Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jul 18, 2017;	2017_618211_0008 (A1)	005946-17	Resident Quality Inspection

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET OTTAWA ON K1N 5C8

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

RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA OTTAWA ON K1C 2Z6

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

JOELLE TAILLEFER (211) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Order (CO) #003 has been changed as requested by the licensee. A sentence in the second paragraph was modified to clarify the order.

The compliance dates for CO #005 and #006 have been changed as requested by the licensee. The new compliance date for CO #005 is August 31, 2017 and the new compliance date for CO #006 is September 28, 2017.

Issued on this 18 day of July 2017 (A1)

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

Original report signed by the inspector.

Ontario

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JOELLE TAILLEFER (211) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): April 18, 19, 20, 21, 24, 25, 26, 27, 28, 2017 and May 1, 2, 3, 5, 8, 9, 2017.

This Resident Quality Inspection also included the following:

-Four logs associated to critical incident the home submitted to the Ministry;

Log #000169-17, Log #032808-16 related to fall that cause injuries

Log #003618-17 and Log #007081-17 related to allegations of abuse,

-Three logs associated to complaints;

Log #007057-17 related to allegation of abuse, a fall, and skin and wound care, and care and services,

Log #035053-16 related to allegation abuse, continence care, and personal support services,

Log #005218-17 related to allegation of abuse and care and services.

During the course of the inspection, the inspector(s) spoke with the home's

Executive Director of Long Term Care (EDLTC), the Administrator/Clinical Manager (ACM), the Director of Care (DOC), the Registered Dietician (RD), the Food Services Manager (FSM), the Maintenance Facility Manager, several Dietary Aides (D.A.), the Food Services Supervisor, the Administrative Coordinator, the Infection Control Nurse, the Clinical Educator, the Advance Practice Nurses, the Physiotherapist, the Physiotherapist Assistant, several Registered Nurses (R.N.), several Registered Practical Nurses (R.P.N.), several Personal Support Workers (PSW), housekeeping staff, the Administrative Coordinator, the Ward Clerk, the maintenance staff, the president of the family council, the president of the resident council, several family members and several residents.

In addition, the inspectors reviewed resident health care records, policies related to prevention of abuse, falls prevention, medication administration, infection control, and restraint minimization, the quarterly medication incident report, education training, family council minutes and resident council minutes. Inspectors also observed resident care and services, staff and resident interaction, and meal services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Safe and Secure Home

Skin and Wound Care

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

26 WN(s)
13 VPC(s)
6 CO(s)
1 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators
Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any elevators in the home are equipped to restrict resident access to the basement level which is considered a non-residential area of the home.

On April 18, 2017 at 08:20, Inspector #592 was on the ground floor of the home and signaled the elevator C to go to the basement. Inspector #592 noted that there was a note posted in the elevator indicating "please note that only employees and volunteers with an access card can get to the basement with this elevator".
The elevator went down and the doors opened in the basement. The elevator was not equipped to restrict resident access to this area.

Inspector #592 observed elevator A and B which had the same posted memo indicating "please note that only employees and volunteers with an access card can get to the basement with this elevator". Inspector #592 observed in both elevators the presence of a card reader. Inspector #592 signaled both elevators to go to the basement and was denied the access.

On April 20, 2017, during an interview with Inspector #592, the Administrator revealed that the basement was considered a non-residential area of the home. She further indicated being aware that one of the three elevators was not equipped with a card reader system preventing the residents to go to the basement. Therefore, one elevator remained accessible to residents as it was not equipped to restrict residents from going to the basement level. [s. 10. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 comply with section 71.(4) of the regulation in that the home has failed to ensure that the planned menu items are offered to each resident and made available at each meal and snack.

On April 18, 2017, Inspector #547 observed the lunch meal on an identified unit. Menu choices for desert according to the week 3 Fall 2016/Winter 2017 menu for day 16 indicated "coconut squares or coconut pudding, diced pears or pureed pears. Resident's on the identified unit were offered red jello, white cake, chocolate cake, diced pears, mixed diced fruit, pureed only had mixed fruit according to dietary aide #148. Pureed pears or coconut pudding were not offered to residents that required or wanted these planned textured items.

On April 24, 2017, Inspector #547 observed the lunch meal on another identified unit. This unit has a smaller dining room in the lounge area where eight residents were seated. One out of the eight residents was shown menu choices for this lunch meal, including salad, soup, main course and dessert planned menu items. The seven other residents were brought food based on the PSW's choice. PSW #154 indicated to Inspector #547 that they do not offer these residents choices as they follow the resident's care plans. Residents #061, #064 and #065 were not shown choices for the lunch meal and the care plans were reviewed by Inspector #547 that did not identify residents that did not require to be shown meal choices.

On April 25, 2017, Inspector #547 observed the lunch meal on an identified unit and noted that residents that required pureed menu were being offered pureed strawberry desert however this was not on the menu for day 2 of week 1 of the Fall 2016/Winter 2017 menu. Residents were not offered mixed fruit puree or yogurt as per the planned menu. The pureed strawberry desert was noted on an identified day on April 2017 which was day 1 of this same menu for week 1.

On April 27, 2017, Inspector #547 interviewed PSW #141 working on another unit. PSW #141 indicated that their dining room had several resident's with cognitive

impairment and that require feeding assistance for their meals that have preferences identified on their plans of care. PSW #141 further indicated that the PSW's always are required to show all residents all menu choices. Often the resident's expect them to know their usual preferred beverages however they are still to offer them a chance to change their mind if they want something different. The PSW indicated that some resident's respond verbally and others respond with their eyes or hands, but they are all still shown menu choices at every meal and snack.

The Administrator/Clinical Manager (Admin/CM) indicated to Inspector #547 that she expected each resident be offered the planned menu items and beverages for each meal or snack service, no matter what texture food they are to receive as every resident should have a choice in what they eat or drink. [s. 71. (4)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The Licensee failed to comply with LTCH Act, 2007 s.29 (1) b regarding

minimization of restraining of residents, Where the Act requires the Licensee of a long-term care home to ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations and the licensee is required to ensure that the policy is complied with, in that the home failed to ensure compliance with the following policy.

This finding is in addition to the findings described in the WN #25 related to the requirements for restraining of physical devices issued under O. Reg 79/10 r. 110 (2) and r. 110 (7).

The Administrator provided a copy of the Licensee's policy and procedure # CLIN CARE 34 titled Restraint Minimization last revised 2013-11 that currently applies to the home to Inspector #547 for review which stated the following:

1.2 Identified physical restraints that refer to the use of any physical or mechanical device to involuntarily restraint the movement of the whole or a portion of a resident's body as a means of controlling his/her activity.

1.3 Identified that bed rails are not a restraint when the resident is not functionally capable of voluntary movement, used as functional/positional devices or the resident can still exit the bed.

1.4 Identified that Personal Assistance Service Devices (PASD's) enabling devices used to assist with routine activities of daily living that are not intended to control behaviour or movement.
PASD must be included in the resident plan of care, must be approved by a physician, nurse, occupational therapist (OT) or physiotherapist and its purpose must be understood by resident/Substitute Decision Maker (SDM) who must agree with its use.

2.0 The policy identified:
2.1 All possible alternative interventions must be considered before a restraint is applied, and least restrictive form of restraint should be used, for the shortest length of time, and removed as soon as the restraint is no longer necessary.
2.2 A physician's order for physical restraint specific to the resident and the situation is required to order, re-order or discontinue a restraint. Orders for a restraint shall be for a maximum of 30 days. Such orders may also be given by a registered nurse in the extended class.

2.3 All restraints must be commercially made and used in accordance with the manufacturer's specifications- no adaptations are permitted.
2.4 All physical restraints must be monitored and documented on an ongoing basis for the duration of their use
2.5 All restraints used must follow a plan of care that the patient or SDM has given consent to, and documented by the physician and other health professionals involved.
2.6 Education shall be provided to all new direct care staff as well as ongoing education annually from their program or unit.
2.7 The Quality, Patient, Safety and Risk Management department will ensure that audits are completed on an ongoing basis in order to analyze physical restraint use and alternative approaches, and that the resident policy and practices are evaluated annually with the goal of reducing restraint utilization.

3.0 Ordering Physical Restraints
3.1 When an assessment has been completed and a decision made by the physician, in consultation with the treatment team, that a restraint is necessary, the physician or delegate discusses the matter with the resident or SDM, outlining the risks and benefits, and obtains verbal consent, documenting the discussion and the decision using the following forms:
-Assessment and Reassessment for the Use of Restraints when Alternatives Unsuccessful (H210050)
-Initial Restraint Monitoring (H210051)
-Ongoing Restraint Monitoring (H210061)
3.2 The physician completes the Physician's order for physical restraint (H600032) with input from the nurse or OT, to initiate, reorder or discontinue a restraint. In Long Term Care (LTC): the external pharmacy enters restraints used on the MAR sheet.

4.0 Resident monitoring and reassessment
4.1 When a physical restraint is applied, the resident is monitored and documented on the initial restraint monitoring form (H210051) at least every 15 minutes for the first hour, then every 30 minutes for the next two hours, or longer if necessary, until the residents behavior is stabilized. Monitoring is then done hourly on the ongoing restraint monitoring sheet.
4.2 When the resident is in the care of other health professionals, that health professional is expected to maintain hourly monitoring of any restraint on the ongoing restraint monitoring sheet and to document unexpected response in the progress notes.

The clinical educator identified to Inspector #547 that this hourly monitoring is now to be documented in the home's Point of Care (POC) electronic documentation system by Personal Support Workers (PSW).

4.3 When the physical restraint is applied, the resident is released and repositioned at least every two hours and as necessary.

The clinical educator further indicated to Inspector #547 this is specified in the POC documentation as well.

4.4 The resident's condition/response to the restraint is reassessed and its effectiveness evaluated by a physician or nurse every eight hours, and as necessary and documented in the progress notes.
4.5 Physical restraints are reassessed (using the form Assessment and Reassessment for the use of Restraints when Alternatives Unsuccessful) and their use documented by the team within 24 hours of a first time application and at least every 30 days thereafter using the Physician's Order for Physical Restraint.

5.0 Tracking and Analysis
5.1 When a physical restraint is ordered or discontinued, the nurse send a copy of the physician's order for Physical Restraints to the units administrative assistant, who enters it in the Risk Management Database within 24 hours.
5.2 The Quality, Patient Safety, and Risk Management department sends monthly reports on physical restraint utilization to the clinical managers and program directors for their review.

Over the course of this inspection, the inspection team identified the use of seat belt restraints and full side rails restraints utilized in the home.

The Licensee has failed to ensure that resident's care related to restraints and seating in wheelchairs, set out in the plan of care is provided to these residents as specified in their plans as per WN # 7(s. 6(7) for resident #048 and resident #049)

The Licensee has failed to ensure that a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the residents plan of care as per WN #14 (r.31)

The Licensee has failed to ensure that Personal Assistance Services Devices

(PASD) that has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release themself from the PASD, to assist the resident with a routine activity of living only if the use of the PASD is included in the residents plan of care as per WN #15 (r.33)

The Licensee has failed to ensure that where bed rails are used,(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident as per WN #19 (s.15(1))

The Licensee has failed to ensure that requirements relating to restraining by a physical device are met with respect to restraining of a resident by a physical device as per WN #25 (s.110)

The Licensee has failed to ensure that the minimization of restraining of residents in the home is evaluated as per WN #26 (s.113) [s. 29. (1) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 71. Director of Nursing and Personal Care

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director of Nursing and Personal Care

(DONPC), shall be a registered nurse and the DONPC shall supervise and direct nursing staff and personal care staff of the long-term care home and the nursing personal care provided by them.

On April 18, 2017, at the beginning of the Resident Quality Inspection, the Inspectors Team (#211, #550 and #592) were informed by the Executive Director of Long Term Care (EDLTC) that Residence St-Louis does not have specifically a DONPC, but instead they have a Director of Care (DOC) who supervises the registered nursing staff and an Administrator/Clinical Manager (ACM) who supervises the personal care nursing staff. The EDLTC indicated that the DOC covers Units 1C / 2C /3C and the ACM covers Units 2AB/ 3AB/ 4AB/C.

During the course of this inspection, several members of the home's nursing staff shared with Inspectors several concerns related to the organizational structure and communication limitations related to the supervision of registered nursing staff and personal support workers staff:

On April 21, 2017, Inspector #211 interviewed the DOC to have a discussion relating to resident #026's care and services and was immediately informed that the resident was under the supervision of the ACM since the resident was residing in an identified unit supervised by ACM. On the same day, Inspector #211 interviewed the ACM who indicated that she was in charge of the identified unit, but the DOC was responsible for resident's skin and wound care.

On an identified date, in an interview with RN #103, he/she indicated to Inspector #592 that he/she was made aware by an identified person related to an identified provision of care for resident #014. RN #103 indicated that yesterday, he/she was made aware again, by the identified person that the PSWs were not providing the identified care to resident's #014. RN #103 indicated that on a daily basis, he/she reminds the PWS to provide the identified care to resident's #014 and because it is not done, he/she will do it himself/herself. RN #103, indicated that he/she had not reported these refusal of PSWs to the managers. PSWs are not taking direction from the registered staff, only from ACM.

On April 26, 2017, Inspector #547 interviewed the DOC, regarding infection control, and hand hygiene requirements for residents. The DOC indicated that she provided the education to all PSW staff, that residents should have their hands washed before and after each meal as well as with AM and PM care. The DOC indicated that she has done follow-up education related to hand hygiene of residents,

however the PSWs staff indicated to her that she was not their manager, and that they only listen to their the ACM. The DOC indicated that I should discuss hand hygiene for the residents with the ACM. The next day, Inspector # 547, interviewed the ACM, who indicated that the DOC was in charge of the education for PSW staff for the Infection Control Program.

On April 26, 2017, during an interview with the DOC, who indicated to Inspector #550 that she could not inform the inspector of the results of the investigation regarding an incident of allegations of staff to resident abuse. The DOC indicated to the inspector that she is not responsible of managing PSWs, therefore she was not able to interview them. The rest of the investigation was then given to the Administration/Clinical Manager as she is the person of managing the Personal Support Workers (PSWs).

On May 1, 2017, during an interview with RN #149, who indicated to Inspector #126 that in an identified month in 2016 there was a situation that he/she requested that an evening PSW, stay until the arrival of the night PSW to ensure residents safety. The evening PSW contacted her manager (ACM) to inform her that he/she was forced to stay on the unit until the night staff arrived. RN #149 indicated that after the incident he/she received an email from the DOC with clear directives on how to manage these situation. In the same email, it was documented by the ACM, that RN #149 had forced an evening PSW to stay to cover and was doing it by seniority and it had to be discussed by the Managers. RN #149 is managed by DOC and the PSWs by the ACM. The RN indicated that the supervision structure of the home makes it complicated for open discussion between registered nursing staff and non registered nursing staff' as he/she discussed the incident with the DOC and the PSW discussed the incident with the ACM.

On May 1, 2017, the Inspector's Team (#126, #211, #547, #550 and #592) discussed with the EDLTC and ACM regarding several comments made by the nursing staff related to supervision by DOC/ ACM and floors supervision of registered nurse and personal support care. The ACM qualifications were reviewed and it was noted that she was not a registered nurse.

On May 2, 2017, Inspector #126 reviewed the Administrator/Clinical Manager LTC (Corporate) Job Description dated January 30, 2015. It was noted that under Section 11. Supervision or Direction exercised, "Provide direct supervision of PCA's at RSL."

The ACM is not a registered nurse and does provide supervision of the personal care staff, therefore the licensee failed to ensure that the personal care staff is supervised by a registered nurse. [s. 71.]

Additional Required Actions:

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care plan identify the resident and include, at a minimum, the care needs identified under O. Reg. 79/10, s. 24 (2) 1. 2. 3. 4. and 6.
-Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.
-Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.
-The type and level of assistance required relating to activities of daily living.
-Customary routines and comfort requirements.
-Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.

A Critical Incident was submitted on an identified date, to the Ministry of Health and Long Term Care in regards to resident #050 for an alleged staff to resident abuse.

A review of resident #050's health care record was done by Inspector #592. The health care record indicated that resident #050 was admitted on the identified unit on an identified date, with several diagnoses. The resident's health care record further indicated that resident was experiencing pain and had responsive behaviours.

In a review of resident #050's health care record, Inspector #592 noted that the care plan for resident #050 was created on an identified date with two identified focus problems related to bathing and skin integrity. There was no identification of the resident's pain and responsive behaviours; no other focus problems were identified.

Inspector #592 reviewed two other residents admitted on the identified unit.

A review of resident #071's health care record was done by Inspector #592. The health care record indicated that resident #071 was admitted on the identified unit on an identified date with several diagnosis.

In a review of resident #071's health care record, Inspector #592 noted that the care plan for resident #071 was created on an identified date with one identified focus problem related to risk of falls. There was no other focus problems identified.

A review of resident #070's health care record was done by Inspector #592. The health care record indicated that resident #070 was admitted on the identified unit on an identified date with several diagnosis. In a review of resident #070's health care record, Inspector #592 noted that the plan of care for resident #070 was created on an identified date with one identified focus problem related to risk of falls; no other focus problems were identified.

On May 02, 2017, interview with PSW #132 indicated to the Inspector that when a resident is admitted on the identified unit, the occupational therapist (OT) and the nurse will evaluate the resident and some instructions for transfers will be left but

no other issues regarding care. He/She further indicated that the information related to transfers would be written up on the white board located in the report room. He/She further indicated that there was no other documented planned care as he/she was communicating well to the resident on a daily basis to ensure that he/she was meeting their daily needs, therefore he/she felt that the care plan was not needed.

On May 03, 2017, interview with PSW #164 indicated to the Inspector that upon admission, the nurse and the physiotherapist will assess the resident for transfers and instructions will be left on the white board. He/She further indicated to the Inspector that there was no other documentation or care instructions other than receiving instructions from the 24 hour report given by the nurse. PSW #164 told the Inspector that the nurse would let her know if the resident has a specific problem. There was no other information given to the staff related to other care issues e.g. responsive behaviours.

On April 28, 2017, during an interview with the DOC, he/she indicated to the Inspector that the residents who were admitted to the home on the identified care unit were to have an individual written plan of care the same as the residents residing on the other long term care unit. She further indicated to the Inspector, upon the written plan of care for resident #050, that she realized that there was only two focus problems identified for resident #050. The DOC indicated that the charge nurse would possibly have more information as the RN is responsible for updating the plan of care manually on a daily basis for all the residents due to frequent changes in the residents' physical status.

On May 02, 2017, during an interview with the charge nurse #104, he/she indicated to the Inspector that since the introduction of the electronic version of the resident health care records, approximately one year ago, he/she was told by the DOC to no longer do the care plan manually as all the plans of care must be done electronically. He/She indicated that the only tool used to communicate the residents care needs is the white board located in the report room for specific interventions such as the transfers and the repositioning of the residents. Charge nurse #104 also indicated to the Inspector that the written plan of care were not developed for the residents residing on the identified care unit. [s. 24. (2)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 005

WN #6: 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. The licensee failed to comply with section 73. of the regulations in that the home

failed to ensure that the home has a dining and snack service that includes the following:

A. Communication of the seven day and daily menus to residents. O.Reg 79/10, s. 73.(1)1.

Over the course of this inspection, Inspector #547 observed the daily menus identified the regular diet texture choices only, and did not include therapeutic substitutions to residents that required these. The weekly at a glance "Menu Corporatif" was observed to include the therapeutic choices for residents. It was noted that these menus identified that pureed and minced choices for residents are not always the same items as on the regular diet texture.

Over the course of this inspection, the identified unit of the home was observed to only post the daily menus for residents on this unit. The weekly “Menu Corporatif” is posted outside the door for this unit, that resident’s on the identified unit cannot access independently daily. The identified unit has several residents, whereby the home's Registered Dietician evaluated a list of diet types for these residents that identified 13 residents out of the several residents on the unit have regular diet textures. These daily menus prevent 10 residents on this unit to be aware of dietary choices for meals as required by this section.

On April 27, 2017 the Inspector spoke with the Food Services Manager(FSM) regarding the communication of the weekly and daily menus. The Patient Food Services Manager stated that the weekly and daily menus are to be communicated by posting both inside each unit near the dining rooms for residents and families. The FSM was not aware that the weekly “Menu Corporatif” for this unit was posted outside the unit for these residents and would ensure that this is moved. [s. 73. (1) 1.]

2. The licensee has failed to ensure that meals are to be served course by course unless otherwise indicated by the resident or the resident's assessed needs.

On April 18, 2017, Inspector #547 observed the lunch meal for the identified unit. During this meal service, it was noted that the dietary aide #148 was not providing residents course by course, the lunch meal items. Inspector #547 reviewed the home’s Diet Type Report for the identified unit and the Registered Dietitican had not assessed any resident on this unit to require multiple courses at the same time. This list identified that only resident #001 required to have the main meal course

before the soup service only.

Resident #048 was being provided a soup by PSW #115 and required a long time to eat. Dietary aide #148 brought the resident the main course to the table in front of the resident before the resident was finished the soup course. The PSW's indicated that the resident was not ready for the main course yet, but the Dietary aide #148 indicated he/she had to serve as he/she had to do the coffee and tea service and leave by a specified time. Resident #058 was provided salad, soup and main meal at the same time during the lunch service. Both resident #048 and #058 are not identified in the plan of care to require multiple courses served at the same time during meals. Resident #059 received desert in the middle of eating the main course for this lunch meal. Resident #059 then began to eat desert and did not complete eating the main meal course. Resident #001 was served the soup course at the beginning of the lunch meal service and not after the main meal course as identified in the Diet type report directions.

Inspector #547 interviewed dietary aide #146 on April 25, 2017 who indicated that they can serve meals to the resident tables once the residents and staff arrive in the dining room.

On April 28, 2017, Inspector #547 observed the lunch meal on the identified unit and residents were served multiple courses to the tables. Dietary Aide #148 indicated to Inspector #547 that he/she places the food on the tables for the residents, but he/she should not leave the kitchen. Dietary Aide #148 indicated the PSW's are not in the dining room as they have some emergency, however he/she cannot wait as he/she has to serve the residents their lunch meal as he/she needs to leave the unit to go to the kitchen to wash dishes for the entire home. Resident #041 had received the main course plate located in front of him/her and the soup course was pushed to the middle of the table. Resident #041 was trying to eat the soup course with a fork by reaching over the main plate. Resident #041's care plan was reviewed and the resident did not require multiple courses served at meals. Resident #001 was seated at a table with both soup and the main meal course in front of him/her, and not eating either course.

On April 27, 2017, Inspector #547 interviewed the Food Services Manager (FSM) and indicated that the dietary aides can start the meal for residents only when staff member is available to assist them. The FSM indicated that course by course service in the dining rooms is to be monitored by the dietary aides and they are not to function in any rush to finish meal serve at a certain time. The Dietary Aide are

to wait to give the next serving, when the resident has completed the first course, unless their care plan indicates multiple courses at the same time. [s. 73. (1) 8.]

3. The licensee has failed to ensure that no person who requires assistance with eating and drinking is served a meal until someone is available to provide the assistance required by the resident.

On April 18, 2017 Inspector #547 observed dietary aide #148 on the identified unit, served soups to residents at 1209 hours to residents, however PSW staff were still bringing residents into the dining room. Resident #058 was seated at a table alone and was provided salad, soup and main meal course at 1218 hours, however was not provided assistance until 1230 hours. Resident #058's care plan indicated the resident required one staff to provide hands on support. Resident #048 began being fed his/her soup 10 minutes after it was served in front of him/her in the dining room. Resident #048 requires total assistance for feeding his/her meal.

On April 25, 2017 Inspector #550 observed dietary aide #148 on another unit at 0849 hours serve breakfast meals to residents that are not there as follows:

Resident #053 was served a bowl of dry cornflake cereals, a banana, a glass of milk, a glass of apple juice, a glass of water and 2 yogurts. A PSW told Inspector #550 that resident #053 was not out of bed yet.

Resident #060 is a resident that eats breakfast in this dining room, and the dietary aide had served the resident a bowl of dry cornflake cereals, a banana, a glass of milk, a glass of apple juice, a glass of water, 2 yogurts.
PSW told the inspector #550 that resident #060 was not up or in the dining room yet.

Resident #061 was served a yogurt, a glass of apple juice, a glass of water, pureed bread and egg, a bowl of oatmeal and a toast with jam cut-up however the resident was not in the dining room yet.

Resident #062 was served a yogurt, a glass of orange juice, a cut-up toast with jam however the resident was not in the dining room yet.

Resident #026 was served a glass of apple juice, a glass of water, a yogurt, oatmeal and pureed banana bread in the same cup, a cut-up toast with jam and egg omelet before the resident arrived in the dining room.

Inspector #547 interviewed dietary aide #146 on April 25, 2017, who indicated that they can serve meals to the resident tables once the residents and staff arrive in the dining room.

On April 28, 2017, Inspector #547 observed the lunch meal on the identified unit at 1205 hours. The residents were served multiple meal courses by Dietary Aide #148 and indicated to Inspector #547 that he/she is not supposed to leave the servery but that there was no PSW's in the dining room. The Dietary Aide indicated that he/she places the food on the tables and leaves it for the PSW's to assist residents even though the PSWs are not ready. The Dietary Aide indicated that he/she had to keep the meal rolling, as he/she has to leave the identified unit to go do the dishes for the entire home and then leave to go home by two pm.

On April 27, 2017, Inspector #547 interviewed the Food Services Manager (FSM) and indicated that the dietary aides can start the meal for residents only when nursing staff members are available to assist them. The FSM further indicated that the dietary aides should not be in any rush to finish meal service at a certain time, especially for these identified units with residents that has cognitive impairment as they required more time. [s. 73. (2) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 006

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 comply with section 73. of the regulations in that the home failed to ensure that the home has a dining and snack service that includes the following:

A. Communication of the seven day and daily menus to residents. O.Reg 79/10, s. 73.(1)1,

-to ensure that meals are to be served course by course unless otherwise indicated by the resident or the resident's assessed needs [s. 73. (1) 8.],

-to ensure that no person who requires assistance with eating and drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed 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.

Resident #038 was admitted to the home on an identified date and diagnosed with multiple health issues.

On three identified days Inspector #211 observed that the resident #038 had a continence device in place. The continence device was found to be discoloured and stained with dark yellow orange.

Review of the current written plan of care and the current Kardex indicated to

change the continence device on the first assigned bath on identified days. The written plan of care did not specify who as the responsibility to change the continence device and there was no indication as to whether the continence device was to be change weekly or monthly.

Review of the sheet titled "Bath of an identified unit" placed in the report room indicated to give the resident's bath on two different other days weekly.

Interview with PSW #139 on an identified date, indicated that he/she provided care of the resident on two consecutive days.

Interviews with PSW #123 on an identified date and PSW #134 on another identified date, indicated that it was not the responsibility of the PSW to change the continence device for resident #038.

Interview with RPN #106 and RN #103 on an identified date, indicated that the resident's continence device was stained with yellow orange color and there was no documentation to indicate when the continence device was changed as indicated in the resident's written plan of care.

On an identified date, RPN #106, stated that a new continence device is replaced during the continence procedure, every identified months by the unit RN or RPN.

Interview with Clinical Educator on an identified date, indicated that the home is following the procedure outlined in an identified book related to the continence device. The continence device procedure does not indicate the frequency that the continence device is to be changed.

Interview with the Administrator/Clinical Manager on an identified date, who stated that the resident's continence device care had conflicting information as the resident's written plan of care indicated to change the continence device on the first assigned bath, on an identified date, and the resident was receiving his/her bath on two different days during the week.

Interviews with the Administrator/Clinical Manager and the Director of Long Term Care on an identified date, acknowledged that the resident's plan of care does not set out clear directions to staff and others when to change the continence device for resident #038.

The licensee has failed that there was a written plan of care for resident #038 that sets out clear directions to staff and others who provide continence care related to the days when the continence device needed to be changed. [s. 6. (1) (c)]

2. The licensee failed to 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.

During a discussion with an identified person related to resident #014, some concerns were brought forward to Inspector #592.

The identified person indicated that each time that they visit the resident, they observed that his/her dentures were loose and falling out of his/her mouth. The identified person further indicated that on several occasions, they have requested staff members to use some adhesive on the resident's dentures to keep them in place. The identified person indicated that he/she has again reported the issue to RN #103 on an identified date.

Review of resident #014 health care records was done by Inspector #592. The health care records indicated that resident #014 was admitted on an identified date with several diagnosis.

The current plan of care for resident #014 was reviewed and indicated under personal hygiene which the home defines as how the resident maintains personal hygiene, including brushing teeth and indicates that resident #014 requires full staff assistance. The resident's health care record (HCR) documentation indicates that staff provided full assistance with personal hygiene to the resident on a daily basis.

On an identified date, Inspector #592 observed resident #014 in his/her bedroom. During an interview with the resident, Inspector #592 observed that one of the denture of the resident was loose and was falling out of his/her mouth when the resident was trying to speak to the Inspector. In order to speak to the Inspector, resident #014 removed one of the denture and indicated that he/she had a hard time to talk because a glue was to be applied on his/her dentures and this was not done this morning. The resident attempted to show the Inspector where the glue for his/her dentures was kept and was unable to open his/her drawer. The Inspector ask the authorization to open the resident's drawer and found a tube of unused denture adhesive. The resident took the tube from the Inspector and attempted to open the tube with no success. He/She indicated that he/she was unable to put the "glue" by himself/herself, therefore would like the staff to do it for

him/her.

On an identified date, in an interview with PSW #112, indicated to Inspector #592 that he/she was the main caregiver for resident #014 and that the resident was requiring total assistance. He/She further indicated that he/she was responsible for the mouth care of resident #014 and that he/she did not noticed any issues with the resident's dentures. Upon asking the PSW about the practice of the use of adhesive for denture care, he/she indicated that there was no adhesive available for dentures on the unit.

On an identified date, in an interview with RN #103, he/she indicated to Inspector #592 that he/she was made aware several times by the identified person related to resident #014 loose dentures and the staff not applying adhesive to the resident's dentures. He/She further indicated that he/she was made aware again by the identified person the day before that the staff were not cooperative. RN #103 further indicated that he/she did not document in the resident's plan of care the need of resident #014 to have adhesive applied to his/her dentures because the staff were not referring to the resident's plan of care. He/She further indicated that he/she has shared his/her concern with the PSW staff members at the 24 hour communication report but when casual staff were working it was hard for the PSW to do the follow-up. He/She further indicated that the adhesive for the dentures was made available to each staff members especially for resident #014 which was kept in his/her top drawer for convenience for the staff members.

Therefore, the plan of care related to the use of adhesive on resident #014 dentures, is not based on needs for this resident. [s. 6. (2)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

This intake log #007057-17 related to resident #073' by an identified person's concerns was included in this RQI. The identified person indicated that on an identified date during the evening, he/she noticed swelling to the resident's identified body area which he/she had brought to a nurse's attention the previous identified day. The identified person stated that an identified nurse brought two pillows to put under the resident's identified body area to decrease the swelling.

Resident #073 was admitted in the home on identified date and was diagnosed with multiple health conditions.

The hospital's discharge summary on an identified dated indicated that the edema of the identified body area was mostly resolved and the radiology showed that the resident did not sustain an identified injury. The cause of the edema was not identified.

On six identified days during a period of two months, the progress notes indicated that the resident's identified body area had edema. On an identified date, the notes indicated that the identified body area had a specific edema and there was a good capillary return. On two identified dates during a period of two months, the notes indicated that the identified body area was still swollen but did not demonstrate warmth, redness or pain and to continue to monitor. On another identified date, the note indicated that the identified body area was still swollen, but there was no pain. Twenty-one days later, the notes indicated that the resident's identified body area was still swollen and the resident was complaining of pain to the area.

Interview with RPN #177 on May 5, 2017, stated that the resident's progress notes already indicated that the resident's identified body area was swollen and an identified RN was informed on an identified date.

Interview with RN #167 on May 5, 2017, informed Inspector #211 that the swelling of the resident's identified body area varied from day to day.

Interview with the attending physician on May 3, 2017, stated that he/she was only informed of resident's identified body area swelling when he/she spoke with the identified person two months later after the identified body area was identified has having edema.

Interview with the Administrator on May 5, 2017, stated that she spoke with RPN #132 regarding his/her documentation on an identified date related to the swelling of the resident's identified body area. The Administrator revealed that the RPN #132 stated that he/she informed a nurse on that day and he/she left a note in the physician book about the resident's identified body area. However, RPN #132 was unable to demonstrate that the physician was informed through the physician book since the note sheets are shredded after a certain time.

The licensee has failed to ensure that the staff and others involved in the different

aspects of care of the resident collaborate with each other, in the assessment of resident #073's edema of the identified body area so that their assessments are integrated and are consistent with and complement each other. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #048 as specified in the plan regarding mobility equipment.

Resident #048 was admitted to the home on an identified date with cognitive impairment and other several medical diagnoses.

Resident #048 was observed over the course of this inspection, to be seated in a wheelchair labelled with resident #049's name. Resident's most recent falls assessment documented that the resident had one or more falls in the last three to twelve months. Mobility status identified unsafe/impulsive/forgets gait aid and observed unsafe use of equipment. Physician orders documented on an identified date for an identified cover over the identified restraint while in wheelchair for this resident. A note documented that the identified cover was added to cover the identified restraint while resident #048 is in his/her wheelchair to minimize the risk of falls as a restraint. Resident #048's current plan of care documented that the resident required seating adjustment to be position at a 90 degree angle using a pillow behind his/her back to straighten his/her while eating as ordered by the home's dietician on an identified date.

On April 27, 2017, RPN #107 indicated that the staff changed resident #48's chair with resident #49's chair as they thought resident #48 would sit better in Resident #49's wheelchair for meals and resident #049 no longer required his/her chair. Resident #049 was later observed seated with the identified restraint applied in resident #048's wheelchair. Resident #049 indicated to Inspector #547 as he/she was holding the identified restraint with both hands, that he/she was not comfortable in that chair. RPN #107 further indicated that he/she did not think the residents were ever re-assessed to use these chairs, or that it was ever consented by any of their substitute decision makers (SDMs).

On an identified date, Inspector #547 informed the Director of Care (DOC) of this switch in wheelchairs for these residents, and that there is no documentation of any seating assessment, or change in the identified restraint in either of the residents HCRs. The DOC reviewed, and indicated that she would direct staff to return residents to their own wheelchairs and to request an OT seating assessment as required for each residents needs.

The next day, resident #048 was observed seated in resident #049's wheelchair with an identified restraint applied and no identified cover restraint was noted over this identified restraint as ordered. Resident's physical chart was reviewed and no changes to the restraint orders or seating assessment was noted.

Five days later, resident #048 was observed by Inspector #547 to be foot propelling a wheelchair that was labelled with his/her name and using his/her identified hand to propel one wheel. Resident had an identified restraint applied, but no identified cover over the identified restraint was observed. RPN #107 and PSW #150 indicated to Inspector #547 that the resident's identified cover was likely gone to laundry as he/she only had one.

Resident #048's plan of care was not provided as per the resident's plan of care, as the resident was being seated in another resident's wheelchair with no restraint, no identified cover over the identified restraint. [s. 6. (7)]

5. The licensee has failed to ensure that the care set out in the plan of care, provided to resident #049 as specified in the plan regarding mobility equipment.

Resident #049 was admitted to the home on an identified date with cognitive impairment and several medical diagnoses.

Resident #049 was observed on four identified days by Inspector #547 to be seated in a wheelchair labelled with resident #048's name while seated in the dining room for the lunch meal. Resident #049 was observed on two occasions during the lunch meal to be very upset and foot propel and hand propel the wheelchair from the dining room to his/her bedroom. The resident was noted to be holding the identified restraint on both occasions.

Resident #049's health care records were reviewed and the most recent falls assessment documented on an identified date as the most recent fall was approximately 6 weeks prior to this fall assessment. Resident's current plan of care documented to make sure resident #049 uses his/her walker for short distances. Inspector #547 noted that the resident's bedroom is located next to the dining room and that the resident is seated at an identified table as he/she enters the room. A review to resident #049's HRC showed that there was no order from the physician for an identified restraint when seated in the wheelchair. Resident's plan of care did not identify any use of wheelchair or the identified restraint.

On April 27, 2017, RPN #107 indicated that the staff changed chairs between resident #48 and #49 as they thought resident #048 would sit better in resident #049's chair for meals and resident #049 no longer required his/her chair. Resident #049 was later observed seated with the identified restraint applied in resident #048's wheelchair. Resident #049 indicated to Inspector #547 as he/she was holding the seat belt with both hands, that he/she was not comfortable in that chair. RPN #107 further indicated that he/she did not think the residents were ever re-assessed to use these chairs, or that it was ever consented by any of their SDMs.

On April 27, 2017, Inspector #547 informed the Director of Care (DOC) of this switch in wheelchairs for these residents, and that no documentation of any seating assessment, or change in the restraint for both residents in the health care records. The DOC reviewed, and indicated that she would direct staff to return residents to their own wheelchairs and to request an OT seating assessment as required for each residents needs.

Resident #049's plan of care was not provided as per the resident's plan of care, as the resident was being seated in another resident's wheelchair with a restraint. [s. 6. (7)]

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 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,

-to 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,

-to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

-to ensure that the care set out in the plan of care is provided to the resident as specified in the plan regarding mobility equipment, to be implemented voluntarily.

WN #8: 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 Act or this Regulations 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,

(b) is complied with.

As per O. Reg 79/10, s. 48. (1) every licensee of a long term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A fall prevention and management program to reduce the incidence of falls and the risk of injury.

The home's policy # CLIN CARE 33 LTC titled "Falls Prevention in Long Term Care" dated December 2015, indicated that for falls without serious injury, a head injury routine should be followed if the fall is not witnessed, the resident is taking anticoagulants, or there is the possibility of a potential head injury. The registered nurse (RN) should complete and document a clinical assessment (including vital signs) of the resident on every shift for seventy-two hours.

This intake log #007057-17 included in the RQI indicated that an identified person was concerned when he/she found resident #073 on an identified date during the evening during his/her visit that the resident had vomited in an identified area with no staff present. The identified person indicated that the resident had a fall in the morning on the same above date.

Resident #073 was admitted in the home on an identified date and was diagnosed with cognitive impairment and other health conditions.

Review of the resident's current written plan of care indicated that he/she was at risk for falls and to ensure that the resident was using a walker, bed in lowest position and to use a wheelchair if he/she was fatigued. The written plan of care indicated that the resident had a previous fall on an identified date.

Review of the resident's progress notes on an identified date, indicated that the resident was found by an identified PSW in the morning, sitting on the floor beside the bed with his/her back leaning on the side of the bed. The resident was assessed for injury and the vital signs were taken and these were stable.

Review of the vital signs in the resident's point click care (PCC) indicated that the vital signs were not documented from the time the resident was found on the floor on the identified date in the morning until late during the evening shift on the same day.

In the resident's PCC under vital signs indicated that the resident's vital signs were taken on the identified date, late during the evening.

The resident's progress notes indicated that resident #073 was transferred to the hospital on the identified date late during the evening and was admitted.

The Bruyere Continuing Care Neurological Assessment sheet indicated to complete the neurological signs as followed:
-every fifteen minutes times four then,
-every thirty minutes times two then,
-every hour times four and then,
-every eight hours if neurological assessment is required.

Interviews with PSW #165 and RPN #166 on May 2, 2017, stated the resident was found sitting on the floor beside the bed with his/her back leaning on the side of the bed on an identified date early in the morning and the fall was unwitnessed. RPN #166 stated that the resident's assessment indicated that there was no injury and the vital signs were stable when he/she discovered the resident sitting on the floor. RPN #166 acknowledged that the result of the resident's vital signs were not documented. RPN #166 stated that the head injury was not initiated since the resident's head did not show an injury and the resident was able to answer questions.

Interview with RN #167 on May 2, 2017, stated that the resident did not sustained an injury from the fall. RN #167 indicated that he/she was informed that the resident's vital signs were completed and the resident's condition was stable.

Interview with RPN #168 on May 2, 2017, stated that on the identified date, the resident's vital signs and the oxygen saturation were taken at the beginning of the evening shift and the result was normal. RPN #168 indicated that he/she did not document the early evening shift' vital signs and the oxygen saturation in the resident's health care records because he/she decided to document only the one taken later during the evening.

Interview with the Administrator on May 3, 2017, stated that an investigation was initiated after a meeting with the identified person, seven days after the resident's incident on the identified date relating to the resident's fall. The investigation also included the resident's health condition on the identified date during the evening

shift that ultimately led to sending the resident to the hospital later during that day. The Administrator indicated that during the investigation she spoke with RPN #166 and RPN #168. RPN #166 told her that he/she assumed that the resident slipped from the bed and the resident's assessment revealed there was no injury. The RPN #168 indicated that the resident's vital signs were taken at the beginning of the evening shift but he/she did not document the result in the resident's health care record. RPN #168 was informed by the Administrator that the resident's vital signs' result should always be documented in the resident's health care record.

The licensee has failed to ensure that the home's policy titled "Falls Prevention in Long Term Care" relating to head injury routine was complied with as directed in the Post Fall Management section of the above policy. [s. 8. (1) (b)]

2. This finding is related to resident #041's fall.

Resident #041 was admitted in the home on an identified date with multiple diagnoses. During a review of the resident's health care records, inspector #550 noted it was documented that the resident was found on the floor in an identified area on his/her unit by a PSW on an identified date during the evening. As a result of the fall, the resident sustained an injury to an identified area.

A post fall assessment (post fall huddle) was completed by RN #156 on the identified date at the time of the fall. On the post fall huddle, RN #156 documented that the resident did not sustain or potentially sustain an identified injury and the neurological assessment was not initiated.

The neurological assessment form was reviewed and it was noted that at the top of the form ''to be completed every fifteen minutes x 4, every thirty minutes x 2, every hour x 4 and every eight hours if neurological assessment is required''. It was also noted that the night RN had documented on the following shift that the neurological assessment was initiated on the identified date during the beginning of the night shift, and then subsequently five hours later and 1100 hrs. The neurological assessment was not started at the time of the fall and completed as indicated on the form.

During an interview on April 26, 2017, RN #156 indicated to the inspector that an injury to the identified area is considered as a possible head injury and that it is an indication to immediately initiate a neurological assessment. He/She indicated that he/she was not sure why a neurological assessment was not immediately initiated

and that sometimes it is the RN who will initiate the neurological assessment, and sometimes it is the RPN. During an interview on April 28, 2017, RPN #157 indicated to the inspector that he/she did not initiate a neurological assessment for resident #041 after the fall on the identified date, as RN #156 had indicated to him/her that he/she would take care of the forms and assessments therefore he/she assumed that this included the neurological assessment.

This finding is related to log #032808-16.

On an identified date in 2016, a Critical Incident report was submitted to the Director reporting a fall to resident #069 on an identified date. It was reported that on an identified date during the night shift, a noise was heard in the hallway and resident #069 was found by a PSW lying on his/her side on the floor. As a result of the fall, the resident was sent to the hospital where he/she received intervention related to the injury.

Inspector #550 reviewed the documentation in the resident's health care records and observed documented for a period of five months, resident #069 fell several times and all falls were unwitnessed. The inspector also noted that the neurological assessment for these falls were either incomplete or not initiated.

The inspector was provided with and reviewed the home's fall program, Policy #CLIN CARE 33LTC, titled "Falls Prevention in Long Term Care", Revised 2015-12. On page 2 of 2, it is documented:

4.5 If the fall is not witnessed, the resident is taking anticoagulants, or there is the possibility of a potential head injury, the head injury routine (HIR) is followed.

During an interview on April 26, 2017, the DOC indicated to the inspector that the head injury routine (HIR) is their neurological assessment. She indicated when a resident sustains an injury to the identified area during a fall, it is an indication that the resident hit his/her head during the fall and because this resident's fall was also unwitnessed, a neurological assessment should have been started immediately. On April 27, 2017, during an interview the Advance Practice Nurse, RN #158 indicated to the inspector that when a resident has a fall, either the RN or the RPN is responsible to initiate the neurological assessment. She further indicated that some of the RPNs are not comfortable doing neurological assessments, hence the reason that the RN is responsible to complete the post fall hub and ensure that a neurological assessment is initiated when a resident has fallen and a head injury is

suspected or the fall is unwitnessed.

As evidenced above, the policy #CLIN CARE 33LTC, titled "Falls Prevention in Long Term Care", revised 2015-12 which is part of the home's fall program, was not implemented when residents #041 and #069 sustained unwitnessed falls with possible head injury and the neurological assessment was not followed. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institutes 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, is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On April 18, 2017, inspector #550 and #592 observed the following doors to be open and/or not locked and not supervised by staff as described below:

4th floor unit:
Room A421 - regular tub room: the door was not locked and not equipped with a call bell.
Room C411 - report room: the door was open and not equipped with a call bell.

3rd floor unit:
Room A309 - Clean utility: the door was held open with a door stopper and it was not equipped with a call bell.
Room A307 - Soiled utility: the door was not locked and it was not equipped with a call bell.
Room A304: the door was not locked and there was a hole in the door where a lock used to be. The room was not equipped with a call bell.
Room A305: the door was not locked and the room was not equipped with a call bell.

2nd floor unit:
Room A209 - Clean utility: there was a face towel placed on the door latch to prevent the door from locking. There was no call bell inside the room. PSW #121 and #122 indicated to inspector #592 that the linen room A209 was not a residential area and that the key pad used to lock/unlock the door was not always working properly. Staff put a facecloth to prevent the door from latching and locking in order to save time and for their convenience.

Subsequent observations:

On April 19, 2017, inspectors #547 observed the following:
Room A211 - report room: both doors were open and there was no call bell inside.
The Minimum Data Set (MDS) office: the door was open and there was no call bell inside.
Room A242 - conference room: the door was open and there was no call bell inside.
Unit 1C - report room: both doors open and there were no call bell inside.

On April 19, 2017, inspector #592 observed room A209 - Linen room: the door was held open with a door stopper.

On April 21, 2017, inspector #550 toured the above identified home areas with the Administrator/Clinical Manager. The Administrator/Clinical Manager indicated that all the identified above areas are non-residential areas and that the doors are to be kept closed and locked when not supervised by staff. [s. 9. (1) 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 all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, 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 resident's equipment are kept clean on an identified unit.

Over the course of this inspection, the following resident's wheelchairs were observed by Inspector #547 as soiled:

Resident #003 wheelchair was observed to have food debris and dust and red sticky dried matter to the right side of the wheelchair frame.

Resident #007 wheelchair was observed to have dried food debris and dust around the frame and brakes. The resident's seat cushion also had a dried white matter.

Resident #046 had heavily soiled wheelchair wheels, brakes, seat belt, seat cushion and frame soiled with dust, debris and sticky food matter.

Resident #048 wheelchair located in an identified room was observed to have dried food matter and dust and debris with sticky food matter.

Resident #049 wheelchair, currently used by resident #048 was observed to be heavily soiled with dust and dried food matter to the wheelchair frame and the identified restraint. The wheel and brake system to the right side were also noted to have sticky dried matter.

Resident #057 was observed seated in a wheelchair that had wheels, brakes, and wheelchair frame were heavily soiled with dust and food debris, resident's identified belt was noted to be sticky and dried food matter. Resident's seat had dried white matter, and food debris noted.

RPN #107 indicated to Inspector #547 that he/she regularly worked days on the identified unit, and was not sure but thought the identified unit routine binder would have the cleaning of mobility devices routine likely as this is a task done on nights.

Upon review of the unit routine binder, the following process was identified: This binder indicated that the unit had a form for the cleaning of the mobility equipment dated on an identified date. PSW routine on evenings indicated that resident #003 is on groupe 1 and requires cleaning of mobility equipment on Sunday and Thursday nights. Resident #007 is on groupe 2 and requires cleaning of mobility of equipment on Saturday and Tuesday nights. This routine identified that all the unit's wheelchairs and geriatric chairs on evenings are to be placed in the dining

room for the night shift staff to wash them.

PSW #115 indicated to Inspector #547 that he/she had no idea who washed the mobility devices in the home for residents. He/She indicated that to wash furniture in the home, he/she can call the maintenance department to ask to have the furniture cleaned. RPN #144 then indicated to Inspector #547 that they can also call the maintenance department to have the mobility equipment washed as required. PSW #115 indicated that he/she was not aware of this process.

On April 25, 2017 the Administrator/Clinical Manager indicated to Inspector #547 that the process for cleaning of mobility equipment found in the identified unit routine binder is old and no longer in function. That for the last year, they have a process of washing mobility equipment with the maintenance department.

The Maintenance Facility Manager (MFM) indicated to Inspector #547 on April 25, 2017, that the home's current process regarding the preventative maintenance schedule for wheelchair cleaning was completed by the home's maintenance department. This cleaning was last completed for the identified unit in January 2017. Resident's identified above had their wheelchair cleaned. The MFM indicated that staff can request resident's wheelchairs to be washed in-between these preventative maintenance schedules by calling the work order desk based on the resident needs. The MFM provided a copy of the list of calls to the work order desk from the identified unit since January 2017, and none of the above identified residents had a request for their wheelchairs to be washed since the by-annual washing was completed in January 2017. [s. 15. (2) (a)]

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

On April 17, 2017, Inspector #550 observed the following areas of disrepair:

3rd floor, B unit:
Tub room B305:
-There is a wood chair with the varnish well-worn almost completely gone which is exposing the wood grain.
-The bottom of the door is warped, the paint is removed exposing the particle board.

4th floor, C unit:

Tub room:
-Inside the ARJO tub on the back rest of the tub, there is an area that was repaired by applying a patch of a hard thin material. This material is now peeling and cracking; the edges are sharp.
-There is a wooden chair in a corner and the varnish is well worn exposing the wood grain.
-Both corner of the wall on the right side of the door, entrance to the tub area, are damaged. The ceramic tiles are broken exposing sharp edges and the linoleum baseboard is unglued.
-Beside the toilet there is a metal pole screwed to the floor. The metal plate at the bottom of the pole is rusted. There is 1 screw missing and the other three are loose making the pole loose and not secure.

On April 25, 2017, the inspector showed the above identified areas of disrepair to the Maintenance Facility Manager staff #119. He/She indicated not being aware of those areas of disrepair except for the pole in the tub room on 4C unit which he/she had just been made aware. During this observation, the pole was on the floor, the screws were completely pulled out from the floor. The Maintenance Facility Manager indicated that this pole was placed there to prevent staff from breaking the toilet when they move the bed. He/She further indicated that every Thursday or Friday, a maintenance person goes in every tub room to fill-up the products for the tubs and that he/she should have reported the broken corners of the walls. The home's process to report areas of disrepair is that employees have to call the "Centrale" for Bruyère Continuing Care to report the areas where a work order will be created.

During an interview, HK aide #140 indicated to the inspector that any maintenance issues are reported to the "Centrale" by dialing 444. He/She further indicated that the corners of the wall have been in this state of disrepair for a long time. He/She indicated that he/she did not report this himself/herself and that sometimes when things are reported, they are not always repaired. PSW #141 indicated that the ARJO tub has been in this condition for over a year and the corners of the wall are always damaged. They are often repaired but not long after they are damaged again. When things are damaged, staffs are required to call the "Centrale" by dialing 444 to created a work order. He/She did not report the tub and the corners of the wall in the tub room.

The inspector reviewed the work orders created for the 3rd and 4th floor units for the last three months and did not find any documentation indicating that these

areas of disrepair were reported to the maintenance department.

As evidenced above, the home, furnishings and equipment were not maintained in a safe condition and in a 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,
(a) the home, furnishings and equipment are kept clean and sanitary,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s. 17. (1) (g) in that the licensee of the long-term care home did not ensure that the home was equipped with a resident-staff communication and response system that:
-in the case of a system that uses sound to alert staff, it is properly calibrated so that the level of sound is audible to staff.

In this report the resident-staff communication and response system is commonly referred to as the call bell system.

On April 19, 2017, during the observation of an identified room, inspector #550 observed that when activated, the call bell in the room and the bathroom lite up at the dome above the resident's bedroom door but no sound was heard. The Administrator/Clinical Manager was walking by and indicated that the call does not even display on the electric communication board located in the hallway above the separation doors between two units. The Administrator/Clinical Manager assisted by PSW #124 activated the call bell in the room and bathroom for 3 identified rooms. The dome light above each bedroom door lite-up when the call bells were activated but no sound was heard in the hallway and they did not display on the electric communication board in the hallway above the separation doors in the identified unit.

During an interview, RN #125 indicated to the inspector that the call bells in some of the rooms on the identified unit are connected to the resident to staff communication system located at the nursing station on the other identified unit. Although the dome lights above those bedroom door light up when activated, the sound can only be heard by staffs on the other identified unit. He/She indicated that it has been this way for a long time.

On April 24, 2017, during an interview, the Executive Director and the Administrator/Clinical Manager both indicated to the inspector that all call bells when activated should be heard in the hallway regardless of which call bell system they are connected to. They indicated they will follow-up with the maintenance department to have this issue resolved. [s. 17. (1) (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 the home was equipped with a resident-staff communication and response system that:
(g) in the case of a system that uses sound to alert staff, it is properly calibrated so that the level of sound is audible to staff, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, 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 has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

According to O.Reg.79/10, s.2.(1) physical abuse is the use of physical force by anyone other than a resident that causes physical injury or pain.

Related to Log# 007081-17.

Inspector #592 completed a review of resident #050 health care records.

Resident #050 was admitted on an identified date on an specific unit for 3 identified health conditions.

The resident's health care records indicates that on an identified date, late during the evening shift, RN #156 was told by resident #050 that two PSWs had pulled an identified body area during his/her care. The resident's health care records indicated that resident #050 stopped the conversation and requested to RN #156 to be transferred to the hospital immediately.

The resident's health care records further indicated that later during that evening, a identified person had contacted RN #156 after being contacted by the resident that he/she had already reported several concerns before to the home regarding the two same PSWs involved in the care of the resident #050 for being rough with the resident. The resident health care records further mentioned that the identified person indicated that they would remove the resident immediately from the home and that they would pursue these issues further.

On April 28, 2017, in an interview with RN #156, he/she indicated to Inspector #592 that he/she did not witness the incident on the identified date but that he/she had contacted the Clinical Manager who was in charge and working on that evening to inform him/her of the situation. RN #156 indicated that he/she was not sure if he/she did mentioned to the clinical manager about the resident's statements of staff pulling the identified body area, the call from the identified person and the concerns brought forward from the roughness provided during care by the two same PSWs as he/she has to deal with several issues at the same time.

On May 01, 2017, in an interview with Clinical Manager #160, he/she indicated to Inspector #592 that he/she does recall being contacted on the identified date regarding resident #050. He/She further indicated that he/she had received a report that resident #050 had pain to the identified body area and had contacted the ambulance by himself/herself in order to be sent immediately to the hospital to receive better care. The Clinical Manager indicated that no statement from the

resident was brought forward and neither concerns from the identified person were mentioned during the discussion with RN #156. He/She indicated to the Inspector that if he/she would have been made aware that the resident had made a specific statement of the identified body area being pulled by staff members which caused pain, that the follow-up would of take another route, as he/she would have to complete an incident report, contact the Managers and call the after hour line of the Ministry immediately for reporting alleged physical abuse as per her education and instructions received by the home. [s. 24. (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 a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written description of their skin and wound care program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Review of resident #026's medical health record indicated that resident was admitted on an identified date, diagnosed with cognitive impairment and other multiple health issues. The resident's head to toe assessment on admission indicated that the resident's skin was intact.

Review of the progress notes on an identified date in 2016, indicated that the resident developed a pressure ulcer Stage 1 on an identified area. The next day,

the notes indicated that the pressure ulcer was still present and Allevyn border and a cushion were applied as a protection.

The physician's documentation in the progress notes indicated that the resident "had an area of skin pressure ulcer and Allevyn border was being applied" on 9 identified dates for a period of 4 months.

On an identified date in 2017, during the evening shift, an identified RPN documented that the resident had redness to an identified body area and started having a wound to another body area.

Two days later, the physician notes indicated that the resident developed multiple superficial wounds to two identified body areas, possibly related to the resident's position in bed and the friction from the wheelchair's cushion. Furthermore, the notes indicated that the resident stayed in his/her wheelchair all day. The plan was to recommend a cushion evaluation from the occupational therapist (OT), to apply a protective cream and to turn the resident every two hours in bed. The notes also indicated that an initial skin and wound care assessment was to be conducted for resident #026.

On the same identified date, the progress notes indicated to turn the resident every two hours in bed, to re-evaluate resident's wheelchair cushion and to include protein powder in the resident's diet.

Review of the "Skin and Wound Care Assessment" on an identified date in 2017, revealed that the resident developed multiple stage 3 pressure ulcers located to an identified area and multiple ulcers to two other identified areas.

On the next day, the progress notes indicated that a follow-up with the occupational therapist (OT) was made and the OT recommended to tilt the resident's wheelchair at 30 degree every two hours instead of the application of a Roho cushion.

Thirteen days later, the progress notes indicated that the resident was seen by the Registered Dietician (RD) and prescribed Beneprotein to be added in the resident's diet three times a day.

According to the documentation in the progress notes for three identified days, the identified wound received treatment and an identified dressing was changed every three days and that the resident's identified wound was healed. On another

identified date, the progress notes revealed a "Skin and Wound skin Assessment" of the pressure sores to the identified areas were evaluated and all the areas were closed.

Interview with PSW #120 on April 21, 2017, stated that the resident was repositioned every two hours in bed and in the wheelchair.

Interview with RN #104 on April 21, 2017, stated that the resident developed a stage 1 pressure ulcer to a specified body area on an identified dated in 2016. Four months later, the nurse practitioner was referred and consulted and found that the wound to two identified body area were stage 3 pressure ulcers. Two day later, the nurse practitioner's consultation revealed that the resident developed multiples small stage 3 wounds to the two identified areas. RN #104 stated that a referral was made to the registered dietician (RD) and the occupational therapist (OT) by the nurse practitioner on that day. An identified dressing treatment to the wounds were started on the identified date. The staff was informed to reposition the resident every two hours in bed and in his/her wheelchair. The Beneprotein was included in the resident's diet three times a day when the resident was seen by the RD. RN #104 revealed that the nurse documented in the Treatment Administration Record (TAR) twenty days later that the wounds were healed on an identified date.

Interviews with RN #104, Nurse Practitioner (NP) and Director of Care (DOC) on April 21, 2017, indicated that the initial "Weekly Wound Care Assessment" instrument placed in the section "Task" was completed on two identified dates. The NP and the DOC indicated that the "Weekly Wound Care" Assessment instrument should have been completed on the other identified dates. The NP and the DOC indicated that the staff may have not completed the 'Weekly Wound Care Assessment" instrument since the home currently does not have skin and wound care's policy. The NP and the DOC indicated that the inter-disciplinary "Skin and Wound Care" committee had met on an identified date, to develop a Skin and Wound Care's policy.

The licensee has failed to ensure when a pressure ulcer to the resident's identified body areas were defined as stage 3 on an identified date, that a "Weekly Wound Care Assessment" instrument was used on two identified dates. Furthermore, the licensee has failed to ensure that a "Skin and Wound Care" policy was developed and implemented in the home. [s. 30. (1) 1.]

2. During an observation of resident #034 on an identified date, inspector #550 observed that the resident had two large purplish bruises on an identified body area. During a subsequent observation two days later of the resident, the inspector observed that the resident's two bruises on the identified body area were now just one large bruise and it was extending to another area of the resident's body. The bruise was observed to be purple, black and red in color. The resident indicated that the bruises to the body area was not painful.

The inspector reviewed the resident's health care records for a period of one month. Resident #034 was admitted to the home on an identified date with several diagnoses. The resident mobilizes with the use of a walker. The inspector was unable to find any documentation related to the resident's bruise. There was no documentation indicating that the resident received a skin assessment using a clinically appropriate assessment instrument, that resident received immediate treatment and interventions to reduce or relieve pain, promote healing an prevent infection and that the resident was reassessed weekly by a member of the registered staff.

During an interview on an identified date, PSW #124 indicated to the inspector that he/she noticed the resident's bruise on the identified body area the day before when he/she returned to work from a day off and that he/she did not mention it to the nurse. He/She indicated that there is no place for him/her to document the new bruise on Point of Care (POC) and that he/she should have reported it to the nurse.

The inspector interviewed RPN #127 who is the regular day RPN on the unit on an identified date. He/She indicated to the inspector that he/she was aware of the bruises of resident #034's identified area but he/she was unaware of how the resident sustained the injury. He/She indicated that when a resident has a new bruise, registered staffs are required to document and assess the bruise in the progress notes. They are not required to do a skin assessment as the skin assessments are done quarterly. RN #125 indicated that he/she was not made aware of resident #034's bruise on the identified body area. He/She reviewed the documentation in POC and PCC and indicated to the inspector that he/she was unable to find any documentation related to the resident's bruise. He/She further indicated that PSWs are to document any skin issues in POC to alert the registered staff.

During an interview with the Director of Care and the Executive Director on an identified date, the DOC indicated to the inspector that the home does not currently

have a written skin-wound program and policies. The DOC indicated that they used to have policies which are no longer in place and that they are currently working on building a program but it is not yet implemented. Her expectation is that new skin issues are to be reported to the registered staff for documentation and evaluation. The inspector indicated that the PSW was not able to document in POC as there was no place for him/her to document a bruise. The DOC and the Executive Director indicated that if a PSW does not know where to document a skin issue, they always have the option of creating an alert in POC to inform the registered staff of new skin issues. The DOC indicated that the resident's bruise should have been reported to the registered staff for an evaluation and documentation. [s. 30. (1) 1.]

3. The licensee has failed to ensure that the following regulation O. Reg. 79/10, s. 30 (1) 2. is complied with in respect of each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

Under the Long-Term Care Homes Act, 2007, S.O. 2007, CHAPTER 8 s. 9. (1) (b), the licensee is required to have an organized interdisciplinary program with a restorative care philosophy that,
(a) Promotes and maximizes independence; and
(b) Where relevant to the resident's assessed care needs, includes, but is not limited to, physiotherapy and other therapy services which may be either arranged or provided by the licensee.

Log #007057-17 is related to concerns that a resident was seated in a wheelchair that was not adapted to that resident's needs.

On an identified date, Inspector #211 observed that the resident #073 was sitting in a wheelchair in the dining room.

Interview with an identified person on an identified date, indicated that the resident was sitting in a too big wheelchair on an identified date. The identified person stated that a nurse brought two pillows to support the resident's identified body area to decrease the swelling since the wheelchair was not adapted for the resident's needs. The identified person indicated that the staff never discussed with

them the reason why they were occasionally using a wheelchair for the resident. The identified person revealed if he/she had known that the resident needed a wheelchair due to medical reason, he/she would have told the staff to order an adapted wheelchair for the resident's needs. The identified person indicated that a proper wheelchair was ordered after the resident returned to the home from the hospital on an identified date.

Interview with RPN #166 on May 2, 2017, indicated that resident #073 had been having difficulty to walk for the past two months. RPN #166 revealed that the wheelchair given to the resident was not adapted to the resident needs since the resident's body area was not supported properly.

Interview with RPN #132 on May 2, 2017, indicated that the resident was walking with a walker before he/she was sent to the hospital on an identified date. However, a wheelchair owned by the home was often used when the resident was tired.

Interview with the Administrator on May 5, 2017, indicated that the identified person was concerned that he/she was not contacted to initiate a wheelchair assessment for the resident. The Administrator stated that the Assistive Devices Program (ADP) for a proper wheelchair should have been discussed with the identified person and then referred when the staff started borrowing a home's wheelchair that was not adapted to the resident's needs.

The licensee has failed to ensure where, under the program, staff was using a wheelchair that was appropriate for resident #073 based on the resident's condition and complied with in respect of each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation. [s. 30. (1) 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 there is a written description of their skin and wound care program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required, and

-to ensure that the following regulation O. Reg. 79/10, s. 30 (1) 2. is complied with in respect of each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

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

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the seat belt restraint by a physical device included in resident #003 plan of care.

Resident #003 was admitted to the home on an identified date with several medical diagnoses including cognitive impairment.

On three identified days, resident #003 had been observed to be wearing an

identified device while seated in a manual wheelchair. Resident #003 was not able to follow directions to open or remove the identified device that was applied and indicated to Inspector #547 that he/she does not like to wear the identified device.

On an identified date, RPN #107 indicated to Inspector #547 that the resident did not require any device while seated in the wheelchair and that it must have been applied in error.

Resident #003's health care records were reviewed by inspector #547. It was noted that resident #003 fell on an identified date in 2016 and was assessed on another identified date in 2016 by the home's Occupational Therapist (OT). OT assessed resident #003's loaner wheelchair. The most recent assessment completed by the RN #125 on an identified date, identified that the resident utilizes a wheelchair to mobilize around the unit. The resident's current plan of care does not identify any need of the identified device to be applied to the resident as a PASD or restraint while in a wheelchair. The device was automatically applied as a PASD. [s. 31. (1)]

2. The licensee has failed to ensure that resident #005 restraint by a physical device was included in the resident's plan of care.

Resident #005 was admitted to the home on an identified date with several medical diagnoses including cognitive impairment. Resident's health care records had documented orders on an identified date in 2015, from the physician for a specific cover over the device as a restraint to prevent the resident from getting out of his/her wheelchair on his/her own.

Inspector #547 observed resident #005 seated in a wheelchair with an identified device applied over the course of this inspection, and no cover noted to be over the wheelchair device.

Inspector #547 interviewed PSW #115 and RPN #106 responsible for the care of the resident, indicated that the resident requires the cover to be applied to the resident's identified device as restraint, but that the cover may have been sent to the laundry as the resident only has one. The resident's cover was discovered below the resident's seat on the right of the seat cushion and PSW #115 indicated that it should have been applied to the resident identified device. RPN #106 and PSW #115 indicated that they knew this as the resident's care plan identified this.

Upon review of the resident's care plan, no indication regarding the use of the device cover was documented. Upon review of the resident's health care records, the point of care (POC) and medication administration records (MAR) electronic documentation, there was no information found related to an order, a consent and application of the device as a restraint [s. 31. (1)]

3. The licensee has failed to ensure that a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care.

This inspection is related to falls prevention.

On an identified date, Critical Incident was submitted to the Director reporting a fall sustained by resident #069 on an identified date in 2016 during the night shift. As a result of the fall, the resident was transferred to the Hospital where he/she received intervention for the injury.

Resident #069 was admitted to the home on an identified date with multiple diagnosis including cognitive impairment.

On an identified date, the inspector observed the resident sitting in the dining room in a wheelchair with a device attached. The next day, the inspector observed the resident sitting in a wheelchair in his/her room with an identified device attached. Inspector #550 asked the resident if he/she was able to remove the device and observed that the resident was cognitively unable to remove the device, even when prompted. Again on another day, in the presence of RN #103, the resident was unable to remove the attached device when asked and prompted.

During a review of the resident's plan of care, the inspector observed that there was no documentation indicating that the resident was restrained by a physical device.

On an identified date, during an interview, RN #103 indicated to the inspector that there was no documentation of the resident's restraining with a device as he/she did not think that the device was considered a restraint. He/She indicated that because the Occupational Therapist had documented the device as a PASD, he/she thought it was a PASD. He/She further indicated being aware that the resident was unable to cognitively remove the device on his/her own.

As evidenced above, the restraining of resident #069 is not included in his/her plan of care. [s. 31. (1)]

4. The licensee has failed to ensure that the restraint plan of care includes the consent by the resident or if the resident is incapable, by the SDM.

On an identified date, RN #142 the home's clinical educator indicated to Inspector #547 that all restraints require physician orders, and consents to be documented in residents health care record.

Resident #048 identified in WN # 25 (r. 110 (2) 1) had a physician's order for the identified device with cover restraint while in his/her wheelchair on an identified date in 2015. Upon review of the resident's health care records, no consent was documented for resident #048's identified device cover restraint while in wheelchair. [s. 31. (2) 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 when a resident is retrained by a physical device as described in paragraph 3 of subsection 30 (1), that the restraining of the resident is included in the resident's plan of care,

-to ensure that the restraint plan of care includes the consent by the resident or if the resident is incapable, by the SDM., to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #046 and #038's Personal Assistance Services Device (PASD) are used to assist the residents with a routine activity of living only if the use of the PASD is included in the residents' plan of care.

The PASD is described in the subsection (2) as a personal assistance services

device, being a device to assist a person with a routine activity of living.

Inspector #547 observed on an identified date, resident #046 to have an identified device applied while seated in a tilted wheelchair. Resident #046 was observed to be agitated and swinging his/her feet, as his/her legs were dangling and fidgeting in the wheelchair. The resident's device was applied loosely, providing a gap of two fists space observed between the resident's device and the resident's abdomen. The resident was unable to follow directions to remove or detach the device.

Inspector #547 reviewed resident #046's health care records on an identified date. Resident #046 was admitted to the home on an identified date in 2016 with several medical diagnoses including cognitive impairment.

The resident's care plan documented that Resident #046's was high risk of falls, with several interventions including to ensure resident uses assistive devices and to check every hour to ensure safety. PASD intervention documented as of an identified date in 2016 identified that the resident is to remain safe and comfortable while PASD is applied and to check resident every two hours when PASD is in use when resident #046 is seated in his/her chair. The resident's written plan of care did not specify what assistive devices or PASDs were used.

On April 24, 2017, the DOC indicated to Inspector #547 that there should always be an assessment for all residents who need for PASDs such as the identified device and/or tilt actions while in the wheelchairs.

RN #125 in charge of the resident's unit indicated that after reviewed resident #046's health care records, it was noted that the assessment of the resident's use of wheelchair with safety device or tilt as PASD's is not documented and that the resident is seated in a borrowed wheelchair from the home.

The home's policy and procedure #CLIN CARE 34 last reviewed November 2013 provided by the home's Administrator identified that PASD's must be included in the resident plan of care with the main purpose to support or enhance seating comfort, or to enable or enhance an individual ability to perform a function independently or with less assistance.

Resident #046's plan of care indicates PASD use while in chair. This PASD does not specify what type of PASD is to be used on this borrowed wheelchair or for what activity of living purpose. [s. 33. (3)]

2. On three identified days, Inspector #211 observed resident #038 with four half side rails elevated in an up position while the resident was lying in bed.

Resident #038 was admitted to the home on an identified date and diagnosed with multiple health issues.

Review of the current written plan of care indicated that the resident is at risk for fall. The interventions are to check the resident every hour, to place the bed in the lowest position and to raise both side rails to prevent the resident from falling from bed. The current written plan of care indicated to turn and reposition the resident every 2 hours.

Interview with resident #038 on an identified date, indicated he/she prefers to have the four side rails in the up position when he/she's lying in bed for safety.

Interview with PSW #134 on an identified date, stated that the resident's four side rails in the up position were not a restraint, but it was for the resident a sense of safety. PSW #134 revealed that the home's policy indicated that if a resident cannot move independently in bed and both side rails are elevated, it is not considered a restraint.

Interview with RPN #106 on an identified date, who stated that resident #038 was cognitively able to make decisions and the resident was requesting to have the four side rails elevated for a sense of safety. RPN #106 indicated that the resident was unable to reposition himself/herself in bed by using the side rails because of limited mobility. RPN #106 revealed that the use of the side rails for the resident were not a restraint and he/she was not certain if they were a PASD.

Interview with RN #103 on an identified date, stated that the resident had uncontrolled body movement especially during repositioning. The application of the four side rails in up position was to prevent a fall if resident had the uncontrolled body movement. The resident was unable to grab the side rails for repositioning. RN #103 revealed that the resident's written plan of care does not indicate if the use of the side rails are a PASD.

Review of the home's policy #CLIN CARE 34 titled "Restraint Minimization" dated November 2013, indicated that the PASD are enabling devices used to assist with routine activities of daily living such as bedrails that are not intended to control

behaviour or movement. Such functional or positional devices are not considered restraints, even if the resident cannot remove the device themselves.

Interview with the Clinical Educator on April 26, 2017, stated that resident #038 was competent to make his/her own decision and to give consent to keep the bed rails elevated when he/she's in bed. The Clinical Educator revealed that the use of the side rails for resident #038 are a PASD since it gives the resident a sense of safety and therefore to assist the resident with the daily activity of living. The clinical Educator indicated that the PASD should have been included in the resident's written plan of care.

The licensee has failed to ensure that a Personal Assistance Service Device (PASD) was included in resident #038's plan of care. [s. 33. (3)]

3. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all the following are satisfied:
-Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living
-The use of the PASD has been approved by
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapist of Ontario, or
vi. any other person provided for in the regulation.

Interview with the Clinical Educator on an identified date, stated that after revision of the resident's health care record for the past 13 months, there was no indication that the alternatives to use of a PASD has not been considered and tried. Additionally, there was no indication that the PASD was approved by the above professional members. [s. 33. (4) 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 a Personal Assistance Services Device (PASD) described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident plan of care,

-to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all the following are satisfied:
-Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living,
-The use of the PASD has been approved by
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapist of Ontario, or
vi. any other person provided for in the regulation., to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Throughout the course of this inspection several resident’s personal items were observed not labeled.

On April 18, 2017, Inspector # 550 observed in the tub and shower room located on the fourth floor C unit:

On the bottom of a shelf, there was an unlabelled white urine collector container soiled with yellowish matter. In the shower area, there was a used unlabelled male deodorant stick on a shelf.

On April 18, 2017, Inspector # 550 also observed in the tub and shower room located in tub room B305:

On a shelf in the tub room on the right, there was an unidentified green basket containing unlabelled, used deodorant stick, one roll-on deodorant and a used disposable blue razor. In the pink basket there was a used men's deodorant stick and a used disposable blue razor. All items were not labelled. On top of a metal storage unit, there was two used male deodorant stick, two used nail clippers and a dirty electric toothbrush. All items were not labelled.

Inside the drawer, there was multiple items including several used deodorant sticks, a pair of red frame eye glasses with petroleum jelly smeared on one of the lens.

On April 18, 2017, Inspector # 592 observed in the tub and shower room located on the second floor B unit:

Five hair brushes were observed with several hair strands, not labeled in tub room 205(4). Five used roll-on deodorant were also observed, not labeled left on the counter beside the tub bath.
One used disposable blue razor and two hairbrushes with several hair strands with one female comb were also observed, not labeled in the tub room (211-1).
Five used roll-on deodorant were also observed, not labeled located in a pink

plastic container beside the bath tub bath.

On April 18, 2017, Inspector #592 observed in the tub and shower room located on the first floor C unit:

Five used roll-on deodorant with one hairbrush with several hair strands were observed not labeled.

On April 20, 2017, in an interview with PSWs #109 and #112, both indicated to Inspector #592 that each resident's personal items were kept in each resident's room in a plastic basket. They both further indicated that each resident is brought to the tub and shower room with their personal basket and is brought back to their rooms once the bath is completed. When Inspector #592 showed to the PSW's the remaining items observed on April 19, 2017, unlabeled in the tub bath, both PSW told the Inspector that often PSW will forget to bring back the resident's personal items once the bath is completed.

On April 20, 2017, in an interview with RPN # 110, he/she indicated that there was a process in place for each resident to have their personal items labelled upon their admission to the home. He/She further indicated that the unit clerk was the person responsible to make personal labels for each resident's. He/She further indicated that extra labels were left in the resident's chart for PSWs to use when resident's were acquire new personal items.

On April 21, 2017, in an interview with the Administrator/ Clinical Manager, she indicated to the Inspector that the home has a process for the labeling of each resident's personal items. She indicated that labels were provided to each family member upon a new resident's admission and that a marker was left available on each unit for the staff members to ensure that new personal items acquired will be identified. She further told the Inspector that all the personal items located in the tub and shower room were not supposed to be there and that each items should have been labeled to be identified for each residents. [s. 37. (1) (a)]

Additional Required Actions:

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

WN #17: 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 all drugs are stored in an area or a medication cart that is secure and locked.

On April 19, 2017, during the home initial tour, Inspector #550 observed in an identified tub room in a identified unit a tube of medicated cream on a shelving unit, in a basket filled with various items. An identified medicated cream was labelled to resident #066. On May 1, 2017, Inspector #126 observed in the identified tub room in an identified unit a tube of medicated cream labelled to resident # 066 with an expiratory date in 2016.

Inspector #126 interviewed RPN #159 who indicated that the medicated cream should be brought back to the nurse after each bath, to be put in the medication cart. RPN #159 indicated that resident #066 was no longer being administered the identified medicated cream.

On an identified date, Inspector # 550 observed in another identified tub room, in a metal cabinet's drawer a bottle of medicated product labelled to resident # 067. On the identified date, PSW# 161 assisted Inspector #126 to open the door to the identified tub room. Upon walking in the tub room, Inspector # 126 observed the bottle of the medicated product labelled for resident #067. PSW #161 took the bottle of medicated product and indicated to Inspector #126 that this bottle shall not be left in the tub room and should have been brought back after resident #067's bath to registered staff to lock the medication. PSW #161 indicated that resident #067 usually receives the bath on the evening shift.

On April 24, 2017, Inspector #547 observed on 3AB unit on top of the locked medication cart a bottle of an identified medication. The medication cart was left unattended in the small dining room of that unit. RPN #129 returned to the cart from the resident care hallway, indicated that the identified medication should have been locked in the medication cart before he/she left to go down the hall.

On April 28, 2017, Inspector #547 observed on an identified unit of the home the medication cart that was locked and unattended. The medication cart was observed to have a medication blister pack card on the side of the cart. Inspector #547 reviewed these medication cards, and noticed identified narcotic medication left in the blister packet labelled to resident #068. Inspector #547 remained at the cart, and the Administrator entered the nursing station 5 minutes later, and said hello to resident #066 seated at one of the doorways near this medication cart. The Administrator indicated that the medication and especially this narcotic should have been locked in the medication cart. RPN #159 indicated to Inspector #547 that he/she was the one that administered the identified narcotic medication that morning and left the medication on top of the cart. [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 all drugs are stored in an area or a medication cart that is secure and locked, 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 has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control Program.

On April 18, 19 and 20, 2017, Inspector #592 and Inspector #550 observed beds located in the tub and shower rooms on three identified floors. Some beds were observed with linen covering the mattress and some beds were observed with no linen exposing the bed mattress.

Inspector #550 observed on an identified floor unit in the identified tub and shower room, a bed located beside the tub with soiled bedrails.

On April 20, 2017, in an interview with PSW #109 who is assigned to another unit indicated to Inspector #592 that the use of the beds was for residents who need complete bed baths. PSW #109 told the Inspector that there was several residents on the unit who were using the beds and that the staff were putting linen on the bed mattress with continence pad and a pillow which was changed after each use. PSW #109 further indicated that there was no cleaning and disinfection needed for the beds' frame and the mattresses.

On April 20, 2017, in an interview with PSW #112 who is assigned to another unit

indicated to Inspector #592 that the use of beds in the tub and shower room was to assist to dry the residents after coming out of the tub. PSW #112 further indicated that linen was applied and changed after each use between residents. He/She further told the Inspector that the housekeeping staff were responsible to clean and disinfect the beds' mattress and frame once the bathing routine was completed on evenings.

On April 21, 2017, in an interview with HKPs #117 and #118, who both indicated to Inspector #592 that they were responsible to clean and disinfect the tub and shower rooms once the PSWs were done providing the baths to the residents but were not the persons assigned to clean and disinfect the bed mattresses and bed frames in the tub and shower rooms.

The licensee's policy titled “Infection Control 01”, last revised May, 2014, was reviewed by Inspector #592 and indicated under Environment and Equipment that all equipment that is being used by more than one resident must be cleaned between residents.

On April 21, 2017, in an interview with the Administrator/ Clinical Manager, who indicated to Inspector #592 that the beds located in the tub and shower rooms were used to assist to dry the residents after coming out of the tub bath. She also indicated that the beds were also used for security purpose when transferring the residents. She further indicated that the bed mattress must be disinfected in between residents with the same disinfected used for the bath tub by PSW as part of their infection prevention and control program.

2. Throughout the course of this inspection several unidentified used bar of soaps were observed in the tub and shower rooms.

On April 18, 2017, Inspector # 550 observed in the tub and shower room located on an identified unit:

On a shelving unit, there was a basket filled with various items, including 2 unidentified dirty soap dish.

On April 18, 2017, Inspector # 550 also observed in the tub and shower room located in an identified tub room from another unit:

On a shelf in the tub room on the right, there was an unidentified basket containing

one used bar of soap. On top of the tub there was a second used white bar of soap.

On April 18, 2017, Inspector # 592 observed in the tub and shower room located on an identified unit from another unit:

Two used bar of soaps were observed not labeled, left on the table beside the tub bath. A plastic container was also observed beside the tub bath with one unidentified bar of soap used.

On April 20, 2017, in an interview with PSW #116, he/she indicated to Inspector #592 when ask about the unidentified used bar of soap in the tub and shower rooms that the bar of soaps were used to wash all the residents in the tub. When ask if a different bar of soap was used for different residents, he/she indicated that, the same bar of soap was used to wash all the residents as part of his current practice.

On April 20, 2017, in an interview with PSW #112, he/she indicated to Inspector #592 when ask about the unidentified used bar of soap in the tub and shower rooms that the bar of soap was used and shared in between PSWs to wash their hands once the care was completed to the residents.

On April 20, 2017, in an interview with RPN #106, he/she indicated to Inspector #592 that each resident should have their own bar of soap identified to used individually but was made aware about a current practice which staff members were using the same bar of soap to clean all the residents.

On April 21, 2017, in an interview with the Administrator/Clinical Manager and the DOC, they both indicated that each resident should have their own bar of soap identified and used individually by each resident for infection purposes. They both indicated that no bar of soap should be left used and not labeled in the tub and shower room.

On April 21, 2017, in an interview with the infection control nurse, she indicated to Inspector #592 that no bar of soap should be used and shared in between residents for infection control purposes. She further indicated that the expectation is for the staff to wash their hands by using the sink available in the tub and shower room with soap and water or using the hand sanitizer available as well in the tub and shower room as part of their infection prevention and control program. [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 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. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Noted that an Amended Order under OREG s. 15 (1) was re-issued on February

27, 2017 under Inspection #2017_619550_004 with a compliance due date of August 31, 2017. This findings is an additional evidence of the order that remains outstanding.

On three identified date, inspector #211 observed resident #038 with four half side rails elevated in an up position while resident was lying in bed.

Review of the current written plan of care indicated to raise both side rails to prevent the resident from falling from bed.

Resident #038 was admitted to the home on an identified date and diagnosed with several health issues.

Interview with resident #038 on an identified date, indicated that the resident prefers to have the four side rails in an up position when he/she's lying in bed for safety.

Interview with RPN #106 on an identified date, indicated that the resident was unable to reposition himself/herself in bed by using the side rails because of limited mobility.

Interview with RN #103 on an identified date, stated that the resident had uncontrolled movements especially during repositioning. The application of the four side rails in up position was to prevent a fall if resident had the uncontrolled movements. The resident was unable to grab the side rails for repositioning.

Interview with the Director of Long Term Care on an identified date, indicated that resident #038 using the four side rails was not assessed nor the bed system was evaluated, to minimize risk to the resident.

The licensee has failed to ensure that resident #038 was assessed and the bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (1) (a)]

2. On two identified days, Inspector #211 observed resident #073 with two full side rails elevated in an up position while resident was lying in bed.

Noted that an Amended Order under O REG s. 15 (1) was re-issued on February

27, 2017 under Inspection #2017_619550_004 with a compliance due date of August 31 2017. This findings is an additional evidence of the order that remains outstanding.

Resident #073 was admitted to the home on an identified date and diagnosed with cognitive impairment and other health issues. The resident's health care record indicated that the resident had a fall on an identified date during the morning. The resident was transferred to the hospital during the evening and returned to the home seventeen days later.

Review of the resident's written plan of care did not indicated that the resident needed to have both full side rails elevated when lying in bed.

Interview with PSW #136 on an identified date, stated that resident #073 was using both full side rails in an up position when the resident was placed into the bed to prevent fall. PSW #136 indicated that the resident right side rail was not elevated prior to the resident's fall and he/she observed that the resident's both full side rails were placed in an up position after the resident returned from a leave of absence. PSW #136 indicated that when a resident requires the side rails to be elevate, a pictogram on the wall above the resident's bed will show how many side rails needs to be elevated. However, resident #073 does not have a pictogram indicating that the resident required side rails.

Interview with RN #103 on an identified date, stated that both full side rails are elevated as requested by an identified person when the resident returned from the leave of absence. RN #103 stated that he/she asked the physiotherapist to assess the resident's side rails. RN #103 confirmed that the resident's written plan of care nor a pictogram above resident's bed indicated to use both full side rails when the resident was in bed.

Interview with the physiotherapist #175 on an identified date, indicated that he/she did not assess the resident's bed rail use nor the bed system.

The licensee has failed to ensure that where bed rails were used for resident #073, the resident was assessed and his/her bed system was evaluated to minimize risk to the resident. [s. 15. (1) (a)]

WN #20: 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 is a member of the staff of the home completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition.

LTCH Inspector #592 reviewed Resident #019's health care record on an identified date.

Resident #019 was admitted to the home on an identified date in 2016 with several diagnosis.

The health care record indicated that the home's registered dietitian entered a progress note on an identified date in 2016 indicating that he/she had visited the resident at lunch and that he/she would have a follow up assessment, the following week.

The health care record further indicated that on an identified date in 2017, resident #019 was sent to the hospital and came back the next day with a identified diagnosis and was requiring medications interventions.

Further review of the health care record indicated that a significant change in status for resident #019 was initiated on an identified date in 2017 through the MDS (Minimum Data Set) assessment.

The MDS was reviewed and it was noted by Inspector #592 that the Dehydration/Fluid Maintenance and the Nutritional Status were triggered as a RAP (Resident Assessment Protocols) and were completed by one Registered Practical Nurse and the RAI Coordinator. The RAP for Nutritional Status was also indicating that a referral was sent to the Dietitian.

LTCH Inspector #592 spoke with the home's registered dietitian on April 25, 2017 regarding the process for completing the nutritional assessment. The registered dietitian stated that the initial nutrition assessment is to be completed at resident's admission, and then quarterly by completing the section K in the MDS (Minimum Data Set). He/She further indicated that if any interventions were needed he/she would do a nutritional note in the resident's health care records with the specific changes and the new interventions.

The registered dietitian further indicated that the nutritional assessment is also completed whenever there is a significant change in the resident's health condition.

In addition, he/she indicated that when a resident is coming back from the hospital, she would be made aware of this by the RAI Coordinator and the registered staff in order to complete a nutritional assessment. The registered dietitian indicated that he/she is reading the daily 24 hour communication report on a daily basis to ensure that any residents who were coming back from the hospital would be followed up.

When Inspector inquired about resident #019, the registered dietitian reviewed the health care record and indicated that he/she was not made aware of resident #019 significant change in condition as he/she was not the one who completed the section k (nutritional status) on the identified date. Upon reading the RAP notes, the dietitian noted that a referral was requested by the registered practical nurse for the registered dietitian to assess resident #019. The registered dietitian indicated that he/she was not made aware that a referral had been done in order for him/her to assess resident #019 as a significant change in the resident's health condition had occurred.

Further review of resident #019 health care record was done by Inspector #592

and it was noted that resident #019 was not evaluated by the RD since an identified date when the initial nutritional assessment was completed. [s. 26. (4) (a),s. 26. (4) (b)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 receives fingernail care, including the cutting of fingernails.

On an identified date, Inspector #547 observed that resident #003's fingernails were long and soiled with brown debris inside the nail beds to both hands. On three other days, Inspector #547 observed resident #003's fingernails to have brown matter embedded inside the nail beds of the identified hand. It was further noted that the resident had broken fingernails to an identified hand that were sharp and jagged.

On an identified date, PSW #151 indicated that the resident is bathed twice a week and nail care is provided at this time. Upon review of the bathing schedule, the resident was due to have a bath on two identified evenings during the week.

Ten days later, the resident was observed after breakfast in the dining room, and noted that the resident's fingernails to both hands had brown matter inside the nail beds as well as broken sharp nails to the identified hand.

Inspector #547 reviewed the resident's point of care electronic documentation of care provided to the resident, that documented the resident last had his/her fingernails trimmed on an identified date. The resident's fingernails were documented to have been cleaned last evening during a bath, however the resident continued to have brown matter embedded into the nail beds to both hands.

The Administrator/Clinical Manager indicated that the home's expectations is that the resident's fingernails should be kept clean and well trimmed at all times when this is noticed by staff, and not just at bath times for hand hygiene. [s. 35. (2)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to promote healing and prevent infection, as required.

Resident #038 was admitted to the home on an identified date and diagnosed with several health issues.

Review of the current plan of care indicated that the resident has a pressure ulcer on an identified body area.

Review of the resident's medication administration record (MAR) for an identified month in 2017 indicated to provide identified treatment to the wound on specific days.

The resident's progress notes on an identified date, indicated that an identified PSW and RN #149 observed during the beginning of the evening shift that half of the resident's dressing was soiled with stool and a glove was found stuck under a part of the dressing. The wound was cleaned and the dressing was changed as indicated in the resident's MAR.

Interview with RN #149 on an identified date, stated that the resident's dressing was due to be changed on an identified date during the evening shift. He/She was informed at the beginning of the evening shift by an identified PSW to examine the resident's dressing and found it to be in poor condition. RN #149 revealed that he/she observed that half of the resident's dressing was soiled with stool and a glove was found stuck under half of the dressing. RN #149 indicated that he/she immediately intervened by taking a picture of the area, sent an email to the DOC, documented his/her observation and changed the dressing.

Interviews with PSW #134 and PSW #139 on April 27, 2017, indicated that on the identified date during the late morning, resident #038 was found soiled with stool. The resident was completely washed, his/her brief and his/her linen were changed and the resident was transferred into the wheelchair. PSW #134 and PSW #139 indicated that the top of the resident's dressing was soiled and cleaned at the time. PSW #134 and PSW #139 acknowledged that they observed at the time that part of the resident's dressing was no longer sticking on the skin. The above PSWs indicated that the resident was transferred back to bed during the afternoon, repositioned in bed and observed that the resident's brief was cleaned.

Interview with PSW #134 on April 27, 2017, indicated he/she notified the nurses on that day that the resident's dressing was slightly loose.

Interview with PSW #139 on April 27, 2017, stated he/she did not inform the day nurses that the resident's dressing was loose because the resident told him/her that it was not necessary to notify the day nurses regarding the dressing since the dressing was scheduled to be changed that evening. PSW #139 acknowledged that he/she should have had informed immediately the nurses when he/she saw the condition of the resident's dressing.

Interview with RPN #106 on April 27, 2017, indicated that RN #103 and himself/herself were not informed by the PSWs who were taking care of the resident during the day shift on the identified date, regarding the condition of the resident's dressing.

Interview with the Administrator on April 27, 2017, indicated that an internal investigation was initiated on an identified date. The Administrator acknowledged that PSWs #134 and #139 should had notified immediately the nursing staff when they found that the resident's dressing was soiled.

The licensee has failed to ensure that resident #038 receive immediate treatment and interventions to promote healing and prevent infection when the identified PSWs observed that part of the resident's dressing was no longer sticking on the skin on the identified date. [s. 50. (2) (b) (ii)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. The licensee has failed to ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include an occupational therapy and a speech-language therapy.

On an identified date, Inspector #211 observed that resident #024 was having difficulty to verbally communicate and demonstrated frustration when he/she was unable to verbally express himself/herself. Inspector #211 observed that the resident's room did not display pictograms or other type of devices to communicate with the resident.

Resident #024 was admitted on an identified date and diagnosed with several health issues.

Review of the "Resident Assessment Instrument-Minimum Data Set" (RAI-MDS) on an identified date, indicated that the resident short and long-term memory is adequate. His/Her communication modes of expression is speech. The resident has difficulty finding words or finishing thoughts. His/Her speech is slurred with mumbled words. The resident has the ability to understand others. The resident doesn't have a communication devices or techniques.

The resident's current written plan of care indicated that the resident has a decreased ability to speak and to provide reassurance and patience when communicating with the resident.

Interview with resident #024 on an identified date, stated that it would help to have pictures to communicate with other people.

Interview with an identified person on an identified date, indicated that the resident was having difficulty to communicate with staff, visitors and the family. The identified person stated that the staff in the home never discussed with them the possibility of a referral to a specialized professional to help the resident to communicate.

Interviews with PSW #128 RPN #129 and RN #104, on an identified date, indicated that the resident was able to be understood by the regular staff since they were aware of his/her basic needs and his/her routine. However, when the resident has a difficult time to communicate, he/she will become more agitated and his/her speech will become more slurred. PSW #128 and RN #104 revealed that the family verbalized they had difficulty to understand resident #024.

Interviews with RPN #129 and RN #104 on April 26, 2017, stated that the resident was never assessed or referred by a speech therapist or the occupational therapist relating to his/her speech difficulty since he/she was admitted to the home. Furthermore, the resident doesn't have any devices or other items to help the resident to communicate.

The licensee has failed to ensure that therapy services for resident #024 was arranged or provided under section 9 of the Act that include an occupational therapy and a speech-language therapy. [s. 59. (b)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that menu substitutions are communicated to residents and staff.

On April 18, 2017, Inspector #547 observed the planned lunch menu as week 3, day 16 on an identified unit as follows:
Green salad
tomatoe noodle soup
tourtiere/meat pie
hamburger au poulet
mais/corn
haricot vert/green beans
mashed potatoes
fries
coconut squares
diced pears

desert options made available to residents were:
red jello
white cake
chocolate cake,
diced pears
mixed diced fruit
pureed mixed fruit

Substitutions for the pureed pears or coconut cake were not identified on the planned menu.

On April 24, 2017 Inspector #547 observed the planned lunch menu on another unit as follows:
Barley/vegetable soup
Chicken teriyaki
Sheppard's pie
carrots
yellow beans
mash potatoes
strawberry roll
diced peaches

Inspector #547 interviewed the Dietary Aide #145 who indicated that they did not have the yellow beans as identified on the menu for regular texture diets but that they did have them for the pureed texture diets. This substitution was not identified on the identified unit menu, or weekly menu for residents.

Resident #047 indicated to Inspector #547 that he/she was never told that they were to have green beans, and that he/she did not like green beans as he/she preferred yellow beans. Resident #047 did not eat any of his/her green beans for this meal.

On April 26, 2017, menu substitutions were not communicated to residents and staff on an identified unit. These substitutions were identified outside the identified unit attached to the weekly menus posted in the hallway outside the unit. Resident's on identified unit are not able to leave the unit unattended and would not have been made aware of the changes to the lunch meal.

On April 26, 2017, Inspector #547 saw dietary aide #147 posting the meal substitution on the weekly menu box, and indicated that these substitutions are provided from the kitchen to the dietary aides, to post them over the daily menus for the units they are assisting. This is to show staff and residents changes to the meal as they are highlighted.

On April 28, 2017, Inspector #547 spoke to dietary aide #148 regarding where he/she posted the meal substitutions on the identified unit, and he/she indicated

that he/she posted them inside the servery, as the meal substitutions are for him/her to know before serving. Dietary aide #148 indicated that he/she is not provided with any menu with substitutions to post to residents and families in this unit.

The Food Services Manager (FSM) indicated to Inspector #547 that the food substitutions for residents should be identified on every unit. The FSM indicated that resident's receiving substitutions related to different textures should also be identified for every meal as required. FSM and Inspector #547 reviewed the identified unit, and did not find any menus identifying the substitutions provided to residents on the identified unit during this inspection. Substitutions were noted to be posted on three identified dates in 2017. [s. 72. (2) (f)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

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

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

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without

limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff apply resident #003's and resident #048 's physical device that has been ordered or approved by a physician or registered nurse in the extended class.

Resident #003 was noted as per WN # 14 (s. 31. (1) to be wearing an identified device while seated in a wheelchair and was not able to remove this device.

Inspector #547 reviewed the plan of care for resident #003 and no orders were completed for any device restraint by a physician or registered nursing staff in the extended class.

RN #125 indicated to Inspector #547 that resident #003 does not need the identified device while in the wheelchair as there was no orders for any restraint. [s. 110. (2) 1.]

2. Resident #048 health care record review indicated the resident was ordered a physical restraint of the identified device cover while in the wheelchair. The cover over the identified device is further documented at the top of the resident's Medication Administration Record (MAR).

Inspector #547 observed resident #048 over the course of this inspection to be seated in a manual wheelchair with an identified physical device applied which the resident was not able to release. This physical device was not covered with any cover as identified in the order for restraint. Over the course of this inspection, resident #048 was observed seated in a wheelchair labelled with resident #049's

name. When this was brought to the attention of RPN #107, he/she indicated that staff decided to switch resident #048's wheelchair with resident #049's wheelchair as it was a better chair and resident #049 did not utilize his/her chair. According to RPN #107, he/she indicated that he/she was not sure who assessed the resident for the need of the identified physical device. RPN #107 indicated that he/she was aware of the need to use a cover over the resident's identified physical device restraint.

On April 28, 2017, Inspector #547 interviewed the Director of Care regarding resident #048's identified physical device restraint and indicated that the resident has an order for this identified device restraint cover and that it should be applied. The resident will also be seated in his/her own wheelchair as of today as the resident was not evaluated for resident #049's chair.

Five days later, resident #048 was observed seated in his/her own wheelchair and the identified physical device applied to the resident and no device cover was observed to be applied to the resident. [s. 110. (2) 1.]

3. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instruction relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6 . All assessment, reassessment and monitoring, including the resident’s response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Under the Long-Term Care Homes Act, S.O. 2007, Chapter 8 under section s. 31 (1), the Act indicated that a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident’s plan of care.

On two identified dates, Inspector #211 observed resident #073 with two full side rails elevated in an up position while the resident was lying in bed.

Resident #073 was admitted to the home on an identified date and diagnosed with cognitive impairment and other health issues. The resident's health care record indicated that the resident had a fall on an identified date during the morning. The resident was transferred to the hospital on the same day of the fall and returned to the home seventeen days later.

Review of the resident's written plan of care did not indicate that the resident required to have both full side rails elevated when lying in bed.

Review of the resident's Minimum Data Set (MDS) assessment on an identified date indicated that resident #073 requires full bed rails on all open sides of bed as a daily use.

Interview with PSW #136 on an identified date, who stated that the resident was using both full side rails in the up position when the resident was placed into the bed to prevent falls. PSW #136 indicated that the resident's right side rail was not elevated prior to the resident's fall on the identified date. PSW #136 indicated that he/she observed that the resident's both full side rails were used in the up position after the resident has returned from the hospital on the identified date. PSW #136 indicated that when a resident requires the side rails to be elevated, a pictogram on the wall above the resident's bed will show how many side rails need to be elevated. However, resident #073 does not have a pictogram indicating that the resident needs side rails.

Interview with PSW #174 on May 9, 2017, indicated that if both side rails were not elevated, the resident may try to get up from the bed. PSW #174 stated that he/she monitored the resident every hour when the resident lied in bed with both full side rails elevated but the monitoring is not documented.

Interview with RN #103 on May 8 and 9, 2017, stated that both full side rails have been put in the up position since the resident returned from the hospital on an identified date, as requested by an identified substitute decision maker (SDM). However, he/she did not document that the SDM consented to have both side rails elevated and the circumstances precipitating the application of the side rails. RN #103 acknowledged that the resident's full side rails were not approved by the

physician. Also, RN #103 confirmed that the resident's written plan of care did not indicate that the resident's side rails are being used as fall prevention interventions. Moreover, a pictogram above resident's bed was not placed to indicate that the resident required both full side rails in the up position when the resident was in bed.

The licensee has failed to ensure that the use of both full side rails physical device to restrain resident #073 under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instruction relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.
Furthermore, the licensee has failed to ensure when a resident is restrained by a physical device, the restraining of the resident is included in the resident's plan of care as indicated under the Long-Term Care Homes Act, S.O. 2007, Chapter 8 under section s. 31 (1).

The licensee has failed to ensure that the documentation include the following related to the physical device for resident #005:

5. The person who applied the device and the time of application,
6. All assessment, reassessment and monitoring, including the resident's response,
7. Every release of the device and all repositioning,
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care

Resident #005 was observed by Inspector #547 to be wearing an identified physical device restraint while seated in his/her wheelchair during the course of this

inspection.

Resident #005's health care records reviewed including the POC and Medication Administration Records (MAR) had no indication of the following:

• Any time of application of the resident's identified physical device cover restraint while resident #005 is seated in his/her wheelchair daily

• Any assessment, reassessment or monitoring including resident response of the resident's identified physical device cover restraint while resident #005 is seated in his/her wheelchair daily.

• Any time of removal of the resident's identified physical device cover restraint while resident #005 is seated in his/her wheelchair daily or any post-restraining care.

RPN #107 indicated to Inspector #547 that the PSW staff monitor the resident restraints and are supposed to document when they apply and remove the seat belt restraint in the home's point of care (POC) electronic documentation system. RPN #107 further indicated that the registered nursing staff are not responsible to document any monitoring of the resident's restraints.

On May 3, 2017, RN #142, the clinical educator for the home indicated to Inspector #547 that the residents with restraints should be monitored hourly in the home's POC by PSW staff when the restraint is applied. RN #142 further indicated that he/she was aware that registered nursing staff were not doing any documentation regarding the assessment, reassessment and monitoring of residents restraints as required. RN #142 indicated the home is reviewing the restraint policy and procedure at this time and will implement a new policy and procedure in the summer 2017.

The licensee has failed to ensure that the documentation include the following related to the physical device for resident #048:

5. The person who applied the device and the time of application,
6. All assessment, reassessment and monitoring, including the resident’s response,
7. Every release of the device and all repositioning,
8. The removal or discontinuance of the device, including time of removal or

discontinuance and the post-restraining care.

Resident ##048 was admitted to the home on an identified date with several medical diagnoses including cognitive impairment. Resident's health care records documented the resident had an order for physical restraint of an identified device with cover while seated in wheelchair.

RPN #107 indicated to Inspector #547 that the resident's restraint was in the POC for monitoring and that is the only place where the staff document the application of these restraints. This is also the location the PSW's document the repositioning for residents.
RPN #107 indicated that the registered nursing staff do not have any documentation regarding restraints used for the resident. RPN #107 indicated that the resident's restraint were to be documented in the home's Point of Care (POC) electronic documentation system for PSW's. POC would be the only place where the PSW staff document the application and removal of these physical restraint devices. RPN #107 indicated that he/she was not aware of any post-restraining care interventions in POC.

May 3, 2017, RN #142 indicated to Inspector #547 that residents with a restraint required monitoring of this restraint and documentation hourly in the home's Point of Care (POC) electronic documentation system. Upon review with RN #142, it was noted that there was no intervention regarding the restraint used for this resident in the plan of care that would pull an intervention to PSW staff in the POC. RN #142 indicated to Inspector #547 that residents with a restraint required assessment, reassessment and monitoring of this restraint and documentation hourly in the home's Point of Care (POC) electronic documentation system. RN #142 indicated that they are aware that registered nursing staff do not document any assessment, reassessment or monitoring of resident's restraints use in the home at this time as required. RN #142 indicated to Inspector #547 that residents with a restraint required release of the device and repositioning at least every two hours in the home. This release and repositioning would be documented in the POC by PSWs. RN #142 indicated to Inspector #547 that residents with a restraint required monitoring of this restraint and documentation hourly in POC, which would include the removal of the physical restraint device and the time. [s. 110. (7)]

4. More specifically, the licensee failed to ensure that the following was documented for resident #069.

This finding is related to Log #032808-16.

On an identified date, Critical Incident was submitted to the Director reporting a fall to resident #069 on an identified date during night shift.

Resident #069 was admitted to the home on an identified date with multiple diagnosis including cognitive impairment.

Inspector #550 reviewed resident #069's progress notes for approximately five months and noted documented that the resident fell several times after the fall on an identified date.

On an identified date, the inspector observed the resident sitting in the dining room in a wheelchair with a identified physical device attached. On the next day, the inspector observed the resident sitting in his/her wheelchair in his/her room with the identified physical device attached. The inspector asked the resident if he/she was able to remove the physical device and observed that the resident was cognitively unable to remove the device, even when prompted. Five days later, in the presence of RN #103, the resident was unable to remove the identified physical device attached seat belt when prompted asked and prompted.

During an interview on an identified date, PSW #165 indicated to the inspector that resident #069 has had a wheelchair with an identified physical device for the past two to three months to prevent the resident from falling and that the resident was being monitored every 2 hours while the physical device was applied. RPN #137 indicated to the inspector that the resident was placed in a wheelchair with the identified physical devicet because he/she was falling often and that this was effective as the resident has not fallen since the use of the wheelchair with the identified physical device.

The inspector reviewed resident #069's health care records including the documentation in Point of Care and the Mar sheets. The inspector noted that there was no documentation of the person who made the order, what device was ordered, any instructions relating to the order, the consent, the person who applied the device, and the time of the application, all assessment, reassessment and monitoring, including the residents response, every release of the device and all repositioning, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

On an identified date, during an interview, RN #103 indicated to the inspector that this resident was falling often and it was decided to place the resident in a wheelchair with an identified physical restraint to prevent his/her from falling. He/She said he/she was aware that the resident was not cognitively capable of removing the physical device on his/her own most of the time but he/she thought that because the Occupational Therapist had documented in the progress notes that the identified physical device was a PASD used for positioning that it would be considered as a PASD and not a restraint even though the initial purpose of the identified physical device is to prevent the resident from falling. [s. 110. (7)]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of the restraining of resident #048 and #005 by use of a physical device undertaken on a monthly basis.

Resident #005 in the home has an order and consent for use of a physical device cover restraint to cover the identified area on the identified physical device while resident #005 is seated in his/her wheelchair.

The home's policy and procedure #CLIN CARE 34 titled Restraint Minimization indicated on page 3 of 7 that 5.0 tracking and analysis is required for physical restraints.This tracking is required based on physical restraints as they are ordered or discontinued in the home's risk management database.The quality, patient safety and risk management department send monthly reports on the physical restraint utilization to clinical managers and program directors for review.

On May 5, 2017 the home's Administrator/Clinical Manager indicated to Inspector #547 that the home has not been conducting an analysis of the restraining of residents by use of a physical device undertaken on a monthly basis for the identified unit. The home's policy is mainly created for resident's in hospital and their policy is going to be updated and in place in the home by Summer 2017.The Administrator/Clinical Manager provided a copy of the Data analysis for three consecutive months in 2017 and noted that resident #005 is identified on their monthly report however is not identified for having any restraint in use at all in the column RES01. [s. 113. (a)]

2. Resident #048 was identified in WN # 14 (s. 31. (2) 5) to have an order for physical restraint of an identified device with cover while seated in his/her wheelchair.

The Administrator/ Clinical Manager indicated to Inspector #547 after review of the Monthly Raw Data Quality Indicator Report for the identified unit for three consecutive months in 2017, and resident #048 was not identified as using any restraint. The Administrator/ Clinical Manager indicated that this data analysis from the Monthly Raw Data Quality Indicator Report process would have to be reviewed. [s. 113. (a)]

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 18 day of July 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JOELLE TAILLEFER (211) - (A1)

Inspection No. / No de l'inspection : 2017_618211_0008 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 005946-17 (A1)

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

Report Date(s) / Date(s) du Rapport : Jul 18, 2017;(A1)

Licensee / Titulaire de permis : BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET, OTTAWA, ON, K1N-5C8

LTC Home / Foyer de SLD : RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA, OTTAWA, ON, K1C-2Z6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Chantale Cameron

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

To BRUYERE CONTINUING CARE INC., 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 :

O.Reg 79/10, s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Order / Ordre :

The licensee shall ensure that:

1. The Elevator C is to be equipped to restrict resident access to the basement level which is a non-residential area.

2. Until such a time, the licensee shall immediately implement measures to ensure resident safety, related to the possibility of unsupervised access to this non-residential area.

Grounds / Motifs :

1. The licensee has failed to ensure that any elevators in the home are equipped to restrict resident access to the basement level which is considered a non-residential area of the home.

On April 18, 2017 at 08:20, Inspector #592 was on the ground floor of the home and signaled the elevator C to go to the basement. Inspector #592 noted that there was a note posted in the elevator indicating "please note that only employees and volunteers with an access card can get to the basement with this elevator".
The elevator went down and the doors opened in the basement. The elevator was not equipped to restrict resident access to this area.

Inspector #592 observed elevator A and B which had the same posted memo indicating "please note that only employees and volunteers with an access card can get to the basement with this elevator". Inspector #592 observed in both elevators the presence of a card reader. Inspector #592 signaled both elevators to go to the basement and was denied the access.

On April 20, 2017, during an interview with Inspector #592, the Administrator revealed that the basement was considered a non-residential area of the home. She further indicated being aware that one of the three elevators was not equipped with a card reader system preventing the residents to go to the basement. Therefore, one elevator remained accessible to residents as it was not equipped to restrict residents from going to the basement level.

The severity related to the identify elevator that was not equipped to restrict residents access was determined to be "potential for actual harm". The scope was identified as "widespread" as one of the elevator remained accessible to the residents residing in the home to have access to the basement level. (592)

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

Sep 28, 2017

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

Ministère 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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

1. The licensee shall ensure that dietary and nursing staff are aware that every resident must be offered and presented two choices at each meal or snack from the home's planned menu items. The licensee is further required to ensure that the offered choices are comparable to the planned menu items as approved by the home's registered dietician for the resident's nutritional needs.

2. The licensee shall ensure that all planned menu items or substitutions identified on the menus are made available to each resident at each meal and snack.

3. The licensee shall ensure that staff are aware of resident's verbal and non-verbal communication methods for making their choices known. Staff are further to be aware that when a resident cannot make a choice after they are provided two choices by staff, that they consult the resident's individual plan of care that will identify resident's likes and dislikes for food and beverages.

Grounds / Motifs :

1. The licensee has failed to comply with section 71.(4) of the regulation in that the home has failed to ensure that the planned menu items are offered to each resident

and made available at each meal and snack.

On April 18, 2017, Inspector #547 observed the lunch meal on an identified unit. Menu choices for desert according to the week 3 Fall 2016/Winter 2017 menu for day 16 indicated "coconut squares or coconut pudding, diced pears or pureed pears. Resident's on the identified unit were offered red jello, white cake, chocolate cake, diced pears, mixed diced fruit, pureed only had mixed fruit according to dietary aide #148. Pureed pears or coconut pudding were not offered to residents that required or wanted these planned textured items.

On April 24, 2017, Inspector #547 observed the lunch meal on another identified unit. This unit has a smaller dining room in the lounge area where eight residents were seated. One out of the eight residents was shown menu choices for this lunch meal, including salad, soup, main course and dessert planned menu items. The seven other residents were brought food based on the PSW's choice. PSW #154 indicated to Inspector #547 that they do not offer these residents choices as they follow the resident's care plans. Residents #061, #064 and #065 were not shown choices for the lunch meal and the care plans were reviewed by Inspector #547 that did not identify residents that did not require to be shown meal choices.

On April 25, 2017, Inspector #547 observed the lunch meal on an identified unit and noted that residents that required pureed menu were being offered pureed strawberry desert however this was not on the menu for day 2 of week 1 of the Fall 2016/Winter 2017 menu. Residents were not offered mixed fruit puree or yogurt as per the planned menu. The pureed strawberry desert was noted on an identified day on April 2017 which was day 1 of this same menu for week 1.

On April 27, 2017, Inspector #547 interviewed PSW #141 working on another unit. PSW #141 indicated that their dining room had several resident's with cognitive impairment and that require feeding assistance for their meals that have preferences identified on their plans of care. PSW #141 further indicated that the PSW's always are required to show all residents all menu choices. Often the resident's expect them to know their usual preferred beverages however they are still to offer them a chance to change their mind if they want something different. The PSW indicated that some resident's respond verbally and others respond with their eyes or hands, but they are all still shown menu choices at every meal and snack.

The Administrator/Clinical Manager (Admin/CM) indicated to Inspector #547 that she

expected each resident be offered the planned menu items and beverages for each meal or snack service, no matter what texture food they are to receive as every resident should have a choice in what they eat or drink. [s. 71. (4)]

This compliance order is warranted for the home's pattern in the scope of practice in the home related to residents with feeding assistance requirements or texture modified menu items. The home further has a history of non-compliance with r. 71. of the regulations as identified in the following:

1.The home's 2014 Resident Quality Inspection (RQI) that started on November 24, 2014 inspection #2014_198117_0031 issued a Written Notification (WN) to the Licensee regarding O. Reg 79/10, r. 71.(1) a and r.71.(5)

2. The home's 2015 RQI that started on November 30, 2015 inspection #2015_289550_0027 issued a Voluntary Plan of Correction (VPC) to the Licensee regarding O. Reg 79/10, r. 71.(4)

3. A Complaint inspection that started on June 20, 2016 inspection #2016_289550_0023 issued a VPC to the Licensee regarding O. Reg 79/10, r. 71. (4)

4. The home's 2016 RQI that started on December 5, 2016 inspection #2017_619550_0004 issued a VPC to the Licensee regarding O. Reg 79/10, r. 71.(4)

5. A Complaint inspection that started on February 7, 2017 inspection #2017_619550_0003 issued a VPC to the Licensee regarding O. Reg 79/10, r. 71.(4) (547)

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

Sep 28, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Order / Ordre :

(A1)
The Licensee shall ensure that the written policy to minimize the restraining of residents that ensures any restraining that is necessary is done in accordance with this Act and the Regulations; and shall ensure that the policy is complied with, more specifically that the license shall ensure the following:

Education is provided to direct care staff on the licensee's policy and procedure for Restraint Minimization. This education shall include hands on demonstrations for nursing staff that are responsible for the procedures. This education shall be documented.

Evaluate each resident that is utilizing any restraint or PASD to ensure that the residents have been evaluated for this physical device based on their individualized needs.

Develop a process to ensure that the tracking and analysis data of restraints and PASDs are accurate via the decided method to gather this information for the home's monthly reports on physical restraint utilization.

Grounds / Motifs :

1. The Licensee failed to comply with LTCH Act, 2007 s.29 (1)b regarding minimization of restraining of residents, Where the Act requires the Licensee of a long-term care home to ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations and the licensee is required to ensure that the policy is complied with, in that the home failed to ensure compliance with the following policy.

This finding is in addition to the findings described in the WN #25 related to the requirements for restraining of physical devices issued under O. Reg 79/10 r. 110 (2) and r. 110 (7).

The Administrator provided a copy of the Licensee's policy and procedure # CLIN CARE 34 titled Restraint Minimization last revised 2013-11 that currently applies to the home to Inspector #547 for review which stated the following:

1.2 Identified physical restraints that refer to the use of any physical or mechanical device to involuntarily restraint the movement of the whole or a portion of a resident's body as a means of controlling his/her activity.

1.3 Identified that bed rails are not a restraint when the resident is not functionally capable of voluntary movement, used as functional/positional devices or the resident can still exit the bed.

1.4 Identified that Personal Assistance Service Devices (PASD's) enabling devices used to assist with routine activities of daily living that are not intended to control behaviour or movement.
PASD must be included in the resident plan of care, must be approved by a physician, nurse, occupational therapist (OT) or physiotherapist and its purpose must be understood by resident/Substitute Decision Maker (SDM) who must agree with its use.

2.0 The policy identified:
2.1 All possible alternative interventions must be considered before a restraint is applied, and least restrictive form of restraint should be used, for the shortest length of time, and removed as soon as the restraint is no longer necessary.
2.2 A physician's order for physical restraint specific to the resident and the situation

is required to order, re-order or discontinue a restraint. Orders for a restraint shall be for a maximum of 30 days. Such orders may also be given by a registered nurse in the extended class.
2.3 All restraints must be commercially made and used in accordance with the manufacturer's specifications- no adaptations are permitted.
2.4 All physical restraints must be monitored and documented on an ongoing basis for the duration of their use
2.5 All restraints used must follow a plan of care that the patient or SDM has given consent to, and documented by the physician and other health professionals involved.
2.6 Education shall be provided to all new direct care staff as well as ongoing education annually from their program or unit.
2.7 The Quality, Patient, Safety and Risk Management department will ensure that audits are completed on an ongoing basis in order to analyze physical restraint use and alternative approaches, and that the resident policy and practices are evaluated annually with the goal of reducing restraint utilization.

3.0 Ordering Physical Restraints
3.1 When an assessment has been completed and a decision made by the physician, in consultation with the treatment team, that a restraint is necessary, the physician or delegate discusses the matter with the resident or SDM, outlining the risks and benefits, and obtains verbal consent, documenting the discussion and the decision using the following forms:
-Assessment and Reassessment for the Use of Restraints when Alternatives Unsuccessful (H210050)
-Initial Restraint Monitoring (H210051)
-Ongoing Restraint Monitoring (H210061)
3.2 The physician completes the Physician's order for physical restraint (H600032) with input from the nurse or OT, to initiate, reorder or discontinue a restraint. In Long Term Care (LTC): the external pharmacy enters restraints used on the MAR sheet.

4.0 Resident monitoring and reassessment
4.1 When a physical restraint is applied, the resident is monitored and documented on the initial restraint monitoring form (H210051) at least every 15 minutes for the first hour, then every 30 minutes for the next two hours, or longer if necessary, until the residents behavior is stabilized. Monitoring is then done hourly on the ongoing restraint monitoring sheet.
4.2 When the resident is in the care of other health professionals, that health

professional is expected to maintain hourly monitoring of any restraint on the ongoing restraint monitoring sheet and to document unexpected response in the progress notes.

The clinical educator identified to Inspector #547 that this hourly monitoring is now to be documented in the home's Point of Care (POC) electronic documentation system by Personal Support Workers (PSW).

4.3 When the physical restraint is applied, the resident is released and repositioned at least every two hours and as necessary.

The clinical educator further indicated to Inspector #547 this is specified in the POC documentation as well.

4.4 The resident's condition/response to the restraint is reassessed and its effectiveness evaluated by a physician or nurse every eight hours, and as necessary and documented in the progress notes.
4.5 Physical restraints are reassessed (using the form Assessment and Reassessment for the use of Restraints when Alternatives Unsuccessful) and their use documented by the team within 24 hours of a first time application and at least every 30 days thereafter using the Physician's Order for Physical Restraint.

5.0 Tracking and Analysis
5.1 When a physical restraint is ordered or discontinued, the nurse send a copy of the physician's order for Physical Restraints to the units administrative assistant, who enters it in the Risk Management Database within 24 hours.
5.2 The Quality, Patient Safety, and Risk Management department sends monthly reports on physical restraint utilization to the clinical managers and program directors for their review.

Over the course of this inspection, the inspection team identified the use of seat belt restraints and full side rails restraints utilized in the home.

The Licensee has failed to ensure that resident's care related to restraints and seating in wheelchairs, set out in the plan of care is provided to these residents as specified in their plans as per WN # 7(s. 6(7) for resident #048 and resident #049)

The Licensee has failed to ensure that a resident may be restrained by a physical

device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the residents plan of care as per WN #14 (r.31)

The Licensee has failed to ensure that Personal Assistance Services Devices (PASD) that has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release themself from the PASD, to assist the resident with a routine activity of living only if the use of the PASD is included in the residents plan of care as per WN #15 (r.33)

The Licensee has failed to ensure that where bed rails are used,(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident as per WN #19 (s.15(1))

The Licensee has failed to ensure that requirements relating to restraining by a physical device are met with respect to restraining of a resident by a physical device as per WN #25 (s.110)

The Licensee has failed to ensure that the minimization of restraining of residents in the home is evaluated as per WN #26 (s.113)

The following non-compliance was identified in the home's history related to the same issues in this order:

Non-compliance was previously identified under LTCHA, 2007, s.6, s.31, s.33 and r.15. as voluntary plans of corrections during an inspection that started on November 24, 2014 (Inspection # 2014_198117_0031).

Non-compliance was previously identified under LTCHA, 2007, s.6 and s.110 as voluntary plans of corrections and s.31 as written notifications during an inspection that started on November 30, 2015 (2015_289550_0027).

Non-compliance was previously identified under LTCHA, 2007, s.6, s.31 as voluntary plans of corrections and r.15 as CO #001 served during an inspection that started on December 5, 2016 (2017_619550_0004).

All items identified in this report regarding restraints were documented in the home's policy #CLIN CARE 34 titled Restraint Minimization identified in this report, that was

not complied with by staff in the home. The severity, scope of practice and history identified of these non-compliances regarding the use of restraints and PASD's in the home indicated this order was warranted. (547)

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

Sep 28, 2017

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 71. Director of Nursing and Personal Care

Order / Ordre :

The licensee is ordered to immediately take the following actions:

The Director of Nursing and Personal Care shall be a registered nurse, and

The Director of Nursing and Personal Care shall supervise and direct the nursing staff as well as the personal care staff of the long-term care home and the nursing and personal care provided by them.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the Director of Nursing and Personal Care (DONPC), shall be a registered nurse and the DONPC shall supervise and

direct nursing staff and personal care staff of the long-term care home and the nursing personal care provided by them.

On April 18, 2017, at the beginning of the Resident Quality Inspection, the Inspectors Team (#211, #550 and #592) were informed by the Executive Director of Long Term Care (EDLTC) that Residence St-Louis does not have specifically a DONPC, but instead they have a Director of Care (DOC) who supervises the registered nursing staff and an Administrator/Clinical Manager (ACM) who supervises the personal care nursing staff. The EDLTC indicated that the DOC covers Units 1C / 2C /3C and the ACM covers Units 2AB/ 3AB/ 4AB/C.

During the course of this inspection, several members of the home's nursing staff shared with Inspectors several concerns related to the organizational structure and communication limitations related to the supervision of registered nursing staff and personal support workers staff:

On April 21, 2017, Inspector #211 interviewed the DOC to have a discussion relating to resident #026's care and services and was immediately informed that the resident was under the supervision of the ACM since the resident was residing in an identified unit supervised by ACM. On the same day, Inspector #211 interviewed the ACM who indicated that she was in charge of the identified unit, but the DOC was responsible for resident's skin and wound care.

On an identified date, in an interview with RN #103, he/she indicated to Inspector #592 that he/she was made aware by an identified person related to an identified provision of care for resident #014. RN #103 indicated that yesterday, he/she was made aware again, by the identified person that the PSWs were not providing the identified care to resident's #014. RN #103 indicated that on a daily basis, he/she reminds the PWS to provide the identified care to resident's #014 and because it is not done, he/she will do it himself/herself. RN #103, indicated that he/she had not reported these refusal of PSWs to the managers. PSWs are not taking direction from the registered staff, only from ACM.

On April 26, 2017, Inspector #547 interviewed the DOC, regarding infection control, and hand hygiene requirements for residents. The DOC indicated that she provided the education to all PSW staff, that residents should have their hands washed before and after each meal as well as with AM and PM care. The DOC indicated that she has done follow-up education related to hand hygiene of residents, however the

PSWs staff indicated to her that she was not their manager, and that they only listen to their the ACM. The DOC indicated that I should discuss hand hygiene for the residents with the ACM. The next day, Inspector # 547, interviewed the ACM, who indicated that the DOC was in charge of the education for PSW staff for the Infection Control Program.

On April 26, 2017, during an interview with the DOC, who indicated to Inspector #550 that she could not inform the inspector of the results of the investigation regarding an incident of allegations of staff to resident abuse. The DOC indicated to the inspector that she is not responsible of managing PSWs, therefore she was not able to interview them. The rest of the investigation was then given to the Administration/Clinical Manager as she is the person of managing the Personal Support Workers (PSWs).

On May 1, 2017, during an interview with RN #149, who indicated to Inspector #126 that in an identified month in 2016 there was a situation that he/she requested that an evening PSW, stay until the arrival of the night PSW to ensure residents safety. The evening PSW contacted her manager (ACM) to inform her that he/she was forced to stay on the unit until the night staff arrived. RN #149 indicated that after the incident he/she received an email from the DOC with clear directives on how to manage these situation. In the same email, it was documented by the ACM, that RN #149 had forced an evening PSW to stay to cover and was doing it by seniority and it had to be discussed by the Managers. RN #149 is managed by DOC and the PSWs by the ACM. The RN indicated that the supervision structure of the home makes it complicated for open discussion between registered nursing staff and non registered nursing staff' as he/she discussed the incident with the DOC and the PSW discussed the incident with the ACM.

On May 1, 2017, the Inspector's Team (#126, #211, #547, #550 and #592) discussed with the EDLTC and ACM regarding several comments made by the nursing staff related to supervision by DOC/ ACM and floors supervision of registered nurse and personal support care. The ACM qualifications were reviewed and it was noted that she was not a registered nurse.

On May 2, 2017, Inspector #126 reviewed the Administrator/Clinical Manager LTC (Corporate) Job Description dated January 30, 2015. It was noted that under Section 11. Supervision or Direction exercised, "Provide direct supervision of PCA's at RSL." The ACM is not a registered nurse and does provide supervision of the personal care

staff, therefore the licensee failed to ensure that the personal care staff is supervised by a registered nurse. [s. 71.]

The severity related to the finding that the Director of Nursing and Personal Care (DONPC) should be a registered nurse to supervise the direct nursing staff and the personal care staff of the long-term care home was determined "potential for actual harm". The scope was identified as "widespread" as the supervision structure is altering an open discussion between registered nursing staff and the non-registered nursing staff. (126)

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

Sep 28, 2017

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.
3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
5. Drugs and treatments required.
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.
7. Skin condition, including interventions.
8. Diet orders, including food texture, fluid consistencies and food restrictions.
O. Reg. 79/10, s. 24 (2).

Order / Ordre :

1. The licensee shall immediately develop a care plan that identify at a minimum, the following with respect to the resident:
• Any responsive behaviours and associated interventions to mitigate risks.
• The type and level of assistance required relating to activities of daily living especially related to toileting, transfers, bathing, mobility aids and physiotherapy needs.
• Daily care routines and comfort requirements such as repositioning and pain management.
• Known health conditions and other condition, that the licensee should be aware upon admission, including interventions.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the care plan identify the resident and include, at a minimum, the care needs identified under O. Reg. 79/10, s. 24 (2) 1. 2. 3. 4. and 6.
-Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.
-Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.
-The type and level of assistance required relating to activities of daily living.

-Customary routines and comfort requirements.
-Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.

A Critical Incident was submitted on an identified date, to the Ministry of Health and Long Term Care in regards to resident #050 for an alleged staff to resident abuse.

A review of resident #050's health care record was done by Inspector #592. The health care record indicated that resident #050 was admitted on the identified unit on an identified date, with several diagnoses. The resident's health care record further indicated that resident was experiencing pain and had responsive behaviours.

In a review of resident #050's health care record, Inspector #592 noted that the care plan for resident #050 was created on an identified date with two identified focus problems related to bathing and skin integrity. There was no identification of the resident's pain and responsive behaviours; no other focus problems were identified.

Inspector #592 reviewed two other residents admitted on the identified unit.

A review of resident #071's health care record was done by Inspector #592. The health care record indicated that resident #071 was admitted on the identified unit on an identified date with several diagnosis.

In a review of resident #071's health care record, Inspector #592 noted that the care plan for resident #071 was created on an identified date with one identified focus problem related to risk of falls. There was no other focus problems identified.

A review of resident #070's health care record was done by Inspector #592. The health care record indicated that resident #070 was admitted on the identified unit on an identified date with several diagnosis. In a review of resident #070's health care record, Inspector #592 noted that the plan of care for resident #070 was created on an identified date with one identified focus problem related to risk of falls; no other focus problems were identified.

On May 02, 2017, interview with PSW #132 indicated to the Inspector that when a resident is admitted on the identified unit, the occupational therapist (OT) and the nurse will evaluate the resident and some instructions for transfers will be left but no other issues regarding care. He/She further indicated that the information related to transfers would be written up on the white board located in the report room. He/She further indicated that there was no other documented planned care as he/she was communicating well to the resident on a daily basis to ensure that he/she was meeting their daily needs, therefore he/she felt that the care plan was not needed.

On May 03, 2017, interview with PSW #164 indicated to the Inspector that upon admission, the nurse and the physiotherapist will assess the resident for transfers and instructions will be left on the white board. He/She further indicated to the Inspector that there was no other documentation or care instructions other than receiving instructions from the 24 hour report given by the nurse. PSW #164 told the Inspector that the nurse would let her know if the resident has a specific problem. There was no other information given to the staff related to other care issues e.g. responsive behaviours.

On April 28, 2017, during an interview with the DOC, he/she indicated to the Inspector that the residents who were admitted to the home on the identified care unit were to have an individual written plan of care the same as the residents residing on the other long term care unit. She further indicated to the Inspector, upon the written plan of care for resident #050, that she realized that there was only two focus problems identified for resident #050. The DOC indicated that the charge nurse would possibly have more information as the RN is responsible for updating the plan of care manually on a daily basis for all the residents due to frequent changes in the residents' physical status.

On May 02, 2017, during an interview with the charge nurse #104, he/she indicated to the Inspector that since the introduction of the electronic version of the resident health care records, approximately one year ago, he/she was told by the DOC to no longer do the care plan manually as all the plans of care must be done electronically. He/She indicated that the only tool used to communicate the residents care needs is the white board located in the report room for specific interventions such as the transfers and the repositioning of the residents. Charge nurse #104 also indicated to the Inspector that the written plan of care were not developed for the residents residing on the identified care unit. [s. 24. (2)]

The severity related to the care must identify the resident and must include, at a minimum, the care needs identified under O. Reg. 79/10, s. 24 (2) 1. 2. 3. 4. and 6, who are residing on the identified unit was determined to be "potential for actual harm". The scope was identified as "widespread" because it is affecting all residents on the identified unit. (211)

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

Aug 31, 2017(A1)

Order # /
Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Order / Ordre :

The licensee shall ensure that residents who require assistance will not be served a meal until someone is available to assist the resident with the meal.

Grounds / Motifs :

1. The licensee has failed to ensure that no person who requires assistance with eating and drinking is served a meal until someone is available to provide the assistance required by the resident.

On April 18, 2017 Inspector #547 observed dietary aide #148 on the identified unit, served soups to residents at 1209 hours to residents, however PSW staff were still bringing residents into the dining room. Resident #058 was seated at a table alone and was provided salad, soup and main meal course at 1218 hours, however was not provided assistance until 1230 hours. Resident #058's care plan indicated the resident required one staff to provide hands on support. Resident #048 began being fed his/her soup 10 minutes after it was served in front of him/her in the dining room. Resident #048 requires total assistance for feeding his/her meal.

On April 25, 2017 Inspector #550 observed dietary aide #148 on another unit at 0849 hours serve breakfast meals to residents that are not there as follows:

Resident #053 was served a bowl of dry cornflake cereals, a banana, a glass of milk, a glass of apple juice, a glass of water and 2 yogurts. A PSW told Inspector #550 that resident #053 was not out of bed yet.

Resident #060 is a resident that eats breakfast in this dining room, and the dietary aide had served the resident a bowl of dry cornflake cereals, a banana, a glass of milk, a glass of apple juice, a glass of water, 2 yogurts.
PSW told the inspector #550 that resident #060 was not up or in the dining room yet.

Resident #061 was served a yogurt, a glass of apple juice, a glass of water, pureed bread and egg, a bowl of oatmeal and a toast with jam cut-up however the resident was not in the dining room yet.

Resident #062 was served a yogurt, a glass of orange juice, a cut-up toast with jam however the resident was not in the dining room yet.

Resident #026 was served a glass of apple juice, a glass of water, a yogurt, oatmeal and pureed banana bread in the same cup, a cut-up toast with jam and egg omelet before the resident arrived in the dining room.

Inspector #547 interviewed dietary aide #146 on April 25, 2017, who indicated that they can serve meals to the resident tables once the residents and staff arrive in the

dining room.

On April 28, 2017, Inspector #547 observed the lunch meal on the identified unit at 1205 hours. The residents were served multiple meal courses by Dietary Aide #148 and indicated to Inspector #547 that he/she is not supposed to leave the servery but that there was no PSW's in the dining room. The Dietary Aide indicated that he/she places the food on the tables and leaves it for the PSW's to assist residents even though the PSWs are not ready. The Dietary Aide indicated that he/she had to keep the meal rolling, as he/she has to leave the identified unit to go do the dishes for the entire home and then leave to go home by two pm.

On April 27, 2017, Inspector #547 interviewed the Food Services Manager (FSM) and indicated that the dietary aides can start the meal for residents only when nursing staff members are available to assist them. The FSM further indicated that the dietary aides should not be in any rush to finish meal service at a certain time, especially for these identified units with residents that has cognitive impairment as they required more time. [s. 73. (2) (b)]

The Licensee has a history of non-compliance with r. 73. of the regulations as identified in the following:

1.The home's 2015 Resident Quality Inspection (RQI) that started on November 30, 2015 inspection #2015_289550_0027 issued a Voluntary Plan of Correction (VPC) to the Licensee regarding O. Reg 79/10, r. 73.(1)1, r.73.(1).8, and r.73. (2).b

2. A Complaint inspection that started on June 20, 2016 inspection #2016_289550_0023 issued a VPC to the Licensee regarding O. Reg 79/10, r. 73. (2).b

3. The home's 2016 RQI that started on December 5, 2016 inspection #2017_619550_0004 issued a VPC to the Licensee regarding O. Reg 79/10, r. 73. (1).8 and r. 73.(2).b

4. A Complaint inspection that started on February 7, 2017 inspection #2017_619550_0003 issued a VPC to the Licensee regarding O. Reg 79/10, r. 73. (1).7

5. Resident Quality Inspection (RQI) that started on April 18, 2017 identified in this

report VPC O. Reg 79/10, r. 73 (1) 1 and r. 73 (1) 8. (211)

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

Sep 28, 2017(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

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

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

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

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

Issued on this 18 day of July 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JOELLE TAILLEFER - (A1)

Service Area Office /
Bureau régional de services : Ottawa