Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 17, 2018	2017_435621_0026	022410-17	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

PRINCESS COURT
PRINCESS STREET BOX 725 DRYDEN ON P8N 2Z4

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

JULIE KUORIKOSKI (621), KATHERINE BARCA (625), LAUREN TENHUNEN (196)

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 30, 31, November 1-3, and November 6-10, 2017.

Concurrent to this inspection, one intake was inspected related to follow up of past due compliance order #001 for O.Reg 79/10, s.229(10), as identified in Inspection report #2016_246196_0022.

During the course of the inspection, the inspector(s) spoke with the Administrator (AD), Director of Care (DOC), Acting Director of Care (ADOC), Environmental Services Manager (ESM), Maintenance Worker, Resident Assessment Instrument (RAI) Coordinator, RAI Assistant, Nutrition Manager (NM), Program Services Coordinator (PSC), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Activity Aides (AAs), Dietary Aides (DAs), Cooks, Physiotherapy Assistant (PTA), family members and residents.

Observations were made of resident care areas, provision of care and services to residents, as well as staff to resident and resident to resident interactions. The home's health records for several residents, and personal files of a number of staff were reviewed, along with relevant policies, procedures and programs of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (10)	CO #001	2016_246196_0022	621

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

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

Specifically failed to comply with the following:

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

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

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

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

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

Findings/Faits saillants :

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

During the inspection, Inspector #625 reviewed resident #013's most recent Resident Assessment Instrument (RAI) – Minimum Data Set (MDS), which identified that the

resident had fallen in the previous during a specific time frame. Inspector #625 also reviewed a section of resident #013's most current care plan, last updated in September 2017, which included a specific number of ambulation interventions.

Inspector #625 reviewed physiotherapy documentation from April 2014, which indicated that resident #013 had a specific medical condition and did not ambulate. Inspector #625 had previously observed resident #013 during the inspection to be in their mobility aide, with the same specified medical condition.

During interviews with PSWs #110 and #137, they stated to Inspector #625 that resident #013 used a mobility aid for locomotion and a medical device for transfers.

During an interview with PSW #138, they stated that resident #013 used a mobility aide for locomotion and did not ambulate. PSW #138 also stated to the Inspector that this resident’s care plan interventions were not based on the resident’s current needs and that the resident had not ambulated for a particular period of time.

During an interview with RPN #125, they stated to Inspector #625 that resident #013 had not ambulated for a specified period of time. RPN #125 further identified that the references to ambulation and the related interventions in this resident's care plan were not specific, but were options that could be selected from a generic library database found on the home's electronic health record.

During an interview with Inspector #625, the RAI Coordinator acknowledged that resident #013 did not ambulate and that the references found under a specific section of this resident's care plan required correction in order to reflect this resident’s current mobility status. [s. 6. (2)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Inspector #625 reviewed resident #013's most recent Resident Assessment Instrument (RAI) – Minimum Data Set (MDS), which identified that resident #013 had a medical condition. Inspector #625 also reviewed resident #013's most current care plan, last updated in September 2017, which identified that this resident had a specific medical condition. The care plan also indicated that this resident’s medical condition would be

supported and maintained over a specified period of time, and that the resident was to be transferred with the assistance of staff, or with the use of a medical device. Furthermore, this resident's care plan identified that resident #013 was to be provided personal support services at specific intervals of time.

During an interview with Inspector #625, PSW #110 stated to Inspector #625 that resident #013 had a specific medical condition; and was provided personal support services at specified times.

During an interview, PSW #138 stated to Inspector #625 that resident #013 had a specific medical condition, and that a certain care activity was no longer being completed since a specified medical device was initiated with this resident. PSW #137 further stated to the Inspector that they would completed a certain care activity with this resident as per the schedule in their care plan, but would only complete the care if the resident was having a good day. Additionally, PSW #138 identified that a specific care activity at a specified time was not being completed as indicated in the care plan, but at another time instead, which the care plan did not indicate. Lastly, PSW #138 stated that another specified care activity was never done and that the care plan was not current and reflective of the care activity in place at the time of inspection.

During an interview with Inspector #625, RPN #125 stated that they assisted resident #013 with a specific care activity using a medical device; that a specific number of staff were required for this task; that use of fewer than the specified number of staff during this task was unsafe; and that the care plan needed to be updated. RPN #125 also stated to the Inspector that they were not sure if the schedule found in resident #013’s care plan, which was related to this specific care activity was followed.

During an interview, the RAI Coordinator stated to Inspector #625 that a specific intervention found in resident #013's care plan indicated that this resident should have been provided the care activity at each identified time to support a specified outcome. The RAI Coordinator also stated to the Inspector that this resident did not have to self-identify the need to for staff to assist them with the specific care activity at the indicated times in the care plan, as the schedule identified was intended to be a proactive measure to promote a certain outcome. [s. 6. (4) (a)]

3. During the inspection, Inspector #625 reviewed resident #013's most recent RAI-MDS assessment, which identified that this resident had been involved in a specific incident within a specific time period.

On November 8, 2017, Inspector #625 reviewed a specific section of resident #013's most current care plan, last updated in November 2017, which identified that this resident was to receive a particular care activity by staff. Additionally, on the same day, Inspector #625 reviewed specific documentation in the electronic health record, which identified:
- On a day in August 2017, a specific medical device was recommended when completing a certain care activity with this resident; that another specific medical device was to be utilized in a certain location for their medical condition; and that staff had an option to use a certain type of medical device for another; and
- On a day in July 2017, tips were outlined for completing a certain care activity using a specific medical device.

During interviews, PSWs #110 and #137 stated to Inspector #625 that resident #013 was assisted by staff using a particular method as they were not able to complete a specific activity otherwise, and that the resident no longer used a specific medical device, for the same reason.

During an interview with Inspector #625, PSW #138 stated that resident #013 did not use two specific types of medical devices to complete a specified activity due to a particular medical condition. PSW #138 also stated that the registered staff had been informed of the resident's inability to use the two specific medical devices on multiple occasions.

During an interview with Inspector #625, RPN #125 stated that resident #013 no longer used a particular medical device for a particular care activity due to a decline in a specific medical condition in recent months. RPN #125 also stated to the Inspector that the resident's inability to use two types of medical devices had been brought up in multidisciplinary meetings, however, they continued to be included in this resident's care plan.

During an interview with Inspector #625, the RAI Coordinator stated that staff would be required to discuss resident #013's inability to use two types of medical devices at their weekly multidisciplinary meetings and that the Assistant Director of Care (ADOC) updated care plans based on discussions during those meetings, as required.

During interviews with Inspector #625, the ADOC acknowledged that resident #013's current care plan continued to identify that this resident used particular medical devices. The ADOC also confirmed that staff had discussed the resident's inability to use two specific types of medical devices at weekly multidisciplinary meetings on more than one

occasion, but that the care plan continued to list that the resident used these same two devices based on notes from a specific registered staff members dated from July and August 2017, and that there had not been a more recent assessment of a particular type completed since August 2017. [s. 6. (4) (a)]

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

During the inspection, Inspector #625 reviewed the most recent Resident Assessment Instrument (RAI) – Minimum Data Set (MDS), relative to the previous assessment, which identified that resident #014 had a medical event which occurred within the previous six months.

Inspector #625 also reviewed a Critical Incident System (CIS) report submitted to the Director for the medical event that occurred on a specific day in July 2017, which resulted in a significant change in health status for resident #014.

Inspector #625 reviewed the home's investigation reports for two additional incidents which occurred after resident #014's medical event in July 2017.

Inspector #625 reviewed a specific section of resident #014's care plan, that was in place at the time of resident #014's incident in September 2017, which identified this resident required a specific number of medical devices to be positioned in a specific way on their bed. A review of the same section of resident #014's care plan, last updated in September 2017, which was in place at the time of another incident from October 2017, identified that this resident required another type of medical device to be attached to resident #014's mobility aid.

During an interview with Inspector #625, PSW #138 stated that they had discovered resident #014 at the time of the incident on the day in October 2017, after the resident attempted a particular activity. PSW #138 confirmed to the Inspector that a particular safety device was not on this resident's mobility aide at that time of the incident, as the home had not transferred the device over from a mobility aide the resident had been previously using.

During an interview with Inspector #625, the Assistant Director of Care (ADOC) acknowledged that resident #014 had another incident on a day in September 2017, and that a specific safety device was not in position on this resident's bed as identified in their

care plan, at the time of the incident. The ADOC also acknowledged that resident #014 had another incident in October 2017, and that the mobility aide that they were using did not have a safety device installed at the time of the incident, as the care plan had indicated. The ADOC stated that, with respect to these two specific incidents, the care set out in the plan of care had not been provided to resident #014 as specified in the plan. [s. 6. (7)]

5. On a day in November 2017, Inspector #621 reviewed resident #006's most recent RAI-MDS assessment, which identified this resident had a medical condition which required a scheduled care routine. On further review of a specific section of resident #006's care plan, last updated in September 2017, it identified that staff were to complete a specific care activity at schedule times.

During observations on a day in November 2017, resident #006 was observed over two specific time periods to be seated in their mobility device, with no attempts made by staff to complete a specific care activity with this resident during times scheduled in their care plan.

During interviews, PSW #110 and RPN #124 reported to Inspector #621 that, resident #006 had a specific care routine where PSW staff assisted them at specific time intervals during the day. When the Inspector inquired what staff would refer to, for the plan of care related to resident #006's specific care routine, PSW #110 and RPN #124 indicated that they referred to a current copy of the resident checklist, as well as this resident's care plan. On review of RPN #124's resident checklist, last updated on a specific day in October 2017, and resident #006's care plan, last revised in September 2017, RPN #124 confirmed to the Inspector that PSW staff were providing care to resident #006 on a schedule different than what was documented in this resident's plan of care.

During an interview with RPN #125, they reported to Inspector #621 that resident #006's plan of care, including care plans, were updated by the RAI Coordinator, or by the RN or RPN on duty in the evenings and weekends. Additionally, RPN #125 indicated that if PSW staff identified a change in a resident's care needs which was different than what was in their plan of care, that the PSWs were to write the required changes on a multidisciplinary record located in the conference room of each unit, which the RN on duty would take with them to review at multidisciplinary meetings each week.

During an interview, the ADOC reported to Inspector #621 that if PSW staff identified changes were required to a resident's plan of care, that they were to communicate their

requested changes on a clip board found in each units conference room; and/or speak with the RPN on duty, and/or complete the resident risk communication tool found on the ADOC's office door. It was identified by the ADOC that information communicated by the PSW staff from any of these methods would then be reviewed at the weekly multidisciplinary team meetings, which included the RN on duty, RAI Coordinator, DOC, ADOC, and Nurse Practitioner.

The ADOC reviewed their weekly multidisciplinary team meeting notes since the last continence care plan update made for resident #006 in September 2017, and confirmed to Inspector #621 that they had no record of any requested changes from PSW staff since the last care plan update. The ADOC also identified that it was their expectation that PSW staff communicate requested changes through the options made available to them by the home, and to provide care to residents as per their plans of care. [s. 6. (7)]

6. During meal service at a specific time on a day in October 2017, Inspector #621 observed resident #015 offered an entrée of a certain consistency by PSW #109. Subsequently, Inspector #621 observed RPN #107 provide resident #015 a dessert of another specific consistency.

During a review of resident #015's plan of care, including their diet census record, last updated on a specific day in October 2017, it was identified that resident #015 required a specific diet texture.

During an interview with Dietary Aide #108, they reported to Inspector #621 that resident #015 required their foods to be prepared by the kitchen to the required consistency. Additionally, Dietary Aide #108 identified that the kitchen had not prepared a dessert option from either the main or alternate planned menu items for that meal, and that the PSW and RPN staff would offer the resident a specific item available from the kitchen par stock, and modify it to the appropriate consistency.

During an interview with RPN #107, they reported to Inspector #621 that resident #015 required a specific diet consistency. Additionally, RPN #107 identified that a dessert option had not been prepared in advance by the kitchen from either dessert options identified on the planned menu, and instead, another item was obtained from the servery par stock to offer resident #015. RPN #107 confirmed to the Inspector that dessert provided to resident #015 was consistency different than what was identified in their plan of care.

During an interview, the Director of Care (DOC) reported to Inspector #621 that it was their expectation that staff assisting residents with their oral intake were aware of each resident's diet requirements, and only offered menu items that were consistent with each resident's prescribed diets as documented in their plans of care. [s. 6. (7)]

7. On a day in November 2017, Inspector #196 completed a review of resident #001's health care record, as this resident was identified to have had an incident during a specific time period from their most recent RAI-MDS assessment.

On another day in November 2017, Inspector #196 observed resident #001 engaged in a specific activity while a particular safety device, situated adjacent to them on a table, was inactive.

Additionally, Inspector #196 reviewed a specific section of resident #001's most current care plan, which identified the use of the particular safety device found in resident #001's room, as one of the interventions.

During an interview with PSW #114, they reported to Inspector #196 that the lights on the safety device did not light up, but that it was working. PSW #114 and another PSW then proceeded to reposition the resident in an attempt to activate the safety device. After several attempts to reposition resident #001 were unsuccessful at activating the safety device, PSW #114 determined to the Inspector that the safety device was not operational and a replacement would be required. [s. 6.(7)] (196)

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

During the inspection, Inspector #196 reviewed the health care records for resident #001 regarding their current care needs. Specifically, Inspector #196 reviewed resident #001's current care plan, which identified under a specific focus, interventions including the use of a specific care item at specified times; and staff to complete certain care activities at specified times. Under another care plan focus, the interventions included the requirement to have a certain number of staff to assist with a specific activity; and a certain number of staff to assist during use of a specific mobility device.

During an interview, PSW #139 and RPN #123 reviewed the current care plan and their PSW worksheet with the Inspector. Both PSW #139 and RPN #123 reported and

confirmed the following:
- staff no longer completed a certain care activity as per the schedule in resident #001's care plan or on their worksheet;
- resident #001 no longer used a certain personal care item, but instead used another type; and
- resident #001 now required the use of a specific mechanical device; and no longer used another type of device, due to a change in the resident's condition.

During an interview, PSW #140 reported to Inspector #196 that resident #001 had personal care and was transferred into their mobility aide with assistance of a mechanical device that morning. In addition, PSW #140 reported that this resident was not provided a certain type of personal care due to their medical condition; and that one type of personal care item was being used instead of another. PSW #140 reviewed the PSW worksheet for information regarding the care needs of this resident and confirmed to the Inspector that what was written in the plan of care was not accurate.

During a subsequent interview, PSW #141 reported to Inspector #196 that changes were not made to resident #001's care plan or their PSW worksheet, in spite of sharing information with the RPN and then the RPN sharing with the ADOC and DOC.

During an interview, RPN #136 reported to Inspector #196 that what was being shared with the multidisciplinary team weekly was not always getting put onto the resident's care plans or PSW worksheets. In addition, RPN #136 reported that they were unaware that resident #001 was not being provided a certain type of personal care over the previous week, and that staff were using a mechanical device now for transfers.

In an interview with the Director of Care (DOC) regarding resident #001 and their current care needs, the DOC reported to Inspector #196 that the RPN on duty was to provide information and direction to the PSWs, as well as obtain information related to the residents in their care. In addition, the DOC identified that the RPNs were to work as the "Team Lead" and utilize the RN for additional assistance when required. Further, the DOC noted that there was a disconnect between the different staff, (i.e., PSW to RPNs and RPN to PSWs), resulting in a lack of communication flow through. Lastly, the DOC stated that the ADOC was currently working on revisions to the PSW worksheets and resident care plans to identify the current care needs within the home. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; that care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident; that staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complemented each other; and 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and

in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On a day in November 2017, Inspector #196 observed the door to a room on a particular unit, to be open, and within view of the Inspector and anyone else walking by, was the reflection in a mirror of an unclothed resident, with a staff member providing a certain type of care to the resident. The Inspector reported this incident to PSW #142 as they were entering the room with this resident, and observed PSW #142 complete a certain task before, stating the "room was warm", and then closed the door. The Inspector determined that the resident who had been observed to be #026. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the rights of residents were fully respected and promoted including the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

On a day in November 2017, over a specific period of time, Inspector #625 observed resident #027 repeatedly calling out for assistance. The resident was observed by the Inspector to be in a mobility aide which had become entangled with another empty mobility aide in the hallway, and the resident was unable to free them self. During the same time period, the Inspector observed resident #028 standing at the nursing station.

At a specific time, Inspector #196 observed PSW #112 walk from a conference room, located behind the nursing station, into the nursing station, and then proceed back to the conference room without acknowledging or responding to either resident #027 or #028.

At a specific time, Inspector #625 entered the conference room and observed PSW #112, the ADOC and DOC present. When the Inspector notified PSW #112 that resident #027 was calling for assistance, PSW #112 acknowledged that they had not yet checked to see why the resident was calling out. PSW #112 then proceeded to attend to resident #027 with the Inspector, and assist the resident to untangle their mobility aide from another.

Immediately thereafter, Inspector #625 observed resident #028 step away from the nursing station with a puddle of liquid on the floor where they had just stood, their footwear print visible from tracking through the liquid, and a wet area staining the front of their clothing. The Inspector informed PSW #112, who then proceeded to clean the puddle of liquid from the floor, but did not attend to the resident. Subsequently, Inspector #625 notified RPN #111 of the incident as the front of resident #028's pants continued to

be wet. Consequently, RPN #111 notified PSW #112, who then took resident #028 and changed their clothing.

During an interview with Inspector #625, the ADOC acknowledged that they had heard resident #027 calling out, did not know why the resident had been calling out, and did not check to determine the reason why.

During an interview with the DOC, they acknowledged to Inspector #625 that they had heard resident #027 calling out, but did not know why. Additionally, the DOC stated that PSW #112 had been completing paperwork in the conference room at the time, but should have been at the nursing station. On a subsequent day in November 2017, the DOC stated to the Inspector that they had spoken to staff and reinforced that responding to residents needs was to be made a priority over completing paperwork.

During an interview with Inspector #625, the Administrator acknowledged that with respect to the incidents which occurred earlier in the inspection, that residents #027 and #028 had not been provided with the assistance and care they required to meet their needs. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity; and 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, where the Long-Term Care Homes Act, 2007, or Ontario Regulation 79/10 required the home to have, institute or otherwise put in place any policies, procedures or protocols, and that they were complied with.

Ontario Regulation 79/10, s.89(1)(a)(iv) requires as part of an organized program for laundry services under clause 15(1)(b) of the Act, the licensee to ensure that there was a process to report and locate residents' lost clothing and personal items.

During an interview with Inspector #625, resident's #002, #008 and #008 stated that they had a particular item of clothing go missing for a specific period of time, that the missing item had been reported to staff, and that the item was still missing.

During an interview, PSW #138 stated to Inspector #625 that if resident's identified they had missing laundry item(s), that staff would call the laundry department to inquire if the missing item(s) were there; search other residents' rooms for the item(s); pass the information on to the next shift for follow up; and write notes that would be placed in a specific location for staff to review. PSW #138 noted that word of mouth was not a great way to communicate information.

During an interview with the Environmental Services Manager (ESM), they stated to Inspector #625 that when a resident notified nursing staff about a missing laundry item, nursing staff were to inform the ESM or laundry staff, and laundry staff would then proceed to look for the item. The ESM also stated that they thought the Administrator would also be informed by unit staff, as the Administrator updated a lost and found list for clothing and personal items. The ESM further stated that they were not aware of the home's policies related to missing resident clothing.

During interviews with Inspector #625, the DOC stated that when a resident's clothing went missing, they would inform the Personal Services Coordinator (PSC), and either they or the PSC would proceed to look for the missing item(s). Additionally, the DOC reported that if a resident informed the unit staff about the issue, then the unit staff would also look for the item and call the laundry staff to see if it was there.

During an interview with Inspector #625, the Administrator stated the process for lost clothing items was for residents and families to tell the Administrator or the front desk if an item went missing. If the unit staff were informed by the resident of the issue, then the staff would tell the RPN on duty, who would then notify the DOC. Additionally, the Administrator identified that the unit staff would look for the item(s) first, and then inform the DOC if they could not locate them. The Administrator further stated that they had not been informed of the missing clothing identified in resident #002's, #008's and #009’s interviews; that they were the person responsible to maintain the missing clothing on a log which listed items lost, found or damaged; and that nothing had been listed on the tracker since a particular day in September 2017.

A review of the home’s “Log for Items Lost, Found or Damaged” by Inspector #625, showed no record of any missing clothing items since an entry last made on a day in August 2015.

Inspector #625 reviewed the home’s policy titled “Lost or Damaged Resident Property”, last updated May 2015, which identified that when a resident reported any item as lost or missing, the nurse in charge was required to initiate a search of the resident’s room, the laundry, and the area where the resident was located. If the search was unsuccessful, the lost item was to be documented in the resident’s progress notes with a home-wide GoldCare electronic notice sent to advise staff of the missing item. The administrative office was then required to print off the notice and maintain a record of it in a “lost and found” log. [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 that, where the Long-Term Care Homes Act, 2007, or Ontario Regulation 79/10 requires the home to have, institute or otherwise put in place any policies, procedures or protocols, that they are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On a day in October 2017, Inspector #625 observed dirt and debris on particular areas of resident #011 and #013's mobility aides.

On a subsequent day in November 2017, Inspector #621 observed the same dirt and debris located on in the same areas of resident #011 and #013's mobility aides.

During interviews with PSW's #110 and #113, they reported to Inspector #621 that the night shift PSW was responsible for the surface cleaning of resident mobility aides. However, if a mobility aide was found to require a deeper cleaning, the night shift PSW would take the mobility aide to the tub room to wash more thoroughly, and then allow it to

air dry. Additionally, PSW's #110 and #113 reported that the night shift PSW was responsible to clean all resident wheelchairs once weekly, or more often if needed, and document completion of the required cleaning according to a PSW work schedule found in the "PSW night shift duties" binder found at the nursing unit of each resident home area.

During interviews with RPN #111 and PSW #113, they confirmed to Inspector #621 that resident #011 and #013's mobility aides were soiled with dirt and debris at the time of inspection and should have been clean. On review of the mobility aide cleaning schedules with Inspector #621 for resident #013, PSW #113 reported to the Inspector that the most recent PSW night schedule identified that resident #013's mobility aide had been cleaned was on a particular day in October 2017, which had been a total of 17 days prior to the time of inspection.

During an interview with resident #013, they reported to Inspector #621 that staff would occasionally take their mobility aide to be cleaned at night, but that this did not occur every week, or every month.

During an interview with the Director of Care (DOC), they reported to Inspector #621 that it was their expectation that PSW staff on the night shift cleaned resident mobility aides at least once weekly (and more often if required). The DOC acknowledged that processes for auditing of mobility aide cleaning needed to be revisited and documentation reviewed more often to ensure cleaning was being completed. [s. 15.(2) (a)]

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

During a tour of the resident care areas, Inspector #196 observed the following:
First Floor Unit:
- the door to the shower/tub room had chipped paint around the door frame, there were areas of scuffed paint throughout the shower/tub room, there were several stained areas on the flooring, and the baseboard trim was damaged.

Second Floor Unit:
- the baseboard trim outside of two resident rooms were affixed with duct tape;
- protective covers at the base of the doors to three resident rooms were missing with the discolored glue backing exposed;

- the resident activity room had numerous holes in the walls, paint scuffs on the wall heater, drywall patching present, behind the TV, as well as areas of stained flooring;
- the resident lounge had paint scuffs on the baseboard heater, a section of the chair rail was detached from the wall, and there were numerous areas of scuffed paint on the drywall;
- the shower/tub room had areas of rust on the tile in the corners of the shower, the shower apparatus, shower head and grab bars had areas of rust, the shower floor tile was stained, the shower commode chair had tape on the seating surface over a screw head, tile grout was stained in several areas, the painted surface of the baseboard heater was scuffed and the heater was detached from the wall. There were broken tiles upon entry to the tub room area along the floor, there was wall patching by the toilet, several holes were present in the wall by the hand sink, there was stained caulking around the base of the shower and tub room toilets, a large area of gouged drywall was present by the tub, several areas of chipped paint were observed on the drywall, and the tub room door frame had numerous paint chips along the door frame.

Third Floor Unit:
- the heater beside the elevator had several areas where the paint was scuffed;
- a cracked baseboard was observed outside one resident room;
- the tub room door frame had chipped paint;
- the shower/tub room was noted to have several holes in the walls, caulking was stained around the toilet base, a large area of gouged drywall was noted by the tub, the base of the tub chair was cracked, the shower apparatus, grab bars and tiles had areas of rust, there was stained grout in shower room, and the tub room door frame had scuffing.

During the inspection, Inspector #196 observed the following in resident rooms:
- Gouged drywall in the one shared washroom;
- Cracked areas in the floor and edging loose;
- Washroom floor with cracked areas; and
- Cracked areas found in one specific washroom.

During the inspection, Inspector #625 observed the following in resident rooms:
- A pull cord for the light switch above the bed in a room had approximately two meters of gauze attached to it;
- the washroom door frame in a room was gouged, with chipped paint and piece of wood exposed, as well as areas of peeling paint noted upon entry to the room, and a gauze string found attached to pull light switch over bed, and hanging to the floor;
- the light cord above the bed in a room had approximately two meters of gauze used for

a pull string;
- the bed's remote control in a room had exposed wires on the top 15 centimeter (cm) portion of the control;
- the call bell mount on the wall in a room was found to be missing the cover for the button used to cancel the call bell;
- the pull cord on the light switch in a room above the resident's bed was attached with a black string approximately 1.5 meters (m) in length;
- drywall in a room was found ripped from the wall with the paper backing exposed near the head of the bed, in an area approximately 10 cm x 15 cm. Additionally, a pull cord for the light switch above the bed had a 1.5 m piece of gauze attached to it;
- the wall in a room near the refrigerator had a 10 cm x 8 cm area of missing paint; and
- the floor in the corner and near the window in a room was covered with an excess of 20 black spots.

During the inspection, Inspector #621 observed the following in resident rooms:
- white gauze cloth tied from light switch to bed rail in a room;
- white gauze tied to light switch toggle in a room; and
- gouged drywall, scrapes and scuffing along walls, along with a missing washroom door, paint and drywall damage from the floor to about 24 inches up the walls adjacent to the washroom door frame, numerous black circular markings on floor by the window, and a blue fabric cloth cord tied to the light switch above the resident's bed.

During an interview, Housekeeping Aide #143 reported to Inspector #196 that if staff discovered disrepair in the home, that they would complete a maintenance requisition form, and put the completed form into the Maintenance Department's mailbox.

During an interview, Housekeeping Aide #144 reported to Inspector #196 that they would fill out a maintenance requisition form for any areas of home found in disrepair and talk with either the Environmental Services Manager (ESM) or the home's Maintenance Worker #145 about the issue(s). Additionally, Housekeeping Aide #144 identified to the Inspector that they thought a form was completed by the health and safety committee with respect to damage to the drywall in the tub/shower rooms.

During the inspection, Inspector #196 and the ESM conducted a tour of the home and together observed the areas of identified disrepair. The ESM acknowledged and confirmed the areas as listed to be in need of repair, and confirmed that the gauze wrap that was attached to the pull cords on the overhead lights pull were unclean, and would arrange to have longer metal pull strings replace the gauze wrap. The ESM also

confirmed that the bed control remote should have been repaired, and that staff should have filled out a maintenance requisition form for its repair. In addition, the ESM reported that the home did not have a formal remedial maintenance process, that staff was expected to submit a completed maintenance requisition for areas that needed repair, so that each issue could be addressed. The ESM further confirmed that the shower commode chair found in the second floor shower/tub room should not have been in use as the chair could not be disinfected properly between uses, and that they were unaware that the Arjo lift bath chair had a crack at its base.

Inspector #196 interviewed the Administrator, who confirmed that there was no formal process to evaluate the need for repairs in the home like paint scuffs, baseboard and drywall damage, or rusting of metal surfaces. The Administrator confirmed that the maintenance program did not have preventive and remedial maintenance schedules and procedures in place related to painting, and repairs of drywall, as well as baseboard trim and door damage. Further, the Administrator reported to the Inspector that staff should have used a maintenance requisition to have maintenance replace and/or extend the length of the pull cords on resident's overhead lights. [s. 15.(2) (c)]

3. On a day in October 2017, Inspector #196 specific areas of resident #011's mobility aide to be worn; and Inspector #625 observed a safety device in resident #006's room in disrepair.

On a day in November 2017, Inspector #625 observed resident #002's wheelchair with specific areas of disrepair.

On a subsequent day in November 2017, Inspector #621 observed resident #006's safety device and resident #011 and #002's wheelchairs in disrepair.

During an interview with PSW #112, they reported to Inspector #621 when staff identified safety devices located in resident rooms to be in disrepair, that registered or non-registered staff were to contact the Acting Director of Care (ADOC) or Director of Care (DOC) to have the item switched out for a new one. PSW #112 observed the condition of resident #006's safety device and confirmed to the Inspector that it was in disrepair, and reported that there was no documentation to confirm whether the ADOC or DOC had already been notified of the disrepair at the time of inspection.

During an interview with PSW #114, they reported to Inspector #621 that resident #002's mobility aide was owned by the resident and that any damage or disrepair of this

resident's mobility aide would require notification of resident #002's family to address the areas of concern.

During an interview with RPN #115, they reported to Inspector #621 that during resident #002's recent annual care conference there had been discussion with the substitute decision maker (SDM) about the acquisition of a new mobility aide in 2018. However, RPN #115 confirmed that the SDM was not made aware at that time of the need for repairs to resident #002's current mobility aide, and should have been. Further, RPN #115 observed resident #002's mobility aide and confirmed with the Inspector the identified disrepair.

During a subsequent interview with RPN #115, they reported to Inspector #621 that any damage or disrepair to a resident's mobility aide, which was on loan to the resident by the home, that staff were to notify the Environmental Services Manager (ESM) either by phone, in person, or by completion of a Maintenance Requisition form. Together with the Inspector, RPN #115 observed resident #011's mobility aide and confirmed that this resident's wheelchair was property of the home and was in disrepair. RPN #115 contacted the ESM and confirmed to the Inspector that there had been no past report made by unit staff to them regarding the observed disrepair of resident #011's mobility aide.

During an interview with the Director of Care (DOC), they reported to Inspector #621 that it was their expectation that any particular safety devices found in disrepair, had a maintenance requisition form completed by unit staff to outline the issue, and either the ESM or the DOC would assist in exchanging the damaged safety device with another one. Additionally, the DOC identified that it was their expectation that resident mobility aides that were owned by the home and found in disrepair would be identified by staff and that the ESM notified through completion of the home's Maintenance Requisition form. Further, if a resident's mobility aide was owned by the resident and found in disrepair, the DOC reported that registered nursing staff were to notify the resident or their SDM immediately, and discuss repair options. [s. 15. (2) (c)]

4. On a day in November 2017, Inspector #625 observed resident #013 to be non-responsive, sitting in their mobility aide with PSW #138 engaged. PSW #138 was then observed to report to RPN #125 that they would return resident #013 to bed due to their condition, but would require additional staff to do so, as the sling component of the mechanical lift device was missing a specified item.

Subsequently, Inspector #625 observed the material component of the mechanical lift device to be situated underneath resident #013 as they sat in their mobility aide, which was worn around the seams, had holes in the material where straps were to attach to the sling, and was frayed.

During an interview with PSW #138, they acknowledged to Inspector #625 that the sling used with resident #013 was in poor condition, but stated that the availability of slings was limited.

On the same day in November 2017, Inspector #625 observed PSW #145 search for a another sling and was observed by the Inspector to locate one clean sling, which was also in the same poor condition as the sling found underneath resident #013. The Inspector was not able to locate a manufacture's label on either sling.

During interviews with Inspector #625, the ADOC and DOC acknowledged that the seams on both slings were worn, that their edges were frayed and there were holes in the sling material. Both the ADOC and DOC were not able to locate a manufacturer's label on either sling and stated to the Inspector that the labels had worn off. The ADOC and DOC acknowledged that both slings available to transfer resident #013 were not in a safe condition or good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

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

On a day in November 2017, Inspector #196 observed resident #003 to be in a particular type of restraint, situated in a specific type of chair, and located in a certain part of the resident home area.

On a day in November 2017, Inspector #625 observed a particular type of restraint applied to a specific type of chair, which was located in a certain part of the resident home area.

During an interview with Inspector #625, PSW #138 stated that resident #029 used a specific type of restraint on a particular type of care in a certain location of the resident home area.

A review of the PSW worksheet by Inspector #625, identified that resident #003 and #029 used a specific type of restraint.

Inspector #625 also reviewed the recommended uses for the specified restraint, as found on its label, which identified that the product should only be used as directed in a chair; that sliding off a chair may cause serious injury or death; and that the product was to be used as necessary, to prevent sliding. Inspector #625 also reviewed the manufacturer's instructions for use of the specified restraint, which stated that the restraint helped prevent forward sliding when used with specific mobility aides.

During an interview with Inspector #625, the ADOC stated that they were aware resident #003 and #029 used a specific type of restraint when seated in two different types of chairs. The ADOC stated they were not able to provide documentation that detailed the use of this restraint in these types of chairs.

On another day in November 2017, Inspector #625 observed a particular type of chair with the specific type of restraint attached to it. On further inspection, the Inspector observed that the frame on the right side of the chair had one of its six bolts missing, the bottom cross piece of the chair to have one of its six bolts missing, and the frame on the left side of the chair to have three of its six bolts missing, with two of the three remaining

bolts to be visibly dangling from the frame. Additionally, the wooden frame on the right side of the chair was observed by the Inspector to be coming apart.

During an interview with the DOC, they acknowledged to Inspector #625 that the chair as found by the Inspector was not in a safe condition.

During a phone interview with the ADOC, they stated to Inspector #625 that they were not able to provide documentation to indicate that the specific type of restraint in question, could be used on a specific type and style of chair. [s. 23.]

Additional Required Actions:

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

WN #6: 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home, a) completed a nutritional assessment for all residents on admission and whenever there was a significant change in the residents' health condition; and b) assessed the resident's nutritional status, including height, weight and any risks related to nutrition care, and hydration status, and any risks related to hydration.

On a day in November 2017, during review of a documented weight change for resident #011, Inspector #621 identified a specific weight change over a specified period of time in the summer of 2017. Additionally, the Inspector identified that there had been no documentation in resident #011's plan of care to indicate that an assessment had been completed by the Registered Dietitian (RD) on or shortly after the documented weight change.

During an interview with RPN #123, they reported to Inspector #621 that residents were weighed by PSW staff on their first bath day, or no later than the eighth day of each month. RPN #123 identified that weights were recorded on a paper copy of the weight report by PSW staff, which was then documented by RPN staff in each resident's electronic medical record (EMR). Additionally, RPN #123 identified that a weight change of two or more kilograms was considered significant, and once entered into the EMR, would generate an automatic email notification to the RD to complete further assessment. Further, RPN #123 reported to Inspector #621 that the home's RD had been off work during the summer of 2017, and that there had been no onsite RD services provided to the home until the RD returned to work again.

During an interview with the RD #127, they reported to Inspector #621 that they had received an automatic email notification of resident #011's weight change after the August 2017, recorded weight; that this weight change was considered significant; and that they should have followed up on it immediately. However, RD #127 reported that they had been off work in July and August 2017, and that no RD site coverage was available in the home during that time to complete an assessment of resident #011's nutritional status related to the documented weight change.

During an interview with the DOC, they reported to Inspector #621 that it was their expectation that the home's RD completed assessments for weight changes or any risk related to nutrition care, on admission, quarterly and whenever there was a significant change in a resident's health condition. [s. 26. (4) (a),s. 26. (4) (b)]

2. On a day in November 2017, during a review of documented weight change for resident #003, Inspector #621 identified a specific weight change over a specified time period in the summer of 2017. Additionally, the Inspector identified that there had been no documentation in resident #003's plan of care to indicate that an assessment had been completed by the Registered Dietitian (RD) on or shortly after the documented weight change.

During an interview with the RD #127, they reported to Inspector #621 that they had received an automatic email notification of resident #003's weight change; that this weight loss was considered significant; and that they should have followed up on it immediately, but didn't. RD #127 reported that they had been off work in July and August 2017, and that no RD site coverage was available in the home during that time to complete an assessment of resident #003's nutritional status related to the July 2017 documented weight change. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a registered dietitian who is a member of the staff of the home, a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in the residents' health condition; and b) assesses the resident's nutritional status, including height, weight and any risks related to nutrition care, and hydration status, and any risks related to hydration, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming, on a daily basis.

On a day in October 2017, Inspector #625 observed resident #007 to have a coloured substance collecting in a specific region of their body.

Subsequently, on another day in November 2017, Inspector #625 observed specified substances on a specific number of places on resident #007's body, as well as dirt and

debris in a specific dimension on their clothing.

Later on the same day in November 2017, the Inspector again observed a coloured substance collecting in a specific part of resident #007's body.

A review of a specific section of resident #007's care plan, last updated in October 2017, identified that this resident required assistance from a specified number of staff with their personal care.

During an interview with resident #007, they stated to Inspector #625 that they required staff to assist them with their personal care needs.

During an interview with PSW #140, they reported to Inspector #625 that staff were required to provide specific personal care to resident #007 on an ongoing basis throughout the day, as the resident was unable to participate in their own care.

During an interview with PSW #110, they confirmed to Inspector #625 that resident #007 had a coloured substance accumulating on a certain areas of their body, and then proceeded to wipe the area with a Prevail wipe.

During an interview with RPN #147, they stated to Inspector #625 that RPNs were to perform a specified type of personal care for resident #007's when they got a chance.

During an interview with PSW #138, they reported to Inspector #625 that resident #007 required staff to complete all personal care for them.

During an interview with RPN #125, they identified to Inspector #625 that resident #007 a specific type of personal care provided to them by staff in the mornings. RPN #125 reported that staff were required to ensure that this specific type of personal care was provided, and that if the particular condition continued to be problematic, that the resident was not receiving their required care.

During an interview with the DOC, they stated to Inspector #625 that the home's nursing staff were required to provide care to resident #007 to address the condition that they had, and that the use of Prevail wipes to complete the task was not appropriate personal care. [s. 32.]

2. On a day in October 2017, Inspector #625 observed resident #013 to have coloured

debris on a certain area of their body. On another day in November 2017, the Inspector again observed this resident to have coloured debris in the same area of their body. On a later date in November 2017, the Inspector observed this resident to have dried coloured debris on another part of their body.

Inspector #625 reviewed a specific section of resident #013's care plan, last updated the same day, which indicated that resident #013 required assistance of a specified number of staff with their care. Additionally, a review of resident #013's most recent Resident Assessment Instrument (RAI) - Material Data Set (MDS) assessment, dated in August 2017, identified that this resident was dependent on staff for their personal care, and required the physical assistance of a specific number of staff to complete this care.

During an interview with Inspector #625, PSW #110 stated that resident #013 required the assistance of a certain number of staff to complete their personal care which was different from that identified in their documentation.

During an interview with Inspector #625, PSW #138 reported that if resident #013 had debris on their body for periods of time after certain activities, they were not receiving the assistance they required with respect to their personal care needs.

During an interview with Inspector #625, RPN #125 indicated that resident #013 required nursing staff to provide personal care when required, and that if the resident was found unclean with debris on their person after a certain activity, they were not receiving the assistance with personal care that they required. [s. 32.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Residents' Council has advised the licensee of concerns or recommendations, the licensee within 10 days of receiving the advice, responded to Residents' Council in writing.

During an interview with resident #023, (who was the President of Residents' Council), they reported to Inspector #621 that the home's management did not always respond to concerns raised at Residents' Council, and that responses were not received by Residents' Council in writing within 10 days of specific concerns being raised at Council.

Inspector #621 reviewed copies of the Residents' Council meeting minutes from August and October 2017, and noted the following recommendations and concerns raised by Residents' Council members:
- Request for more beef stroganoff and meals like this, as well as concerns that toast was too greasy, portions were too large, and there was too much fish on the menu;
- Concerns regarding wait times for toileting;
- Concerns that socks and handkerchiefs were not coming back from laundry; and
- Concerns that resident's rooms were too cold at night.
The Inspector further identified that there was no documented response from the licensee to any of the identified concerns brought forward from these meetings.

During an interview, Program Services Coordinator #106, who served as the Assistant to Residents' Council, reported to Inspector #621 that a written response from the Administrator, or management designate(s) had not been provided to Resident's Council in writing within 10 days of specific concerns or recommendations being raised at Residents' Council meetings.

During an interview, the Administrator identified to Inspector #621 that it was their expectation that a written response was provided to Residents' Council for any concerns or recommendations brought forward by the Council, as per legislative requirements. [s.57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that if the Residents' Council advises the licensee of concerns or recommendations, the licensee within 10 days of receiving the advice, responds to Residents' Council in writing, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Residents' Council, if any, and in any case, was consulted with at least every three months.

During an interview with resident #023, (who was the President of Residents' Council), they reported to Inspector #621 that the home's management had not consulted with Residents' Council, at least every three months over the previous year.

Inspector #621 reviewed copies of the Residents' Council meeting minutes over the previous 12 months, which documented that a representative of the licensee was present only twice; specifically, at the December2016 and April 2017, Residents' Council meetings.

During an interview, Program Services Coordinator #106, who served as the Assistant to Residents' Council reported to Inspector #621 that Residents' Council convened for meetings every two months, however, the Administrator or a management designate had not consulted with the Residents' Council in any case, at least every three months over the past year.

During an interview, the Administrator confirmed to Inspector #621 that neither they nor a designated management representative had consulted with Residents' Council at least every three months as per legislative requirements. [s. 67.] (621)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Residents' Council, if any, and in any case, is consulted with at least every three months, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On a day in October 2017, Inspector #621 observed a specific meal service in a particular resident dining room area.

During the meal service, Inspector #621 observed PSW #109 offer resident #015 a plastic coffee cup containing an unidentifiable food item that had been texture modified. Additionally, the Inspector observed RPN #107 offer this resident a dessert item of a different consistency than the item found in the coffee cup.

During an interview with Dietary Aide #108, they reported to Inspector #621 that resident #015 required foods of a certain texture. Dietary Aide #108 also reported that they were unsure of what had been offered for the main entrée for resident #015 as the kitchen did the texture modifications for this resident, and there was no label on the item to specify what the item was in relation to the planned menu. However, Dietary Aide #108 reported that the kitchen usually provided a reheated commercial product that was texture modified instead of modifying the main or alternate items from the menu, so suspected that it was one of those options that was in the cup. Dietary Aide #108 confirmed that there was no second entrée option available for resident #015, and that there was no dessert item prepared by the kitchen for this resident in the consistency that was required.

Inspector #621 reviewed resident #015's diet as listed in the diet census, last updated on a specific day in October 2017, which identified this resident required a specific diet texture.

During interviews with PSW #109 and RPN #107, they reported to Inspector #621 that there had been only one entrée option available for resident #015 for the meal service, and that there had been no communication from food services as to what had been in the plastic coffee cup, that they subsequently fed to the resident. Additionally, RPN #107 indicated to the Inspector that a dessert option had not been prepared in advance by the kitchen that was consistent with the planned menu, and that the dessert item that they had fed to resident #015 had been a different consistency than what was indicated in their plan of care.

During a subsequent interview, the Nutrition Manager (NM) reported to Inspector #621 that cooks were to prepare and make available both the main and alternate planned menu choices to the required texture for all resident diets. Additionally, the NM identified that if a menu item was not suitable for a resident due to issues processing the menu items down to the required consistency, or due to resident diet intolerances, that a comparable commercial product would be substituted for the menu item that it replaced. Further, the NM indicated that menu items that were modified in their texture by the food services were to be labelled to identify what the contents contained. [s. 71. (4)]

2. On a day in November 2017, Inspector #621 observed a particular meal service in a specific resident dining room.

During the meal service, Inspector #621 observed resident #022 assisted with a texture modified meal by PSW #118.

During an interview with PSW #118, they reported to Inspector #621 that resident #022 had been offered and completed a certain texture modified item from the menu, but were unsure what the entrée was that they offered this resident #022. PSW #118 also identified that there had been only one texture modified entrée option provided to them by the dietary aide, and were unclear if there was a second option available.

During an interview, Dietary Aide #119 reported to Inspector #621 that the entrée prepared by the cook for resident #022 was a texture modified commercial product that most closely matched one of the entrée items listed on the planned menu; that there had been no texture modified bread product to go with the entrée item provided to resident #022; and that there had been no second entrée option for prepared by the kitchen that was consistent with the
planned menu.

Inspector #621 reviewed the diet census, which identified that resident #022 required a specific texture modified diet.

During an interview with Cook #120, they reported to Inspector #621 that they prepared the menu items for the specified meal service that day, which included what was required for texture modified diets. Additionally, Cook #120 identified that for specific texture modified diets, they did not process the items from either the main or alternate planned menu options that had been served to the rest of the resident population; but instead, provided a texture modified commercial product. Further, Cook #120 indicated that use of

a commercial product alternative instead of modifying the texture of the main or alternate menu items was a common practice. [s. 71. (4)]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During a review of resident #003, #011 and #022's plans of care on a specific day in November 2017, Inspector #621 identified that there had been no quarterly assessments completed by the Registered Dietitian (RD) between specific dates in May and October 2017 for resident's #003 and #011; and after a specific date in March 2017 for resident #022.

During an interview, RPN #123 reported to Inspector #621 that the home's RD had been off work during the summer of 2017, and that there had been no onsite RD services provided to the home until the RD returned to work again approximately one month prior.

Inspector #621 reviewed copies of the RD's payroll records provided by the home

between specific dates in May and November 2017, which identified the absence of paid service hours for the months of July and August 2017, as well as a specific number of hours for September 2017. The following calculation was used by the Inspector to determine the RD's required on-site service hours for the home:

Resident census = 97 residents x 30 minutes per month = 2910 minutes or 48.5 hours per month.

During an interview with the RD #127, they reported to Inspector #621 that they had been off work for the months of July and August 2017, and that no RD site coverage had been available to the home during that time. Additionally, RD #127 reported that they were not aware that legislative requirements required by them to provide a minimum of 30 minutes per resident per month of on-site RD service time.

When Inspector #621 inquired with RD #127 when the last RD quarterly assessment had been completed for each of resident's #003, #011 and #022, the RD #127 reported to the Inspector that the quarterly assessment for resident #003 was missed for August 2017; that resident #011's was missed for July 2017; and that resident #022's was missed for both July and September 2017.

During an interview with the Administrator, they confirmed to Inspector #621 that there had been no onsite RD nutrition services for the months of July and August 2017, and that following RD #127's return to work on a specific date in September 2017, that the home had not met the minimum onsite RD hours per legislative requirements. [s. 74. (2)]

Additional Required Actions:

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

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, shall ensure that, there were schedules and procedures in place for routine, preventive and remedial maintenance.

On October 30, 2017, Inspector #196 observed numerous areas of disrepair within the home, including resident equipment.

During an interview with the Environmental Services Manager (ESM), they reported to Inspector #196 that there was no procedure or audits done for routine maintenance needs in the home and there was no formal schedule that was used for routine, preventative and remedial maintenance. They went on to report that they had developed a schedule but it had not yet been put into place.

During an interview with Maintenance Worker #145, they reported to Inspector #196 that there was no remedial maintenance program in place, and no formal walk through of the home areas to identify repair needs. Maintenance Worker #145 identified that if there were areas of the home identified by staff to be in need of repair, that staff were to complete a maintenance requisition, or even write a note and forward it to them outlining the area of concern.

Further, Maintenance Worker #145 reported to the Inspector that they were the only staff person working in the maintenance department, other than their manager, and that there was no time to spend making repairs to drywall, paint scuffs, broken tiles, or holes in the

walls. [s. 90. (1) (b)] (196)

2. The licensee has failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.

On a specific day in November 2017, Inspector #625 observed resident #013 to be nonresponsive, sitting in a mobility aide with PSW #138 intermittently engaged with the resident. The Inspector noted that a specific type of mechanical lift had been used to transfer the resident into bed, which was missing a plastic end cap from one side of its base, exposing the metal edges and a screw, as well as strands from a housekeeper's mop were found entangled in the casters, and both brakes, which despite being depressed, were not functional.

Inspector #625 interviewed RN #148 and PSW #138, who confirmed that the mechanical lift identified by the Inspector, was in disrepair. PSW #138 also stated that staff required the lift to lock each time they transferred a resident, and that they had not been aware that the brakes did not work.

Additionally, Inspector #625 interviewed the Environmental Services Manager (ESM) who stated that they did not know if the home's mechanical lifts were checked monthly. The ESM stated that some of the home's monthly "Princess Court Mag. Locks/Lifts" documents had no documentation, but that Maintenance Worker #145 would be able to verify if the monthly checks were completed. The ESM proceeded to look at the specific mechanical lift on a specified resident home area with the Inspector and confirmed that a plastic end cap was missing from its base, debris was entangled in both casters, and both brakes did not work. The ESM also stated that the lift required repair and would be pulled from service until it was fixed.

Inspector #625 reviewed the home's documents titled "Princess Court Mag. Locks/Lifts" from May to October, 2017. It was identified by the Inspector that the May and September 2017 documents listed "all floors" and "s" for satisfactory. However, documents for June, July, August and October 2017 were blank.

Inspector #625 also reviewed the "Liko Inc. Annual Checkup Procedure Manual" with a focus on section four, regarding the specific mechanical lift. The manual identified what areas to inspect and perform preventative maintenance on, which included, but were not limited to: damaged plastic caps that would indicate potential damage to nuts and/or

bolts underneath; damaged end caps which may have fallen out and exposed sharp edges which may lead to potential injury; and a build-up of debris in the caster bearings including an accumulation of dust or hair, etc., which would require the casters to be taken apart, cleaned, lubricated and reinstalled.

During an interview with Inspector #625, Maintenance Worker #145 stated that they did not complete checks of all of the home's mechanical lifts monthly as they did not have the time to do so. Maintenance Worker #145 also stated to the Inspector that they could not recall when the specific mechanical lift on the specified resident home area had last been checked and that, when they did check the lifts, they focused on the mechanical aspects of the lift, as they were the most important related to safety, and did not complete a check of the items listed in the manual. [s. 90. (2) (b)]

3. On a day in October 2017, Inspector #196 observed the home's lift tub chair to have a large crack in the base and the shower/commode chair had a piece of tape over a metal screw head on the seat surface and rust on its wheels.

During the inspection, Inspector #196 interviewed the Environmental Services Manager (ESM) who confirmed that the lift tub chair was cracked in several places at its base. The ESM acknowledged that the tub chair was in disrepair and that a shower/commode chair had a patch of tape over a screw head, and that this chair could not be disinfected adequately between residents, and that it should not have been used in that condition. In addition, the ESM reported to the Inspector that they were unaware that these pieces of resident equipment were in disrepair and that normally staff would complete a maintenance requisition for such issues, but that they had no record of a requisition being received by them.

Subsequently, Inspector #196 interviewed the Administrator who reported that the licensee did not have specific policies related to the home's maintenance program ensuring equipment, devices and assistive devices were in good repair and that these needed to be developed. The Administrator also confirmed to the Inspector that the tub lift chair should have been removed from service as it was not in proper condition for use, and the ESM had placed an order for a new chair after the issue was brought to their attention by the Inspector in the previous week. [s. 90. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, shall ensure that, there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (3) The quarterly evaluation of the medication management system must include at least,
(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk; O. Reg. 79/10, s. 115 (3).
(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and O. Reg. 79/10, s. 115 (3).
(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 115 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the quarterly evaluation of the medication management system by an interdisciplinary team included at least reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3).

On a day in November 2017, Inspector #625 reviewed Interdisciplinary Medication Management Committee meeting minutes from June 2016, up to the time of the inspection. Documentation relating to the review of medication incidents and adverse drug reactions was identified in the June 2016 minutes. However, the meeting minutes dated from October 2016, as well as February June and October 2017, did not include any documentation indicating that medication incidents and adverse drug reactions were evaluated quarterly.

During an interview with Inspector #625, the DOC acknowledged that medication incidents and adverse drug reactions had not been reviewed at the quarterly Interdisciplinary Medication Management Committee meetings since the summer of 2016. [s. 115. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the quarterly evaluation of the medication management system by an interdisciplinary team includes at least reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3), to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On specific day in October and November 2017, Inspector #625 observed a container of ointment in a specific location within resident #007's room.

During an interview with RPN # 125, they reported to Inspector #625 that resident #007 did not have an order for ointment.

During an interview with Inspector #625, the DOC stated that ointment was a stock item provided by the home, that it should not be used unless it was prescribed for a resident, and that all drugs should be stored securely and locked. [s. 129. (1) (a)]

2. During the inspection, Inspector #625 observed on two occasions, a specified number and type of drugs at resident #002's bedside.

Inspector #625 reviewed resident #002's electronic medication administration record (e-MAR) for the month of November 2017, and identified that there was no record for a specified number of the drugs that were observed at resident #002' bedside.

During an interview with Inspector #625, RN #148 stated that resident #002 did not have an order for a particular topical product as found at this resident's bedside, or an order to keep any drugs at their bedside.

During an interview with Inspector #625, the DOC stated that with respect to topical drugs which were observed at resident #002's beside, all drugs, including topical drugs, should have been securely stored and locked. [s. 129. (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 that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #15: 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).

Findings/Faits saillants :

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

On a day in October 2017, Inspector #625 observed a specific number of topical drugs on resident #007's night stand. One container had expired on a specific day in April 2017, and the other had expired on a specific day in June 2017.

During an interview with Inspector #625, RPN #147 stated that they had administered one of the topical drugs which had been observed on resident #007's nightstand, to resident #007 earlier that day, but had not yet signed for it. RPN #147 checked the e-MAR and acknowledged that the specific topical drug was not listed, and that they had applied it to the resident without a prescription to do so. RPN #147 also acknowledged that both containers of the topical drug had expired.

During an interview with Inspector #625, the DOC stated that the application of the expired topical drug to resident #007 should not have occurred, as it was not prescribed for the resident. [s. 131. (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 that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #16: 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 :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

A review of the home's policy titled "Policy 190: Medication Incidents and Adverse Drug Reactions", last updated in January 2017, identified that every medication incident involving a resident and every adverse drug reaction was to be documented, together with a record of the immediate actions taken to assess and maintain the resident's health and, where the incorrect medication had been administered to a resident, the nurse was to provide regular monitoring throughout the shift and for 24 hours thereafter, with an entry made in the resident's progress notes relaying the specific facts and nursing actions taken.

(a) Inspector #625 reviewed a Medication Incident report dated from August 2017, for resident #130 which indicated this resident was administered a specific type and dose of medication which was different than was reported to have been ordered.

Inspector #625 reviewed resident #130's electronic progress notes, dated from August 2017, and was unable to locate any documentation to identify that a medication incident had occurred, or what immediate actions were taken to assess and maintain the resident's health. On further review of this resident's health record, the Inspector was

unable to locate any documentation regarding the medication incident.

During an interview with Inspector #625, the DOC stated that documentation of the medication incident involving resident #130 which occurred in August 2017, as well as any follow up taken to assess and maintain the resident's health should have been documented in the this resident's health record.

(b) Inspector #625 reviewed a Medication Incident report dated from October 2017, for resident #023 which indicated this resident was administered an incorrect dose of medication.

Inspector #625 reviewed resident #023's healthcare records between specific days in October and November 2017, and was unable to locate any documentation that identified that a medication incident had occurred, or what immediate actions were taken to assess and maintain the resident's health.

During an interview with Inspector #625, the DOC stated that documentation of the medication incident which occurred in October 2017, involving resident #023, as well as any follow up taken to assess and maintain the resident's health, should have been documented in this resident's healthcare record. [s. 135. (1) (a)]

2. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was 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.

A review of the home's policy titled "Policy 190: Medication Incidents and Adverse Drug Reactions", last updated in January 2017, identified that a medication incident involving a resident or adverse drug reaction was to be reported to the resident, the resident's substitute decision-maker, the DONPC, the Medical Director, the prescriber of the drug, the resident's attending physician or RN (EC), and the pharmacy service provider.

(a) Inspector #625 reviewed a Medication Incident report dated from July 2017, for resident # 031, which indicated this resident was administered a "scheduled", as well as an "as needed" dose of a particular medication, without orders to do so. The Medication Incident Report indicated that the physician, this resident's family and the pharmacy were not notified of the incident.

During an interview with Inspector #625, the DOC confirmed that the physician, resident #031's family and the pharmacy had not been notified of the incident which occurred on a specified day in the summer of 2017, as reported on the home's Medication Incident report.

(b) Inspector #625 reviewed a Medication Incident report dated from August 2017, for resident #030 that indicated this resident was administered a dose of a specific medication at one specific time, and the same specific medication administered at a different time, utilizing a different dose. The incident report identified that there was an order for the dosing of the specified medication, but not for the times of administration. The Medication Incident report also did not indicate whether the physician, resident #030's family or the pharmacy were notified of the incident.

Inspector #625 reviewed resident #030's GoldCare progress notes, over a specific time period in August 2017, and was unable to locate documentation regarding the medication incident, including documentation that the required notifications were completed.

During an interview with Inspector #625, the DOC stated that they were not sure if family was notified; that they believed the Nurse Practitioner had been notified of the incident, although the notification was not documented; and that the physician and pharmacy had not been notified of the medication incident which occurred on a specific day in August 2017, involving resident # 030.

(c) Inspector #625 reviewed a Medication Incident report dated from October 2017, for resident #023, which indicated this resident was administered a particular dose of a medication, instead of the dose that had been ordered. The Medication Incident report identified that the physician and family were not notified of the incident.

During an interview with Inspector #625, the DOC stated that they did not know if the Nurse Practitioner had been notified, but confirmed that the physician and pharmacy had not been notified of the medication incident which occurred on a specific day in the autumn of 2017, involving resident #023. [s. 135. (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 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 to ensure that every medication incident involving a resident and every adverse drug reaction is 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, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the infection prevention and control program required under subsection 86 (1) of the Long-Term Care Homes Act, 2007, complied with the requirement for all staff to participate in the implementation of the program.

On a day in November 2017, on a specific resident area, Inspector #196 observed PSW #149 enter the dirty utility room while wearing a specific type of personal protective equipment (PPE), and carrying soiled linens. PSW #149 was then observed to exit the room, proceed down the corridor to resident #014's room, and provide care to this resident wearing the same PPE.

During a subsequent interview with PSW #149, they reported to Inspector #196 that they should have removed and discarded the PPE they had on before leaving the dirty utility room, but stated that they needed to respond to the resident #014's alarm. PSW #149

confirmed to the Inspector that they should have removed their PPE and completed a specific infection control activity before entering resident #014's room and providing care.

Subsequently, Inspector #196 interviewed the DOC, who reported that a specific part of the home's infection control program was reflected in the licensee's routine precautions policy.

Inspector reviewed the home's policy titled "IPAC Routine Precautions - OHS 410 – 09/15", which identified that a specific type of PPE:
- was required to be changed between residents, between care activities with the same resident and after
contact with a certain type of fluid; and
- was required to be removed immediately after the completion of resident care, disposed of in the nearest
garbage receptacle, with a particular part of the body then washed.

During an interview with the ADOC, they confirmed to Inspector #196 that staff were to dispose of a specific type of PPE and perform a specific type of infection control activity before assisting other residents. [s.229. (4)] (196)

2. On a day in October 2017, Inspector #196 observed a soiled and unlabelled personal care item, of a particular colour, in a specific shower room. PSW #137 confirmed to the Inspector that the personal care item should have been labelled with a resident name, then proceeded to dispose of it as they did not know who the personal care item belonged to.

On the same day in October 2017, Inspector #196 observed another soiled and unlabelled personal care item, of a particular colour, in another specific shower room. PSW #139 confirmed to Inspector #196 that the personal care item in question had been used, was soiled and unlabelled, and that they did not know who it belonged to. In addition, the Inspector observed the same shower room, a specific type of chair in disrepair.

During an interview, Environmental Services Manager (ESM) #105 identified to Inspector #196 that the chair identified in a specific shower room should not have been in use. Additionally, during an interview with Maintenance Worker #145 on another day in November 2017, they reported that the specified chair had been in use in the observed condition for a specific number of years.

During an interview with the ADOC, they confirmed to Inspector #196 that the condition of the chair observed in a specified shower room would not be able to be disinfected sufficiently between residents.

Inspector reviewed the licensee's policy titled "IPAC Routine Precautions - OHS 410 – revision 09/15", which identified under the resident supplies and equipment section that:
- Personal care supplies were to be dedicated to one resident, and not shared between residents;
- All items were to be marked with resident ID to prevent unintended use by others;
- Any used unmarked items were to be disposed of; and
- Reusable non-disposable equipment that was in direct contact with resident skin was to be washed with disinfectant solution between resident uses.

During a subsequent interview with the DOC, they reported to Inspector #196 that all personal care items were to be labelled with the resident's name, and that the specific chair found in the specified shower room should not have been used by staff in the condition that it was in. [s. 229.(4)]

3. On two days in November 2017, Inspector #625 observed a number and type of opened and undated containers with particular types of solution in them, in a specific area of resident #002's room.

During a subsequent interview with RPN #147, they reported to Inspector #625 that it was the home's practice to continue to use an open container of two particular types of solution for up to 30 days from the date that they were first opened. Additionally, RPN #147 acknowledged that the containers of the particular types of solution were labeled as single use in order to stop cross contamination of the contents, and that these containers should have been discarded after a single use, as per the instructions on the label. In regards to resident #002, RPN #147 reported to the Inspector that they had used opened containers of both solution types, in order to complete a care activity involving resident #002.

During an interview with RPN #123, they stated to Inspector #625 that once containers with particular types of solution were opened and dated, they would be used for 30 days, and that this was the practice used for each resident in the home. RPN #123 attended resident #002's washroom with the Inspector, reviewed the labels on the containers, and stated that any unused contents should have been discarded after one use, as instructed

on the labels. RPN #123 also acknowledged that storage of these type of products in a specific area of the resident's room were a potential cause for contamination.

During an interview with Inspector #625, RN #148 stated that the containers of solution found in resident #002's room, would have been used to complete a certain care activity with this resident, but that since September 2017, the resident no longer required that type of care. RN #148 attended resident #002's room with the Inspector, reviewed the labelled containers and confirmed that, any unused portions in the containers should have been discarded after one use, as instructed on the labels. The RN also acknowledged that storage of these containers in a particular area of this resident's room could have potentially contaminated the containers.

During an interview with Inspector #625, the DOC stated that the home had been using containers labelled as single use, with particular types of solution in them, more than once. Additionally, the DOC acknowledged that, as the containers were identified as single use, and unused portions to be discarded, that this should have been followed. Lastly, the DOC confirmed multiple potential infection prevention and control concerns with the current practices observed by the Inspector, including storage of containers in a particular area of resident #002's room and the use of "single use" containers more than once. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the infection prevention and control program required under subsection 86 (1) of the Long-Term Care Homes Act, 2007, complies with the requirement for all staff to participate in the implementation of the program, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident occurred, immediately reported the suspicion and the information upon which it was based to the Director.

During the inspection, Inspector #625 identified that the home had been notified of the details of an allegation of staff to resident neglect which had occurred several years prior.

A review of an employee file for PSW #150, who was a former employee, identified notes made by the DOC on a day in June 2012, regarding the allegations made by resident #005 and a "Memo to File of [PSW #150]", dated from July 2012, which detailed a meeting held with resident #005 and PSW #150 at that time.

During an interview with the DOC, they stated to Inspector #625 that the allegations made by resident #005 regarding PSW #150 were consistent with allegations of abuse and neglect. The DOC also stated that the home was just getting used to reporting requirements at that time and did not report the allegations to the Director immediately, as required. [s. 24. (1)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was assisted with getting dressed as required, and was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

On a day in October 2017, Inspector #625 observed resident #013 wearing a piece of clothing found in disrepair.

On a day in November 2017, resident #013 was observed by Inspector #625 to be wearing another article of clothing in disrepair.

On three separate occasions on another day in November 2017, Inspector #625 observed resident #013 to be wearing clothing which was both soiled and in disrepair.

During a subsequent interview with Inspector #625, PSW #110 acknowledged that a particular piece of clothing that resident #013's was wearing at that time was in disrepair. PSW #110 also reported that about 50 per cent of this resident's clothing had a particular type of disrepair, and that the resident's clothing would often get soiled during a specific activity. The PSW further indicated that staff would not change this resident's clothing during the day if it became soiled, as they were too busy providing care to other residents.

During an interview with RPN #125, they stated to Inspector #625 that resident #013 required staff assistance with activities of daily living. The RPN acknowledged that this resident's clothing which was observed by the Inspector to be in disrepair, were not items that were appropriate to dress this resident in, and that the resident's family should have been notified to replace items which were in poor condition. RPN #125 further reported that they were unable to locate documentation to verify that resident #013's family had been notified that replacement clothing was needed for this resident. Lastly, RPN #125 confirmed that, if the resident's clothing remained soiled after certain activities, that they were not receiving the care required to change their clothing, and remain clean. [s. 40.]

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 58. Residents' Council assistant

Specifically failed to comply with the following:

s. 58. (1) Every licensee of a long-term care home shall appoint a Residents' Council assistant who is acceptable to that Council to assist the Residents' Council. 2007, c. 8, s. 58. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the appointment of a Residents' Council assistant to assist the Residents' Council was acceptable to the Council.

During an interview with resident #023, they reported to Inspector #621 that the Program Services Coordinator, and/or one of several Activity Aides, had served in the role of assistant to Residents' Council. However, resident #023 further identified that it was never discussed at past Residents' Council meetings whether the Council accepted the Program Services Coordinator or Activity Aides assisting Residents' Council.

Inspector #621 reviewed copies of Residents' Council meeting minutes from the previous 12 months, which identified that the Program Services Coordinator #106, and/or Activity Aides #128, #129, #130 and #131 had been present and serving in capacity of the Residents' Council assistant.

During an interview, Program Services Coordinator #106 confirmed that they or Activity Aide #128, #129, #130 and #131 had served in the role of assistant to Residents' Council over the previous year. Further, it was identified that although the home had appointed the Program Services Coordinator to be the assistant to Residents' Council, that the home' management had not appointed any other staff person to be the assistant, and that they had not sought confirmation from Residents' Council if they, or an Activity Aide, was acceptable to serve as an assistant to Council.

During an interview with the Administrator, they confirmed to Inspector #621 that they had appointed Program Services Coordinator #106 to serve as an assistant to Resident's Council; that they had not appointed any other staff members to serve in this role as an alternate to the Program Services Coordinator; and that they had not consulted with Residents' Council to determine whether the appointment of the Program Services Coordinator as their assistant was acceptable to the Council [s. 58. (1)]

WN #21: 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: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure a review, subject to compliance with subsection 71(6), of meal and snack times by Residents' Council.

During an interview with resident #023, they reported to Inspector #621 that the home's food services management staff had not completed a review of the meal and snack times with Residents' Council.

Inspector #621 reviewed copies of the Residents' Council meeting minutes from the previous 12 months, which documented that the Nutrition Manager was present at the December 2016 and April 2017. On further review of the minutes, the Inspector found no documentation to support that a review of the home's meal and snack times had been completed with the Council.

During an interview, Program Services Coordinator #106, who served as the Assistant to Residents' Council, reported to Inspector #621 that they did not recall there being a review of meal and snack times by the home's Nutrition Manager and/or designate since they had assumed the role of Assistant to the Council three years prior.

During a subsequent interview with the Nutrition Manager, they reported to Inspector #621 that in keeping with legislative requirements, neither they nor a designated management representative had reviewed the home's meal and snack times in the past with Residents' Council. [s. 73. (1) 2.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure, that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures were developed and implemented for cleaning of the home, including, common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

On a day in October 2017, Inspector #196 observed the a specific dining room floor, walls around the area of the serving cart and the grille covers on the ceiling vents to be unclean.

On a day in November 2017, the Environmental Services Manager (ESM) observed the same specific dining room floor, and acknowledged to Inspector #196 that the floor, walls and ceiling vents were unclean, and that they would have expected them to be clean. In addition, the ESM indicated that the housekeeping aides were responsible for cleaning these areas, and it should have been done.

Inspector #196 reviewed the "Unit 2 Housekeeping Schedule", as provided by the ESM, and noted that there was no information identifying that housekeeping staff were required to clean the dining room ceiling vents.

Inspector #196 also reviewed the home’s policy titled "Preventative Maintenance - Air Handling Systems - ENV 230-13", which documented that "Grills and Diffusers will be cleaned on a semi-annual basis" and that "each month the maintenance department will inspect the air handling systems...", and "HVAC Equipment...dryness and cleanliness".

On another day in November 2017, Maintenance Worker #145 reported to Inspector #196 that the ESM had cleaned the grilles on the dining room ceiling vents. [s. 87. (2) (a) (ii)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was acquired, received or stored by or in the home unless the drug had been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and had been provided by, or through an arrangement made by, the pharmacy service provider of the Government of Ontario.

On a day in October 2017, Inspector #625 observed an unlabelled container medication in resident #007's room. Specifically, the container did not have a label indicating that it had been supplied by the home's pharmacy service provider.

On another day in November 2017, Inspector #625 observed the same container of medication in resident #007's room.

During an interview with Inspector #625, RPN #147 reported that resident #007 did not have prescription for the medication located in their room.

During an interview with Inspector #625, RPN #125 stated that the medication in resident #007's room likely came from their family, that their family would apply the medication, and that there was no order for the use of the medication.

During an interview with Inspector #625, the DOC stated that the medication observed in resident #007's room, should not have been stored in the home unless they were prescribed for this resident, and had been obtained from the pharmacy service provider of the Government of Ontario. [s. 122. (1)]

2. On a day in November 2017, Inspector #625 observed a medication in resident #002's room, which did not have a label indicating that it had been supplied by the home's pharmacy service provider.

On another day in November 2017, Inspector #625 again observed the medication in resident #002's room.

During an interview with Inspector #625, the DOC stated that the medication observed in resident #002's room was not supplied by the pharmacy, as indicated by its appearance and lack of a pharmacy label, and that the medication should not have been stored in the home unless it had been obtained from the pharmacy service provider of the Government of Ontario. [s. 122. (1)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including the following: All areas where drugs are stored shall be kept locked at all times, when not in use.

On a day in November 2017, Inspector #196 observed a specific treatment room door propped open with a garbage receptacle. Within the treatment room, the Inspector observed a cart with two plastic bins which contained several containers of prescription medications.

Subsequently, Inspector #196 interviewed RPN#135, who confirmed that the door to the treatment room was not to be propped open and left unsupervised. RPN #135 also confirmed to the Inspector the presence of prescription creams.

Inspector #196 reviewed the home’s policy titled "Safe Storage of Medications - 080 - Draft V2 January 18, 2017", which indicated that "All areas where drugs are stored must be kept locked at all times when not in use."

During an interview with the DOC, they confirmed to Inspector #196 that the doors to the treatment rooms in the home were not to be propped open, and that drugs were to be kept locked up. [s. 130.1.]

Issued on this 17th day of January, 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) :	JULIE KUORIKOSKI (621), KATHERINE BARCA (625), LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2017_435621_0026
Log No. / No de registre :	022410-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 17, 2018
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA 1220 Valley Drive, KENORA, ON, P9N-2W7
LTC Home / Foyer de SLD :	PRINCESS COURT PRINCESS STREET, BOX 725, DRYDEN, ON, P8N-2Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patrick Berrey

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:
a) Ensure that for every resident in the home, staff provide care as specified in each resident's plan of care, including the care of residents #001, #006, #014 and #015;

b) Develop and implement a system to ensure that all direct care staff (PSWs, RPNs, RNs) who are involved in the care of residents, are engaged in the review and revision process of resident's plans of care, and are kept aware of every resident's most up to date plans of care as changes occur;

c) Implement an auditing process for resident's plans of care to ensure that all direct care staff are providing care as per the plan; and

d) Provide retraining to all direct care staff involved in the care of resident's in the home, of the home's policies and procedures related to resident's plans of care, staff responsibilities with respect to providing care as specified in each resident's plan of care, and risks associated with not providing care as per the plan. The home is to maintain a record of the required retraining, who completed the retraining, when the retraining was completed, and what the retraining entailed.

Grounds / Motifs :

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

On a day in November 2017, Inspector #196 completed a review of resident #001's health care record, as this resident was identified to have had an incident

during a specific time period from their most recent RAI-MDS assessment.

On another day in November 2017, Inspector #196 observed resident #001 engaged in a specific activity while a particular safety device, situated adjacent to them on a table, was inactive.

Inspector #196 reviewed a specific section of resident #001's most current care plan, which identified the use of the particular safety device found in resident #001's room, as one of the interventions.

During an interview with PSW #114, they reported to Inspector #196 that the lights on the safety device did not light up, but that it was working. PSW #114 and another PSW then proceeded to reposition the resident in an attempt to activate the safety device. After several attempts to reposition resident #001 were unsuccessful at activating the safety device, PSW #114 determined to the Inspector that the safety device was not operational and a replacement would be required. (196)

2. During meal service at a specific time on a day in October 2017, Inspector #621 observed resident #015 offered an entrée of a certain consistency by PSW #109. Subsequently, Inspector #621 observed RPN #107 provide resident #015 a dessert of another specific consistency.

During a review of resident #015's plan of care, including their diet census record, last updated on a specific day in October 2017, it was identified that resident #015 required a specific diet texture.

During an interview with Dietary Aide #108, they reported to Inspector #621 that resident #015 required their foods to be prepared by the kitchen to the required consistency. Additionally, Dietary Aide #108 identified that the kitchen had not prepared a dessert option from either the main or alternate planned menu items for that meal, and that the PSW and RPN staff would offer the resident a specific item available from the kitchen par stock, and modify it to the appropriate consistency.

During an interview with RPN #107, they reported to Inspector #621 that resident #015 required a specific diet consistency. Additionally, RPN #107 identified that a dessert option had not been prepared in advance by the kitchen from either dessert options identified on the planned menu, and instead, another

item was obtained from the servery par stock to offer resident #015. RPN #107 confirmed to the Inspector that dessert provided to resident #015 was consistency different than what was identified in their plan of care.

During an interview with the Director of Care (DOC), they reported to Inspector #621 that it was their expectation that staff assisting residents with their oral intake were aware of each resident's diet requirements, and only offered menu items that were consistent with each resident's prescribed diets as documented in their plans of care. (621)

3. On a day in November 2017, Inspector #621 reviewed resident #006's most recent RAI-MDS assessment, which identified this resident had a medical condition which required a scheduled care routine. On further review of a specific section of resident #006's care plan, last updated in September 2017, it identified that staff were to complete a specific care activity at schedule times.

During observations on a day in November 2017, resident #006 was observed over two specific time periods to be seated in their mobility device, with no attempts made by staff to complete a specific care activity with this resident during times scheduled in their care plan.

During interviews with PSW #110 and RPN #124, they reported to Inspector #621 that, resident #006 had a specific care routine where PSW staff assisted them at specific time intervals during the day. When the Inspector inquired what staff would refer to, for the plan of care related to resident #006's specific care routine, PSW #110 and RPN #124 indicated that they referred to a current copy of the resident checklist, as well as this resident's care plan. On review of RPN #124's resident checklist, last updated on a specific day in October 2017, and resident #006's care plan, last revised in September 2017, RPN #124 confirmed to the Inspector that PSW staff were providing care to resident #006 on a schedule different than what was documented in this resident's plan of care.

During an interview with RPN #125, they reported to Inspector #621 that resident #006's plan of care, including care plans, were updated by the RAI Coordinator, or by the RN or RPN on duty in the evenings and weekends. Additionally, RPN #125 indicated that if PSW staff identified a change in a resident's care needs which was different than what was in their plan of care, that the PSWs were to write the required changes on a multidisciplinary record located in the conference room of each unit, which the RN on duty would take

with them to review at multidisciplinary meetings each week.

During an interview with the ADOC, they reported to Inspector #621 that if PSW staff identified changes were required to a resident's plan of care, that they were to communicate their requested changes on a clip board found in each units conference room; and/or speak with the RPN on duty, and/or complete the resident risk communication tool found on the ADOC's office door. It was identified by the ADOC that information communicated by the PSW staff from any of these methods would then be reviewed at the weekly multidisciplinary team meetings, which included the RN on duty, RAI Coordinator, DOC, ADOC, and Nurse Practitioner.

The ADOC reviewed their weekly multidisciplinary team meeting notes since the last continence care plan update made for resident #006 in September 2017, and confirmed to Inspector #621 that they had no record of any requested changes from PSW staff since the last care plan update. The ADOC also identified that it was their expectation that PSW staff communicate requested changes through the options made available to them by the home, and to provide care to residents as per their plans of care. (621)

4. During the inspection, Inspector #625 reviewed the most recent Resident Assessment Instrument (RAI) – Minimum Data Set (MDS), relative to the previous assessment, which identified that resident #104 had a medical event which occurred within the previous six months.

Inspector #625 also reviewed a Critical Incident System (CIS) report submitted to the Director for the medical event that occurred on a specific day in July 2017, which resulted in a significant change in health status for resident #014.

Inspector #625 reviewed the home's investigation reports for two additional incidents which occurred after resident #014's medical event in July 2017.

Inspector #625 reviewed a specific section of resident #014's care plan, that was in place at the time of resident #014's incident in September 2017, which identified this resident required a specific number of medical devices to be positioned in a specific way on their bed. A review of the same section of resident #014's care plan, last updated in September 2017, which was in place at the time of another incident from October 2017, identified that this resident required another type of medical device to be attached to resident #014's

mobility aid.

During an interview with Inspector #625, PSW #138 stated that they had discovered resident #014 at the time of the incident on the day in October 2017, after the resident attempted a particular activity. PSW #138 confirmed to the Inspector that a particular safety device was not on this resident's mobility aide at that time of the incident, as the home had not transferred the device over from a mobility aide the resident had been previously using.

During an interview with Inspector #625, the ADOC acknowledged that resident #014 had another incident on a day in September 2017, and that a specific safety device was not in position on this resident's bed as identified in their care plan, at the time of the incident. The ADOC also acknowledged that resident #014 had another incident in October 2017, and that the mobility aide that they were using did not have a safety device installed at the time of the incident, as the care plan had indicated. The ADOC stated that, with respect to these two specific incidents, the care set out in the plan of care had not been provided to resident #014 as specified in the plan.

The decision to issue this compliance order was based on the severity which indicated a potential risk of actual harm; the scope which was a pattern of care not being provided as per resident plans of care; and the compliance history, which indicated that in spite of non-compliance pursuant to LTCHA, 2007 S.O. 2007, s.6(7) which was previously identified under inspection reports 2015_281542_0017 and 2014_211106_0019, with voluntary plans of correction issued, there was continued non-compliance in this area of the legislation. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 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 17th day of January, 2018

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 : Julie Kuorikoski

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