class time and practical experience time, and meets, (i) the vocational standards established by the Ministry of Training, Colleges and Universities, (ii) the

standards established by the National Association of Career Colleges, or (iii) the standards established by the Ontario Community Support Association, but such a person must work under the supervision of a member of the registered nursing staff and an instructor from the program; or (g) a person who, by July 1, 2018, has successfully completed a personal support worker program that meets the requirements set out in clause (f), other than the requirement to work under supervision, and has provided the licensee with proof of graduation issued by the education provider.

Related to Intake #005826-17:

The Nursing Clerk provided Inspector #554 with a list, of names and start dates of nursing personnel hired, by the Director of Care, during a period of approximately three months.

The Director of Care reviewed the list, of nursing personnel hired, with Inspector #554 and provided confirmation of start dates for the identified staff. The DOC indicated that the identified staff had been hired to work in a Personal Support Worker (PSW) role.

The Director of Care indicated that PSW's #146, 147, 148, 149 and 150 started their employment on an identified date. The Director of Care was unable to provide documentation indicating that the identified PSW's had successfully completed a Personal Support Worker (PSW) Program, nor held certification as a PSW. The Director of Care indicated that the identified PSW's did they not meet the requirements identified under subsections (2) and/or (3).

The Director of Care indicated that he/she is aware of the legislation surrounding the hiring of qualified nursing personnel, specifically the qualifications of a Personal Support Worker (PSW).

The Administrator, and the Licensee, both indicated, to Inspector #554, that they were aware that the Director of Care had hired non-qualified workers, to work within a Personal Support Worker role. Both indicated that staff had been hired without the required qualifications as it is difficult to find staff qualified in rural areas.

During this inspection it was determined the that licensee failed to hire qualified staff to work as Personal Support Workers. The licensee or its designate hired

PSW #146, 147, 148, 149, and 150, indicated knowing that the identified staff did meet the qualifications under O. Reg. 79/10, s. 47 (1) and or subsections (2) and (3). All identified staff were hired after January 01, 2016. Hiring of non-qualified personnel, places residents at potential risk of harm. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 245. 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,
i. 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.
O. Reg. 79/10, s. 245.

Order / Ordre :

The licensee shall:

- Immediately stop charging residents #007, and/or the resident's Substitute Decision Makers (SDM) for the 'parking and charging' of resident #007's mobility aid, which is utilized for resident #007, based on his/her assessed need.
- Reimburse the resident and/or resident's SDM for any charges, specific to 'parking' and or 'charging' which have occurred since an identified date, to current date.

Grounds / Motifs :

1. The licensee failed to comply with O. Reg. 79/10, s. 245 (1) (ii) by charging residents for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from the Minister under section 90 of the Act.

Related to resident #007:

During an interview with resident #007, resident indicated that the licensee was charging him/her an identified sum of money per day to for an identified service. Resident #007 expressed feeling upset.

Inspector #461 reviewed the "Long-Term Care Home Unfunded Services Agreement" between the Pinecrest Nursing Home and resident #007, which showed that the resident agreed to pay an identified sum of money, and had signed the agreement on an identified date.

The Licensee confirmed to Inspector #461 that resident #007 was charged an identified sum of money per day related to an identified service. The Licensee indicated, that in the past, residents had not been charged a fee for the service.

During an interview with resident #007, resident confirmed that he/she had a meeting with the Licensee on an identified date, to review the charges. Resident #007 felt obligated to sign the agreement.

The licensee failed to provide residents goods and services that a licensee is required to provide to a resident using funding that the licensee receives from the Minister. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall ensure:

- The heating, ventilation and air conditioning (HVAC) systems are cleaned and in good state of repair, and inspected at least every six months by a certified individual, and that documentation is kept of the inspection. The inspection of the HVAC system, by a certified individual, must be completed forthwith.
- The licensee shall ensure that gas or electric fireplaces and heat generating equipment (e.g. propane dryers) other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection. The inspection of all heat generating equipment, by a qualified individual, must be completed forthwith.
- The licensee shall ensure that hot water boilers, and hot water holding tanks are serviced at least annually, and that documentation is kept of the service. The servicing of the hot water boilers and/or holding tanks must be completed forthwith.

In addition, the licensee shall:
- Develop and implement policies and procedures to ensure that all components of the HVAC system, other heat generating systems, hot water boilers and hot water holding tanks are kept in good repair and are maintained; and that the HVAC system and other heat generating systems are cleaned at a level that meets manufacturer's specifications.
- Establish a comprehensive preventative maintenance program that satisfies both manufacturer specifications and requirements for inspection and servicing of the above identified systems or equipment. The preventative maintenance program, must specify actions to be taken by outside contractors and actions to be taken by the licensee's staff, requirements for documentation. The licensee must be able to demonstrate when each system, component or equipment is inspected, what has been done as a result of the inspection and/or servicing.
- Inventory and document, all components of the HVAC system, heat generating systems and hot water boilers and/or hot water holding tanks; the documentation will include the precise location of the inventoried equipment. All inventoried equipment is to be captured on an equipment list associated with the legislated inspection and maintenance agreements.
- Implement a process to ensure that Administrator, or designate, will ensure that the preventative maintenance program, policies and procedures, specific to the HVAC, other heat generating systems and hot water boilers/tanks are in place, and followed, and that such is in keeping with the legislation.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures are developed and implanted to ensure that the heating, ventilation, and air conditioning systems (HVAC) are kept in a good state of repair, that it is inspected at least every six months by a certified individual, and that documentation is kept of the inspection.

Related to Intake #005826-17:

Pinecrest has sixty-five licensed beds. The long-term care home is heated by baseboard heaters; there are six roof top exhaust units which service the north and south halls, tub room, laundry room, staff room/housekeeping, and the kitchen; there are two roof top make-up air units that service the kitchen and corridors; and the home has approximately seven stand-alone heat-air conditioning units.

Observations, by Inspector #554:

- On an identified date - black discolouration was observed inside the tub-shower room, specifically on the ceiling above on of the two tubs, and along the flooring and walls inside the shower stall.
- On an identified date - Three of the five ceiling exhaust vents were observed to be non-functioning.

The Maintenance Worker indicated, to Inspector #554, that the ventilation system in the tub-shower room was operational, and further indicated that he/she "was unsure why three of the exhaust vents in the ceiling were not working". During a second interview, that same day, the Maintenance Worker indicated that he/she had closed three of the five ceiling exhaust vents, as it was his/her belief that the tub-shower room did not need all five operational.

The Maintenance Worker, and the Administrator, both indicated that the licensee does not have any policies specific to the HVAC system. Both indicated that the Maintenance Worker, cleans the filter on the Make-Up Air Units twice yearly, and will oil the motor of the unit as needed.

The Administrator indicated being unaware of the qualifications held by the Maintenance Worker.

The Maintenance Worker indicated that he/she does not have any certifications related to HVAC systems.

The Administrator, and the Licensee both indicated that the HVAC system had not been inspected every six months by a certified individual. The Administrator indicated being unaware of when the HVAC system was last inspected, and commented that "the Licensee looks after all service contracts" for the long-term care home, and he/she him/herself is not involved with such. (554)

2. The licensee failed to ensure that procedures are developed and implemented to ensure that the gas, electric fireplaces and other heat generating equipment (other than the home's HVAC system) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection.

The Administrator and the Licensee indicated that the long-term care home has two dryers, both operated using propane.

The Administrator indicated, to Inspector #554, that the licensee does not have maintenance specific policies, but does have procedures, and schedules for maintenance staff to follow. Copies of the procedures and/or schedules completed by the Maintenance Worker were provided to Inspector #554 for review.

The procedure/schedule titled, "Seasonal and Occasional Maintenance-Monthly" was reviewed by Inspector #554. The document identifies that during the month, of June, the dryer burners in the laundry room are to be cleaned either by maintenance or an identified contractor. The identified item (dryer burners) had been 'checked off" as completed in June of 2017. There is not documentation as to the specific date that the task was completed and/or who completed the identified task.

The Administrator indicated that the cleaning (identified above) had been completed by the Maintenance Worker.

The Administrator and the Licensee indicated, to Inspector #554, that the propane dryers had not been inspected annually by a qualified individual. The Administrator was unable to provide documentation of any inspections relating to the propane dryers. The Administrator indicated that he/she is not aware of

when the propane dryers were last inspected. (554)

3. The licensee failed to ensure that procedures are developed and implemented to ensure that hot water boilers, and hot water holding tanks are serviced at least annually, and that documentation is kept of the service.

The Administrator and the Licensee indicated that the long-term care home has a hot water holding tank which is operated using propane.

The Administrator and the Licensee indicated, to Inspector #554, that the hot water holding tank had not been serviced annually by a qualified individual. The Administrator was unable to provide documentation of any servicing related to the hot water holding tank. The Administrator was uncertain as to the last time the hot water holding tank was serviced.

The Licensee indicated, to Inspector #554, being aware of the legislation specifically required for the inspections, service and required documentation, in relation to the HVAC system, heat generating equipment, and hot water boilers/hot water holding tanks.

On October 24, 2017, the Administrator indicated, to Inspector #554, that the Licensee has signed a contract with an identified contractor, as of October 18, 2017, for the inspection of the HVAC, and servicing of the propane dryers and hot water tank, but a time for such has not yet been established.

During this inspection, it was determined that the HVAC system, other heat generating equipment, and hold water holding tanks have not been inspected or serviced as per legislative requirements. The Administrator, who oversees the operations of the long-term care home indicated being unaware of when such equipment was last inspected and or serviced. Failure to inspect or service required equipment places all residents and staff at potential risk for environmental hazards. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2018

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance to ensure that strategies are developed and implemented to respond to responsive behaviours exhibited by residents; and to ensure that actions taken to respond to the needs of residents, including assessments, reassessments, interventions and that the resident's response to the interventions are documented.

The licensee's plan shall include:

- How and when the licensee or designate, and staff will seek appropriate support if implemented strategies provided prove to be ineffective.
- Processes for monitoring that planned interventions for responding to responsive behaviours are implemented by staff and the effect of the intervention is documented.
- A process to ensure that the plan of care, for residents exhibiting responsive behaviours, is reassessed, monitored and re-evaluated when interventions and/or strategies are ineffective.
- A monitoring tool to ensure the planned, and/or revised interventions and strategies are effective in managing the responsive behaviours of resident #036, with special attention to minimizing risks associated with potential harmful interactions between resident #036 and
other residents.
- A process whereby the Director of Care and or designate are monitoring all documentation and communication from the front line staff at least daily to determine if any high risk responsive behaviours have occurred in the home, what actions have been taken by staff and if planned interventions have been effective. If planned interventions have not been effective, has the interdisciplinary team met to discuss next steps in managing identified responsive behaviours. The monitoring, by the Director of Care or designate shall continue until compliance with O. Reg. 79/10, s. 53 (4) has been achieved.

The plan shall identify who will be responsible for each items and expected completion dates.

The plan must be submitted in writing to the Attention of: Kelly Burns, LTC Homes Inspector-Nursing, and faxed to (613) 569-9670, on or before December 12, 2017.

Grounds / Motifs :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to interventions are documented.

Related to Resident #036:

Resident #036 was admitted to the long-term care home on an identified date.

Registered Practical Nurse (RPN) #109, Registered Nurse(s) (RN) #106, and #117, the Director of Care, and the Administrator, all indicated, to Inspector #554, that resident #036 is known to exhibit identified responsive behaviours. All indicated that the identified responsive behaviours are directed towards both residents and staff.
Registered Nurse #117, the Director of Care, and the Administrator indicated that resident #036, shares a room with other residents. RN #117, the Director of Care and the Administrator, all indicated that resident #036 exhibits identified responsive behaviours towards his/her roommates.

The clinical health record, specifically progress notes, for resident #036 were reviewed, by Inspector #554, for the period of approximately four months. There were approximately forty documented incidents of exhibited responsive behaviours. Documentation indicated that interventions, such as explanation of tasks being performed by staff, rationale for care of co-residents, apologies, medication reviews, and as needed medications, were of limited effect, or rarely effective, and thus the exhibited responsive behaviour continued to be exhibited by resident #036.

Resident #035 indicated, to Inspector #554, that he/she has been yelled at by resident #036.

On October 13, 2017, Inspector #554 heard a voice yelling profanities in the hallway. Inspector #554 observed RN #106 come down the hallway with a medication cart; RN #106 indicated to staff and Inspector #554 that was resident #036, was upset with him/her. RN #106 was not observed taking any action to address resident #036's behaviour. Registered Nurse #106 entered the medication room, and closed the door. Resident #036 was then observed, by Inspector #554, coming down the hallway, and entering the Director of Care's office, resident #036 continued to exhibit responsive behaviours directed at the

Director of Care. Staff and/or the Director of Care did not intervene. These incidents were observed by fifteen (approximate) residents, who were seated in the main foyer lounge.

On October 18, 2017, resident #036 was observed in the front entrance of the long-term care home, exhibiting identified responsive behaviours. Registered Nurse #106 was observed upset as resident #036 exhibited responsive behaviours directed towards him/her. Registered Nurse #106 walked away from resident #036, while resident continued to exhibit the responsive behaviour. Resident #018 and #042 were heard voicing concern to registered nursing staff about resident #036's responsive behaviours. This incident was observed by other staff, and approximately ten to fifteen residents who were in the lounge.

The Director of Care indicated that the physician, for resident #036, had in the past ordered a referral to a community resource consultant, but DOC indicated that the referral was declined, as resident #036 did not meet the required criteria for the ordered assessment. The Director of Care indicated that no other arrangements, specific to resident #036's responsive behaviours, had been made, and indicated that resident's (responsive) behaviours continue to escalate.

Registered Nurse(s) #106, and #117, the Director of Care, and the Administrator all indicated that resident #036's exhibited responsive behaviours are a challenge, and that the interventions taken by the staff are usually ineffective. All indicated that resident #036's responsive behaviours are upsetting to residents living in the home, especially those residing with him/her in the shared room, and are disruptive to the care being provided to others. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2018

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10,
78. (1) Every licensee of a long-term care home shall ensure that food service workers hired on or after July 1, 2010, other than cooks to whom section 76 applies,
(a) have successfully completed or are enrolled in a Food Service Worker program at a college established under the Ontario Colleges of Applied Arts and Technology Act, 2002 or a Food Service Worker program provided by a registered private career college and approved by the Superintendent of Private Career Colleges under the Private Career Colleges Act, 2005;
(b) have successfully completed an apprenticeship program in the trade of Cook, Institutional Cook or Assistant Cook under the Apprenticeship and Certification Act, 1998 or the Ontario College of Trades and Apprenticeship Act, 2009; or
(c) have entered into a registered training agreement in the trade of Cook, Institutional Cook or Assistant Cook under the Apprenticeship and Certification Act, 1998 or the Ontario College of Trades and Apprenticeship Act, 2009.

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 47.

The licensee's plan shall include:

- Review personnel files, ensuring that all personnel hired on or after July 01, 2010, as a Food Service Worker, other than cooks, have successfully completed or are enrolled in a Food Service Worker program.
- Develop and implement a plan to closely supervise and monitor any 'current' staff, hired after July 01, 2010, that have been identified, by the licensee, as working as a Food Service Worker. This supervision and monitoring, by the licensee or designated, is to continue until such time that the identified staff have successfully completed the required education/training. The monitoring and supervision must be documented, including dates, persons involved, and description of what was entailed in the monitoring/supervision of the Food Service Worker(s).
- Refrain from employing a person hired by the licensee as a Food Service Worker, unless and until the identified person has successfully completed a Food Service Worker Program, and/or has met the requirements in O. Reg. 79/10, s. 78.

The plan shall identify who will be responsible for each items and expected completion dates.

The plan must be submitted in writing to the Attention of: Kelly Burns, LTC Homes Inspector-Nursing, and faxed to (613) 569-9670, on or before December 12, 2017.

Grounds / Motifs :

1. The licensee failed to ensure that Food Service Workers hired, on or after July 01, 2010, had successfully completed or were enrolled in a Food Service Worker Program, had successfully completed an apprenticeship program in the trade as a Cook, and or had entered into a registered training agreement in the trade as a Cook.

Related to Intake #005826-17:

Dietary Aid #134 began his/her employment at the long-term care home on an identified date, in 2017.

The Administrator indicated, to Inspector #554, that the personnel file, for Dietary Aid #134, does not contain documentation that the Dietary Aid holds certification as a Food Service Worker, nor is there documentation to support that Dietary Aid #134 is enrolled in any associated program. The Administrator referred Inspector #554 to the Food Service Supervisor who hired Dietary Aid #134.

Food Service Supervisor indicated, to Inspector #554, that he/she hired Dietary Aid #134. The Food Service Supervisor indicated that Dietary Aid #134 did not have a Food Service Worker Certificate upon hire, nor was he/she enrolled in a program as indicated by the legislation.

The Food Service Supervisor, and the Administrator, both indicated being aware of the legislation, specifically related to hiring of Food Service Workers on or after July 01, 2010, and the required qualifications for employment.

At the time of this inspection, Food Service Supervisor provided, Inspector #554 with documentation that indicates that Dietary Aid #134 has enrolled in the Food Service Worker Program as of October 17, 2017, but has not yet started the program.

During this inspection it was determined the that licensee failed to hire qualified staff to work as a Food Service Worker. The licensee or its designate hired DA #134, indicated knowing that the identified staff did meet the qualifications under O. Reg. 79/10, s. 78. The identified staff was hired after July 01, 2010. The hiring of non-qualified personnel, places residents at potential risk of harm. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

Order # / Ordre no : 007

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

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 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.

- Ensure 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.

Grounds / Motifs :

1. The licensee failed to ensure that 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.

Resident #006's Substitute Decision Maker (SDM) indicated that resident was using an identified continence product prior to his/her admission to the long-term care home. Substitute Decision Maker indicating asking that the identified continence product be used, for resident #006, while residing in the long-term care home to maintain resident's independence. The SDM indicated that he/she had asked the DOC if the home could provide the identified continence product; SDM indicated he/she was advised that the licensee did not provide the identified continence product, and it SDM/resident choose to use the identified continence product, it would be the SDM/resident's responsibility to pay for it. The DOC indicated to the SDM that the long-term care home (licensee) only purchased specific continence products, and that families had to purchase other continence products, if they chose to use them.

Inspector #461 reviewed the licensee's product list located on the linen/product carts, which listed twelve residents that were currently using continence products supplied by their families. Residents #006, #024, #012, #023, #051, #032, #052, #034, #044, #010, and #038 were included on the list.

Personal Support Workers #102 and #133 were interviewed by Inspector #461, PSW #133 indicated that resident #024 used an identified continence product

brought in by family. PSW #102 reported that resident #024 used the identified continence product supplied by family. Both PSWs #133 and #102 indicated the long-term care home only had certain continence products available, not the identified continence product used by resident #024.

Registered Nurse (RN) #106 and the DOC were interviewed by Inspector #461. Registered Nurse #106 reported the long-term care home (the licensee) had assessed and identified continence products available for residents. RN #106 indicated that whether a resident was assessed and identified by staff to need a specific continence product or was a SDM preference, the family always had to purchase the continence product, if the home did not supply the identified continence product. The DOC confirmed that all the residents listed on the continence product list attached to the care carts were using identified continence products provided by their SDM not provided by the licensee.

The DOC further indicated that the identified continence products, being used by the above identified residents, were costly, and indicated that SDM, for identified residents, were given the list of products offered in the long-term care home, but they preferred to use an alternate continence product for their loved ones, the long-term care home did not have the identified continence product available among the products offered to the residents.

The licensee failed to ensure there a range of continence care products available and accessible to residents, specifically the identified continence product. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2018

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 5th day of December, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Kelly Burns

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