Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 19, 2015	2015_188168_0015	H-002400-15	Resident Quality Inspection

Licensee/Titulaire de permis

LIUNA LOCAL 837 NURSING HOME(HAMILTON) CORPORATION
44 HUGHSON STREET SOUTH HAMILTON ON L8N 2A7

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

QUEEN'S GARDEN
80 Queen Street North HAMILTON ON L8R 3P6

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

LISA VINK (168), BERNADETTE SUSNIK (120), CYNTHIA DITOMASSO (528), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 20, 21, 22, 25, 26, 27, 28 and 29, 2015 and June 2 and 3, 2015.

The following Complaint and Critical Incident Inspections were conducted concurrently with this RQI and any findings identified are included in this Inspection Report: H-000775-14, H-000838-14, H-000956-14, H-001244-14, H-001318-14, H-001365-14, H-001384-14, H-001436-14, H-001442-14, H-001507-14, H-001520-14, H-001623-14, H-001697-14, H-001852-15, H-001943-15, H-002022-15, H-002240-15, H-002297-15, H-002356-15 and H-002467-15.

Inspector Samantha DiPiero observed a portion of this RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nursing Unit Clerk, Program and Support Services Manager, Food Services Supervisor (FSS), Environmental Supervisor/Maintenance (ESM), Resident Assessment Instrument (RAI) Coordinator, registered nursing staff, personal support workers (PSW's), housekeeping and dietary staff, registered dietitian (RD), families and residents.

During the course of this inspection the inspectors: toured the home, observed the provision of care and services and reviewed relevant documents including but not limited to clinical health records, meeting minutes, menus, and policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

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

Resident #26 was incontinent of bladder and usually continent of bowel functioning

according to the most recent Minimum Date Set (MDS) assessments and resident and staff interviews. A review of the plan of care did not include the planned care for the resident related to bowel functioning as there was no focus statement for bowel elimination or continence as confirmed during an interview with registered staff. [s. 6. (1) (a)]

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

On May 25, 2015, resident #18 was observed in bed with a bed pad in place and wearing a brief. The plan of care indicated that they had been wearing a brief; however, a sign posted in the room identified staff were to only use bed pads, no briefs or pads. Staff interviewed reported the resident was only to use a bed pad due to a history of skin breakdown. Registered nursing staff confirmed the plan of care did not provide clear direction to staff regarding the use of pads and briefs. [s. 6. (1) (c)]

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

Resident #14 was admitted to the home in 2014. On admission the resident's Substitute Decision Maker (SDM) communicated to the FSS that the resident was lactose intolerant. A review of the Admission Dietary Assessment and Resident Assessment Protocol (RAPs) completed by the RD did not indicate the lactose intolerance. Review of the plan of care and dietary profile did not identify the need to avoid milk products due to the intolerance. A dietary aide confirmed the resident's intolerance was not included on the profile, despite their awareness of the SDM's comments but also that they were sometimes served milk products. Interview with registered staff confirmed the lactose intolerance and the need to avoid milk products, but confirmed this was not included in the plan of care. Interview with the RD confirmed that the dietary assessments were not consistent with each other related to the intolerance. [s. 6. (4) (a)]

4. The licensee failed to ensure that the resident, the SDM, if any, were provided the opportunity to participate fully in the development and implementation of the plan of care.

Resident #22 was not able to make decisions regarding their care. The physician wrote on order that read "if ok with family then start melatonin". Interview with the resident's SDM, who was the first emergency contact, identified that they were not aware of the use

of the melatonin until a charge statement was received from the pharmacy. A review of the clinical record, confirmed the use of the treatment; however, did not include that the family was notified. Interview with registered staff indicated that since the notification was not recorded on the order sheet or in the progress notes and based on the statement of the family that the SDM was not given an opportunity to participate in this aspect of the plan of care. [s. 6. (5)]

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

A. Resident #11 was identified at high nutritional risk and had a recent significant change in status following an injury. The resident was assessed by the RD for difficulty with a regular texture diet and changed the diet to minced to promote intake. On May 27, 2015, the resident was served a regular texture diet and ate less than fifty percent (%) of their meal. Dietary and nursing staff confirmed that a regular textured diet was provided and that the resident should have received a minced diet. (585)

B. Resident #11 had a plan of care to have two covered bed rails raised when in bed, to prevent injury. On May 27 and 28, 2015, the resident was observed sleeping in bed with two bed rails raised, with only one rail covered by a bed pad. When observed their hands were grasped together through the uncovered rail. Staff reported the resident had a history of getting their limbs caught in the rails, which resulted in the intervention to have the rails covered. Staff confirmed the care set out in the plan of care was not provided. (585)

C. In June 2014, resident #56, required total assistance with their activities of daily living and received non-opioid analgesia for pain routinely, multiple times a day. Later that month the physician ordered a change in routine analgesia, now an opioid and pain assessments to be completed for better pain control. That evening and the following morning registered staff documented that the resident had difficulty swallowing and did not take oral medications. The next day at 1620 hours, the resident was deemed palliative and new orders were received including ongoing monitoring, as needed oral balance gel for comfort, subcutaneous opioid analgesia every fours hours as needed for pain, to reassess pain every shift and notify the physician if pain was not well controlled or more than two to three breakthrough doses of analgesic was required in a 24 hours period.
A review of the Electronic Medication Administration Records (eMARS) revealed that from the date of the change in orders at 1515 hours until two days later at 0159 hours,

the resident did not receive any analgesia. The daily pain flow sheet for the identified time period noted the resident had verbal or nonverbal complaints of pain on the day and evening shift. Interview with registered staff, who cared for the resident, confirmed that prior to and including when the resident's was deemed palliative, they experienced pain daily due to end stage disease, with bed mobility and when turned or repositioned. Since the resident experienced pain when turned or repositioned, as confirmed by documentation and staff interview, the care set out in the plan for pain management was not provided to the resident for approximately 34 hours. (528)

D. Resident #11 experienced a fall, which resulted in an injury and transfer to hospital. Upon return from hospital, clinical documentation identified that registered staff contacted the DOC and ESM to determine if a new intervention could be implemented for the resident's safety and as requested by the family. The DOC and ESM both confirmed they were aware of the staff's request but did not follow-up with the staff. (585)

E. Resident #30 was admitted to the home with a diagnosis of atrial fibrillation. The resident was on anti-coagulation therapy at the time of admission and had routine blood testing to determine the dosage. On admission the anti-coagulation medication was on hold, pending blood work to be completed, which was ordered by the physician. The admission blood work order was not processed for the required blood test. The anti-coagulant medication was not resumed until it was identified as absent from the medication profile by a specialist approximately seven weeks later. The plan of care developed on admission included the use of anti-coagulant therapy. Care set out in the plan of care was not provided to the resident as specified. (168) [s. 6. (7)]

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

A. In December 2014, resident #18 was assessed as having a high pressure risk score. Due to recurring areas of altered skin integrity in early 2015, the resident was placed on bed rest and an air mattress was provided to promote wound healing. Review of the plan of care did not include the residents recurring areas of altered skin integrity or the interventions to promote skin and wound healing. Interview with the Skin Care Coordinator confirmed that the written plan of care was not revised to include the recurring areas of altered skin integrity or interventions. (528)

B. Resident #18 had a goal in their plan of care, last revised in July 2013, that they would

be safe when one bed rail was used. Staff confirmed that the resident had two rails for safety and positioning. Registered staff confirmed that the resident originally had one rail; however, an additional was implemented to promote safety and the care plan was not reviewed with the change in care needs. (585)

C. Resident #58 was readmitted to the home in 2015, under palliative status. Palliative orders included but were not limited to, discontinuation of all medications, new subcutaneous medications for pain/shortness of breath/respiratory secretions/agitation, oxygen, an indwelling catheter and an air mattress. Review of the plan of care did not include new interventions when the resident's status changed to palliative upon readmission. Interview with the DOC confirmed that the written plan of care was not revised to include the palliative status. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident, that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent and complement each other, that the resident, the SDM, if any, are provided the opportunity to participate fully in the development and implementation of the plan of care 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, procedure or system put into place was complied with.

A. The home's policy for Skin Care Program Overview, LTC-CA-WQ-200-08-01, last revised November 2014, was not complied with.
The policy directed registered staff to complete a comprehensive skin assessment within 24 hours of admission, on readmission, following a leave of absence greater than 24 hours, following any readmission from the hospital, with any significant change in status and with each quarterly assessment.

In 2015, resident #20 had a fall with injury and was transferred to hospital for assessment. Upon return to the home, it was identified that the new injury impacted more than one aspect of the resident's health condition and a significant change in status MDS Assessment was completed. Review of the plan of care did not include a completed comprehensive skin assessment with the change in condition, as required by the policy and confirmed during interview with registered staff. (528)

B. The home's policy Continence Care, LTC-CA-WQ-200-02-05, last revised November 2014, was not complied with.
The policy identified that registered staff would determine the level of continence and a plan of care in response to the pattern of continence be developed and documented. The plan was to include but not be limited to: the resident's level of continence for both bladder and bowel, individual patterns of toileting for bladder and bowel, any safety concerns, cognitive ability related to the urge to void or the ability to use the toilet.

Resident #51 was admitted to the home in 2009. Review of MDS Assessments from

2014 and interview with PSW staff revealed that the resident was continent of bladder and was able to toilet independently but at times required assistance with hygiene. Review of the written plan of care did not include the level of continence for bladder functioning, individual patterns for toileting, safety concerns, nor the cognitive ability related to the urge to void or use the toilet. Interview with registered staff confirmed that the written plan of care did not include a toileting or bladder focus as required by the Continence Care policy. (528)

C. MediSystem Pharmacy provided pharmacy services to the home. The home had a Medisystem procedure related to Narcotic and Controlled Substances Administration Record, 04-07-10, last reviewed June 23, 2014, which indicated that "a daily count of all narcotics can be made on the Narcotic and Controlled Substance Administration Record. A check of the balance on hand must be done by two nurses or care providers as per facility policy at the time of every shift change".

Staff in the home identified three missing Fentanyl patches on January 2, 2015. An internal investigation was completed which included interviews with pharmacy staff and registered staff who had access to the medication since December 31, 2014. Registered staff confirmed during interviews that they did not consistently comply with the procedure related to the check of the balance on hand by two nurses at every shift change as required and that there were occasions when staff counted narcotics and controlled substances independently at the change of shift. The procedure was not complied with. (168)

D. The home's policy Privacy and Confidentiality, effective January 1, 2014, identified a procedure under disposal that "medication pack/strip must have the name and numbers removed from the packaging before disposal".

On May 27, 2015, during the noon medication pass staff were observed to place the discarded medication pouches in the garbage bin located on the med cart. The pouches once discarded still contained the resident's name, room number and the name of the prescribed medication, their personal health information, which was confirmed with registered staff. The staff confirmed that the garbage would be placed in the regular garbage and not discarded separately. The housekeeper was observed to remove the garbage from the cart and place it in the large garbage bin on the cleaning cart. The medication packs were not disposed of as per the home's procedure. (168)

E. The home's Hydration Program, LTC-CA-WQ-300-05-07, was not complied with. The

program stated if a resident consumed less than eight cups of fluid per day for three consecutive days, a referral was to be initiated to the RD.

In February 2015, resident #18, who was identified at high nutritional risk, had two occurrences where they consumed less than eight cups of fluid over periods greater than three consecutive days. For the first occurrence, a referral was not initiated until the ninth consecutive day the resident was below target. On the second occurrence, the resident did not meet the target fluid intake for four days and no referral was initiated. Registered staff confirmed the home did not comply with the hydration program. (585)

F. The home's policy Diagnostic Testing, LTC-CA-WQ-200-04-02, last revised November 2014, identified that "upon receipt of a physician or nurse practitioner order for diagnostic test, registered staff will: process the physician order as per the home procedure".
Interview with registered staff confirmed the home's procedure to process orders included one nurse to process the order and a second to complete a check of the order the following shift and that these activities were to be completed in a timely fashion, up to one day.

Resident #30 was admitted to the home in 2014. A review of the clinical record, specifically the New Admission Order Form, identified that the admission orders for lab work was received via telephone on the day of admission; however, were not signed as processed until five days later and were not signed as double checked until the eighth day after admission. The registered staff did not process the orders the day they were received nor did the following shift complete a check, which was confirmed during an interview with registered staff. (168) [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 any plan, policy, procedure or system put into place was complied with., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee failed to ensure that the lighting requirements set out in the table to this section were maintained.

The home was built prior to 2009 and therefore the section of the lighting table that applied was titled "All other areas of the home".
A hand held light meter was used (Sekonic Handi Lumi) to measure the lux levels in corridors, shower rooms and one private washroom. The meter was held a standard 30 inches above the floor and held parallel to the floor. Lights were determined to be on more than 10 minutes prior to measuring. Outdoor conditions were semi-bright during the measuring process; however, natural light was managed wherever possible by shutting doors or window coverings.

i. Resident bathroom #183 was measured on May 26, 2015 and was similarly equipped with the same light fixtures as all of the other corner rooms in the home. Each washroom had a wall mounted fluorescent tube light with a valence over the vanity area. The lux level at the vanity was adequate at 400; however, dropped to 100 just in front of the toilet area. The minimum required lux level for the washrooms is 215.28 lux.
ii. Shower rooms located on each of the six home areas were similarly equipped with a small round ceiling light with an opaque lens. The lux level directly under the light was 25. The minimum required lux level for shower areas is 215.28 lux.
iii. The lighting fixture placement on the Gage Park corridor was different from the other two floors. The section in front of the nurse's desk and the resident lounge were equipped with fluorescent lights spaced 14 feet apart with a louvered lens. The lux level was 100 between these fixtures. The area in front of the elevators on the third floor also had lighting fixtures placed differently from other floors. The fixtures were spaced 14 feet apart and the area in front of one elevator was 85-100 lux.
iv. The first floor corridor in the Durand home area had a number of burnt out light tubes, creating inadequate lighting levels. While standing in the corridor (centrally), the lux was 100 in front of room 114, 130 lux between room 111 and 113 and 120 lux in front of rooms 107 and 109.
The minimum required lux level in corridors must be a consistent and continuous level of 215.28. [s. 18.]

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 lighting requirements set out in the table to this section are maintained, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promoted zero tolerance of abuse of residents was complied with.

The home's policy Resident Abuse-Abuse Prevention Program - Whistle Blowing Protection, LTC-CA-ALL-100-05-02, last revised October 2014, identified the following:
-"All provincial legislative reporting requirements will be followed (MOHLTC, RHRA, AB/BC Authorities)". All reports of an abuse allegation are to be investigated immediately by the supervisor who receives the report. The investigation includes: immediate notification/mandatory reporting to the governing provincial authority as applicable to the home, province and sector; the "Authority" is to determine what constitutes abuse, harm or risk and if they will respond to the allegation".
-"The supervisor/designate is responsible to ensure all events related to a reported allegation investigation are documented in the resident health chart".

A. Staff communicated to the Administrator, via a letter, that resident #34 reported rough care by a PSW and was denied access to a device. The Administrator initiated an investigation into the allegations and resolved the situation to the satisfaction of the resident and their family. A review of the clinical record did not include any progress

notes regarding the reported allegation or the investigation, as required in policy and confirmed during an interview with registered staff.

B. The home received a report from a family member that a PSW was rough with resident #35 on an identified date and shift. The home immediately responded to the allegation and conducted an internal investigation which included a review of the incident on video and was not able to support the allegation. Documentation of the allegation and investigation were not included in the clinical record as required and confirmed during staff interview.

C. The home received a report from a family member that a PSW was rough with resident #36 on an identified date and shift. The home immediately responded to the allegation and following an internal investigation which included a review of the incident on video was not able to support the allegation. A review of the allegation and investigation were not in included in the clinical record as required and confirmed during staff interview.

D. Resident #37 reported that a staff member used a derogatory term when speaking with them in 2014 and then in 2015, was rough in the provision of care a the time of a transfer. The home investigated the allegations and resolved the concerns to the satisfaction of the family. The allegations nor investigations were documented in the clinical record as confirmed during a staff interview.

E. Resident #39 reported an allegation of rough care by a staff member during the provision of a transfer. The allegation was reported to the charge nurse who communicated the concerns to the Administrator the same day. The home did not notify the Director of the allegation until the day following, via the Critical Incident System. The Ministry was not notified immediately of the allegation of abuse. A review of the clinical record did not include the allegation of rough care or the investigation completed as a result, which was confirmed during an interview with registered staff. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy that promoted zero tolerance of abuse of residents is complied with, 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 failed to ensure that all equipment was used in the home in accordance with manufacturers' instructions.

Resident #18 used a Power Pro Elite air mattress for comfort and positioning. The manufacturers' instructions stated the mattress was to be cleaned on the bed weekly using a damp soft cloth and mild detergent and if the top sheet (top cover) or base (bottom cover) becomes excessively soiled, to remove the top and/or bottom cover and clean or dispose of the cover. In addition, the instructions identified that covers could be washed in a washing machine. On May 25, 2015, a strong odour was detected from the mattress and a dry white fluid debris on top right area of the mattress.
On May 26, 2015, the odour and dry fluid debris was observed again and the cover had notable wear in seven areas where internal fabric was exposed. One PSW reported the bed was cleaned using a disinfectant cleaning solution. A second PSW reported their duty was to clean the top of the mattress with soap and a cleaning solution; however, despite cleaning, the odour had been present for a long time. Housekeeping staff reported the covers were not removed or washed. The DOC confirmed that within the last year, air mattress covers in the home had not been removed to wash in a washing machine or replaced. [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 all equipment is used 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 failed to ensure that the RD 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.

A. According to the clinical record resident #18 was identified at nutritional risk on multiple occasions by nursing staff and was referred to the RD:
i. On January 29, 2015, for inadequate fluid intake,
ii. On February 3, 2015, for significant weight change of greater than 5% over one month and 10% over 6 months,
iii. On February 12, 2015, for skin breakdown; and
iv. On February 15, 2015, for inadequate fluid intake.
Review of the clinical record revealed the resident was not assessed by the RD until March 3, 2015. The DOC confirmed there was no documentation to indicate the resident was assessed before March 3, 2015 and that they were not assessed within an acceptable period of time.

B. A referral was made to the RD on April 20, 2015, as resident #22 was noted to have lost 12.9% body weight over one, three, and six months. Then on May 9, 2015, the resident was weighed again and was noted to have lost 10.3% body weight over three and six months. The resident was not assessed for the change in weight until May 19, 2015, which was confirmed by the RD. [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 the RD assess 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 LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(a) the device is used in accordance with any requirements provided for in the regulations; 2007, c. 8, s. 31 (3).
(b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).
(c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).
(d) the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).
(e) the resident is restrained only for as long as is necessary to address the risk referred to in paragraph 1 of subsection (2); 2007, c. 8, s. 31 (3).
(f) the method of restraining used is discontinued if, as a result of the reassessment of the resident's condition, one of the following is identified that would address the risk referred to in paragraph 1 of subsection (2):
(i) an alternative to restraining, or
(ii) a less restrictive method of restraining that would be reasonable, in light of the resident's physical and mental condition and personal history; 2007, c. 8, s. 31 (3).
(g) any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was restrained by a physical device under subsection (1), the device was used in accordance with the requirements provided for in section 110 of the regulations; that staff applied the physical device in accordance with any manufacturer's instructions.

Resident #55 was observed with a loose front fastening seat belt, not applied according to manufacturer's instructions. On May 26, 2015, at 1100 hours, the resident was observed in their wheelchair with a fastened front seat belt, resting on their knees. The resident was unable to undo the seat belt on request. Review of the plan of care, identified that the belt was a restraint. Interview with PSW staff confirmed the belt was loose and should be approximately two fingers breadth away from the residents body, as per manufacturer's and home's instructions. Interview with registered staff, who tightened the belt, confirmed the belt was used at all times when in the wheelchair as a restraint.
On June 2, 2015, at 1100 hours, the resident was observed seated in their wheelchair with a loose front fastening seat belt, approximately seven fingers breadth away from their body. Interview with the registered staff confirmed that the seat belt was loose and identified it to be applied at two fingers breadth away from the resident's body before they tightened the device as per manufacturer's instructions. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that if a resident is restrained by a physical device under subsection (1), the device is used in accordance with any requirements provided for in section 110 of the regulations; that staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 33. (5) If a PASD is used under subsection (3), the licensee shall ensure that the PASD is used in accordance with any requirements provided for in the regulations. 2007, c. 8, s. 33. (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the PASD used under subsection (3) was used in accordance with any requirements provided for in the regulations.

On June 2, 2015, resident #60 was observed repositioned in their wheelchair by staff. The tilt feature of the chair was activated by PSW staff and a front fastening seat belt was noted to be loose, approximately six fingers breadth away from the resident's body. Review of the plan of care identified that the resident required a tilt wheelchair and front fastening seat belt as a PASD for safety and positioning. Interview with the PSW confirmed that the seat belt was loose. Registered staff confirmed that the seat belt should be two fingers breadth away from the resident's body, as per manufacturer's instructions. The seat belt was then tightened and applied as per manufacturer's instructions. [s. 33. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the PASD used under subsection (3) is used in accordance with any requirements provided for in the regulations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee failed to ensure that no prohibited restraint devices were used on a resident.

Ontario Regulation 79/10, section 112(7) identified that "For the purpose of section 35 of the Act, every licensee of a long term care home shall ensure that the following devices are not used in the home: sheets, wraps, tensors or other types of strips or bandages used other than for therapeutic purpose."

Interview conducted with registered staff identified that in the summer of 2014, a bed sheet was used as a restraint for resident #33, when up in the wheelchair, for a short period of time, while under staff supervision. The staff member and a witness, who notified the Administrator, confirmed the use of the device. The staff who applied the device communicated that in their opinion it was for the safety and comfort of the resident; however, acknowledged current awareness that this type of device was prohibited for use as a restraint. [s. 35. (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 no prohibited restraint devices are used on a resident, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when they assisted residents.

A. In May 2015, resident #24 was observed up in the wheelchair and in need of repositioning, as their hips were not seated at the back of the chair. The PSW who positioned the resident, confirmed during an interview, that they pushed forward on the resident's upper back, twice, in order to allow them to pull the resident back in the chair from the waist. This positioning technique was witnessed by the Administrator, who deemed the actions of the PSW to be inappropriate and unsafe.

B. Resident #23 reported complaints of pain following a transfer with the mechanical lift. Interview conducted with registered staff confirmed at the time that the resident complained of pain they were to be transferred using a hoyer lift. PSW staff confirmed that they previously used the sit to stand to lift when transferring the resident at times. The resident's lift status was reassessed following the reports of pain and it was confirmed that a hoyer lift was required for transfers. A review of the plan of care and all interventions included since the time of admission under the focus of transfers, identified the use of a mechanical hoyer lift only. Staff did not use safe transferring techniques when caring for the resident, when they used a sit to stand lift. [s. 36.]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. The plan of care for resident #18 identified that they were assessed as having a high pressure score risk and recurring areas of altered skin integrity. In February 2015, registered staff identified three new areas of altered skin integrity related to pressure. The wounds were all documented as closed three months later; however, weekly assessments were not completed approximately 50% of the time. In April 2015, registered staff identified two new areas of altered skin integrity related to pressure, which were documented as closed approximately five weeks later. Review of the plan of care revealed weekly assessments were not completed by registered staff for two out of five weeks. Interview with registered staff confirmed weekly wound assessment were not completed consistently as identified above. (528)

B. Resident #22 was identified to have a necrotic wound which was assessed by registered staff and treatment initiated. This area of altered skin integrity was not reassessed at least weekly from March 14, 2015, until April 7, 2015, as confirmed during an chart review with the registered staff. (168) [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

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

The February 2015, MDS Assessment for resident #57 identified that they were incontinent of bladder and bowel and required total assistance of two staff for toileting. The plan of care directed staff to check the resident at least every two hours and to take them to the bathroom to eliminate after each meal. On May 27, 2015, at approximately 0930 hours, the resident was transported to their room after breakfast. At approximately 1030 hours they were taken to recreation activity and transported to the dining room at approximately 1215 hours. Interview with PSW's confirmed that the resident was not taken to the bathroom after breakfast as specified in the plan and activity staff confirmed the resident was not toileted or checked for incontinence during the activity program. The resident was not toileted or checked for incontinence for over two and a half hours. The resident's plan to manage bowel and bladder continence was not implemented. [s. 51. (2) (b)]

2. The licensee failed to ensure that the resident who required continence care products had sufficient changes to remain clean, dry and comfortable.

Resident #18 required total assistance of staff to manage their urinary incontinence and had a history of altered skin integrity, including pressure ulcers. On May 27, 2015, the resident was observed lying in bed, on a continence pad which was saturated in urine. Following this observation, the resident was monitored for two and a half hours, during which time their continent pad was not changed. After the pad was changed, the registered staff reported to the inspector that they were aware the resident was wet and had informed PSW staff of the resident's status approximately two hours before the resident was changed. [s. 51. (2) (g)]

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 who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented and that the resident who requires continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident with the following weight changes was assessed using an interdisciplinary approach and that actions were taken and outcomes evaluated:
1. A change of 5% of body weight, or more, over one month
2. A change of 7.5% of body weight, or more, over three months
3. A change of 10% of body weight, or more, over 6 months

A. In January 2015, clinical records indicated resident #11 had a weight change of 9.1% over three months and 10.6% over six months. In February 2015, records indicated the resident had a change of 6.3% over one month. Progress notes reviewed did not include that an interdisciplinary approach was taken to assess the change in weight. The RD was interviewed and reported that they assessed residents for weight change only upon a referral. The RD confirmed no referrals were received and no interdisciplinary assessments occurred for the changes in weight in January and February 2015.

B. In February 2015, clinical records indicated resident #22 had a change in weight of 9.8% over three months and 10.4% over six months. In March 2015, records indicated the resident had a change of 10.9% over three and six months. Progress notes reviewed did not include that an interdisciplinary approach was taken to assess the change in weight. The RD was interviewed and reported that they assessed residents for weight change only upon receiving a referral. The RD confirmed that no referrals were received and no interdisciplinary assessments occurred for the changes in weight in February and March 2015. [s. 69.]

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 resident with the following weight changes are assessed using an interdisciplinary approach and that actions are taken and outcomes evaluated: for a change of 5% of body weight, or more, over one month or a change of 7.5% of body weight, or more, over three months or a change of 10% of body weight, or more, over 6 months, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

On May 20, 2015, puree fruit was prepared and served to a resident. The item appeared runny and pooled on the plate and was not visually appealing. On May 26, 2015, pre-made puree bread as well as puree whole wheat bread was prepared and served to residents. The pre-made bread appeared dry with a cake-like texture and the whole wheat bread pooled on the plate. The FSM confirmed puree food should hold its shape and should not pool when served or be dry. [s. 72. (3) (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 all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On May 25, 2015, a PSW adjusted the position of resident #54's wheelchair from upright to a tilted position of approximately 45 degrees before they fed them their thickened morning beverage. When the PSW was asked about the positioning she indicated that due to the resident's neck positioning, it was easier to feed them in a tilted position. Review of the resident's plan of care identified that they required total assistance with feeding in an upright position for all meals. Interview with the registered staff confirmed that the resident should have been in an upright position to minimize aspiration risk. [s. 73. (1) 10.]

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 proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that they sought the advice of the Residents' Council in the development and carrying out the satisfaction survey and in acting on its results.

Interview with the Council Assistant identified that in 2014 and to date in 2015 the home did not seek out the advice of the Residents' Council in the development and carrying out of the satisfaction survey, which was confirmed during a review of the Residents' Council Meeting Minutes. [s. 85. (3)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).
(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).
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service; O. Reg. 79/10, s. 90 (2).
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and O. Reg. 79/10, s. 90 (2).
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, the licensee did not ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance related to the resident staff communication and response system (RSCRS).

The home's RSCRS was designed and approved to function with the use of portable pagers. The requirement was that each PSW be equipped with a pager that would alert them of the location of an activation station when pulled.
i. On May 26, 2015, 4 PSW's did not have a fully functioning pagers on their person. The first pager, on Dundurn, did not display the location of the station after the first 10 seconds as the recall function was not working. The second pager, on Gage Park, did not have a working battery. The third pager on Jamesville, did not receive a signal from an activated station in a resident bedroom and the last pager, in Westdale, was not worn by the PSW who stated they were not sure why it was unavailable. Maintenance staff were unaware of the issues regarding the pagers. It was identified that the PSWs were required to document any issues in the Maintenance Log and/or contact maintenance staff. The expectations for the PSW staff, according to the Administrator, was that they checked the pager batteries, be familiar with how the pager operated, carry the pagers at all times, report any operating issues and turn in their pagers at the end of their shift. None of the expectations for the care and use of the pagers was available in the procedures provided.
ii. The activation station in the chapel was tested and could not be canceled at the point of activation. The maintenance staff was aware of the issue but had not ordered a replacement station prior to the inspection. According to the staff, a preventive inspection of the system was completed in 2015, for functionality of the activation stations. The pagers were not included in the preventive component as they were expected to be monitored by the nursing staff. No procedures were developed to direct staff as to how, when and what exactly would be included in the preventive inspection process and what follow up actions would be necessary should a component of the system fail. [s. 90. (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 as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, the licensee ensure that schedules and procedures are in place for routine, preventive and remedial maintenance related to the resident staff communication and response system, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Staff did not comply with the home's infection prevention and control program. This program included a Hand Hygiene Program, LTC-CA-WQ-205-02-04, last revised January 2015, which identified staff were to perform hand hygiene before initial contact with the resident or resident environment, after body fluid exposure risk, and after resident or resident environment contact. On May 20, 2015, two PSW staff were observed during the course of the noon meal service to remove soiled dishes from the dining room tables and then proceed to serve residents the next course of their meal and/or assist residents with feeding, without performing hand hygiene in between the tasks. [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 ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In May 2015, resident #18 was observed in bed, with two half rails raised. Multiple staff confirmed the rails were in place for safety and positioning. Registered nursing staff reported the resident originally had one rail; however, was later assessed and the SDM consented to the use of two rails. A review of the clinical documentation included only an assessment for the use of one rail and not the revised assessment or consent, which was confirmed by registered staff. [s. 30. (2)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident had their desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

Resident #38, who was able to make decisions regarding their own care; however, was dependent on staff for the provision of care, made a request of staff to go to bed at approximately 1830 hours, on an identified date, due to fatigue. The staff member did not assist the resident to bed for at least one hours after the request, as confirmed during an internal investigation conducted by the home, due to part the PSW's routine. The PSW did not ensure that the resident had their desired bedtime supported, as confirmed during statements of the resident and the employee. [s. 41.]

Issued on this 22nd day of June, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168), BERNADETTE SUSNIK (120), CYNTHIA DITOMASSO (528), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2015_188168_0015
Log No. / Registre no:	H-002400-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 19, 2015
Licensee / Titulaire de permis :	LIUNA LOCAL 837 NURSING HOME(HAMILTON) CORPORATION 44 HUGHSON STREET SOUTH, HAMILTON, ON, L8N-2A7
LTC Home / Foyer de SLD :	QUEEN'S GARDEN 80 Queen Street North, HAMILTON, ON, L8R-3P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brent Kerwin

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

To LIUNA LOCAL 837 NURSING HOME(HAMILTON) CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to all residents as specified in the plans specifically related to the following areas:
a. diet textures,
b. use of safety devices,
c. pain management and
d. diagnostic testing.

The licensee shall develop and implement a system to ensure that staff are aware of the individualized care needs of each resident and that this care is provided.

The implementation of this system shall include but not be limited to: staff education, clear identified of staff roles for care needs and ongoing audits to ensure that the care is provided.

Grounds / Motifs :

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

A. Resident #11 was identified at high nutritional risk and had a recent significant change in status following an injury. The resident was assessed by the RD for difficulty with a regular texture diet and changed the diet to minced to promote intake. On May 27, 2015, the resident was served a regular texture diet and ate less than fifty percent (%) of their meal. Dietary and nursing staff confirmed that a regular textured diet was provided and that the resident should have received a minced diet. (585)

B. Resident #11 had a plan of care to have two covered bed rails raised when in bed, to prevent injury. On May 27 and 28, 2015, the resident was observed sleeping in bed with two bed rails raised, with only one rail covered by a bed pad. When observed their hands were grasped together through the uncovered rail. Staff reported the resident had a history of getting their limbs caught in the rails, which resulted in the intervention to have the rails covered. Staff confirmed the care set out in the plan of care was not provided. (585)

C. In June 2014, resident #56, required total assistance with their activities of daily living and received non-opioid analgesia for pain routinely, multiple times a day. Later that month the physician ordered a change in routine analgesia, now an opioid and pain assessments to be completed for better pain control. That evening and the following morning registered staff documented that the resident had difficulty swallowing and did not take oral medications. The next day at 1620 hours, the resident was deemed palliative and new orders were received including ongoing monitoring, as needed oral balance gel for comfort, subcutaneous opioid analgesia every fours hours as needed for pain, to reassess pain every shift and notify the physician if pain was not well controlled or more than two to three breakthrough doses of analgesic was required in a 24 hours period.
A review of the Electronic Medication Administration Records (eMARS) revealed that from the date of the change in orders at 1515 hours until two days later at 0159 hours, the resident did not receive any analgesia. The daily pain flow sheet for the identified time period noted the resident had verbal or nonverbal complaints of pain on the day and evening shift. Interview with registered staff, who cared for the resident, confirmed that prior to and including when the resident's was deemed palliative, they experienced pain daily due to end stage disease, with bed mobility and when turned or repositioned. Since the resident experienced pain when turned or repositioned, as confirmed by documentation and staff interview, the care set out in the plan for pain management was not provided to the resident for approximately 34 hours. (528)

D. Resident #11 experienced a fall, which resulted in an injury and transfer to hospital. Upon return from hospital, clinical documentation identified that registered staff contacted the DOC and ESM to determine if a new intervention could be implemented for the resident's safety and as requested by the family. The DOC and ESM both confirmed they were aware of the staff's request but did not follow-up with the staff. (585)

E. Resident #30 was admitted to the home with a diagnosis of atrial fibrillation. The resident was on anti-coagulation therapy at the time of admission and had routine blood testing to determine the dosage. On admission the anti-coagulation medication was on hold, pending blood work to be completed, which was ordered by the physician. The admission blood work order was not processed for the required blood test. The anti-coagulant medication was not resumed until it was identified as absent from the medication profile by a specialist approximately seven weeks later. The plan of care developed on admission included the use of anti-coagulant therapy. Care set out in the plan of care was not provided to the resident as specified. (168) (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 16, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 19th day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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