Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 6, 2015	2015_381592_0008	O-001933-15	Resident Quality Inspection

Licensee/Titulaire de permis

peopleCare Not-For-Profit Inc
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Long-Term Care Home/Foyer de soins de longue durée

THE SALVATION ARMY OTTAWA GRACE MANOR
1156 WELLINGTON STREET OTTAWA ON K1Y 2Z3

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

MELANIE SARRAZIN (592), AMANDA NIXON (148), RUZICA SUBOTIC-HOWELL (548), WENDY PATTERSON (556)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 20, 21, 22, 23, 24, 27, 28, 29, 30 and May 1, 2015

It is noted that Log# O-001977-15, #O-001733-15, #O-001673-15, #O-001695-15, #O-004623-15, #O-005858-15, #O-001752-15 and #O-002015-15 were conducted during and included in this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, a member of Residents' Council, Chair of Family Council, Personal Support Workers (PSW), Dietary Aid, Housekeeping Aide, Registered Practical Nurses (RPN), Registered Nurses (RN), Maintenance Worker, Environmental Service Supervisor, RPN/RAI MDS Coordinator (back-up), Scheduler, Resident Care Coordinator, Assistant Director of Care/Clinical Educator, Director of Care and the Executive Director.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

12 WN(s)
6 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The Licensee failed to ensure that every resident shower has two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall.

On April 20, 2015 Inspector #548 conducted a general tour of the home. It was observed on units Gladstone, Queens, Parkdale and Rosemount that each shower room has a yellow bar anchored at waist height at close proximity to the faucet.

On April 21, 2015 PSW S#123 observed the inspector near the shower room on Queens unit and brought her attention forward by showing her safety concerns with the yellow bar which the staff use as a grab bar and indicated that she felt that it was unstable for resident use. PSW S#123 indicated that there are some residents who stand up, hold the bar and brace themselves against the tile on the opposite side of the bar while showering.

On April 22, 2015, during interviews, PSW's S#103, S#104 and S#115 on these units, all identified the yellow bar to be a grab bar. All three PSW's indicated they seat all residents in a shower chair and discourage residents from holding onto the yellow grab bar while showering due to safety issues.

On April 23, 2015 during an interview the Director of Care (DOC) initially agreed that the yellow bars were the grab bars however, the DOC indicated that she would do a follow-up with the Maintenance department as she was not sure. The DOC indicated that she was not aware that there was a requirement to have two accessible grab bars in each shower room.

On April 23, 2015 during an interview with Maintenance worker S#120, he indicated that there is only one shower that has a one grab bar. S#120 confirmed that the yellow bar in all of the showers is a shower curtain rod and that there are no grab bars in the remaining showers at the home. Inspector #548, S#120 and the DOC observed the shower on Wellington unit. It was observed that there is only one grab bar, silver in color, anchored on the opposite side of the faucet in the shower.

On April 23, 2015 during an interview the DOC, she indicated that she will look into this matter immediately as it was a matter of safety for the residents. S#120 indicated to the inspector that he is looking into when and how to install two grab bars in each of the showers. [s. 14.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident shower is equipped with at least one grab bar located on the same wall as the faucet and at least one grab located on an adjacent wall, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On April 21, 2015, Inspector #592 observed in room #273 a raised toilet seat sitting on top of the toilet seat without any method of being secure. The position of the seat could be easily altered when in use, posing a risk to the safety of the resident.

Upon showing the raised toilet seat to RPN S#113, she told inspector #592 that the raised toilet seat was not maintained in a safe condition and contacted the maintenance department.

On April 21, 2015, Inspector #592 observed in room #332 a raised toilet seat sitting unevenly on the toilet seat and when the raised toilet seat was touched, the position of

the seat was easily altered. Inspector #592 further observed one point of attachment being loose at the front of the raised toilet seat which was not holding the raised toilet seat in place.

Upon showing the raised toilet seat to RPN S#117, she removed the raised toilet seat from the toilet and told inspector #592 that it was not maintained in a safe condition and safe for the residents. RPN S#117 reported it to her co-worker who immediately contacted the maintenance department.

Upon a review of the Resident Health Care Record it was noted that Resident in room #273 was assessed as being transfer on/off the toilet with the extensive assistance of 2 staff members.

Upon a review of the Resident Health Care Record it was noted that Resident in room #332-1 was assessed as being able to transfer on/off the toilet without assistance.

Upon a review of the Resident Health Care Record it was noted that Resident in room #332-2 was assessed as being at high risk for falls and is using the toilet with one person constant supervision due to limited physical assist for his safety.

On April 22, 2015, during an interview with PSW S#109, he told inspector #592 that PSW's are responsible to report any disrepair to the RPN on the unit. He added that the RPN will fill out a form on the computer system to have maintenance staff do the follow-up.

On April 22, 2015, during an interview with RPN S#101, she told inspector #592 that PSW's report to them any disrepair and the RPNs are responsible to fill the maintenance request located in the computer software. She further indicated that the raised toilet seat in room # 273 and room # 332 were not reported by any staff recently other than the LTCH inspector the day before.

On April 22, 2015, during an interview with the Supervisor of Environmental Services (ES), he told inspector #592 that maintenance were doing daily visual checks of each resident bathroom in the building and in addition a weekly program maintenance which was including raised seated seat was in place.
He further indicated that he was not made aware of the unsafe condition of the raised toilet seat in room#273 and 332.
Inspector #592 accompanied by the (ES) to room #273, informed Inspector #592 that it

was not the home’s furnishing equipment but provided by the Resident's family. He further indicated that the raised toilet seat was not in a safe condition and if it was owned by the home he would immediately remove it from the unit.

On April 22, 2015, on a conversation with the Resident’s spouse, he/she indicated that his/her spouse was admitted to the home several years ago and that he/she was using the same raised toilet seat which was provided by the home at that time. The spouse further told inspector #592 that the raised toilet did not belong to the family and that he/she did find that the raised toilet seat was "rocking" and needed to be changed or fixed to ensure his/her spouse safety.

On April 22, 2015, during an interview with the Director of Care and Nursing, she indicated that the home's responsibility is to ensure that the home's furnishing and equipment are being maintained in a safe condition. She further indicated that the home should ensure that the raised toilet seats are fitting properly regardless if it is provided by the home or by the family members. [s. 15. (2) (c)]

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.

The home is equipped with a resident-staff communication and response system, thereafter referred to as the system, which residents activate by pushing the button on the activator located at their bedside.

On April 21, 2015 Inspector #592 tested the system in room #273-1 and found the system was not able to be activated by the push button activator at the bedside. The issue was reported to the maintenance department and was repaired immediately.

On April 23, 2015 Inspector #556 accompanied by the DOC tested the system in room #188, and the system was not able to be activated using the push button activator at the bedside. The DOC reported the issue to the maintenance department and it was repaired immediately. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's raised toilet seat will be maintained in a safe condition and in a good state of repair and that regular monitoring occurs to ensure that the resident-staff communication and response system at each bedside, and in each resident bathroom is functioning, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
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).
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).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
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).
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).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the restraining of a resident by a physical device is

included in the resident's plan of care only if all of the requirements of s.31(2) are satisfied.

Resident #27 was observed on several occasions to be seated in a wheelchair with lap belt, table top and tilt applied. It was confirmed by the writer and staff who are responsible for the resident's care, that the resident is unable to both physically and cognitively release any of the three physical devices.

Inspector #148 spoke with the unit RPN #S124, who indicated that the lap belt is used to maintain the resident from sliding out of the wheelchair and injuring him/herself. RPN #S124 indicated that when the lap belt was initially implemented, time of implementation unknown, the resident could physically release the belt and a pen lock belt was used to inhibit the resident's ability to release the device. At the present time a lap belt with an appropriate release is used, at this time the resident no longer attempts to release the lap belt. RPN #S124 indicated that the table top is to maintain the arms of the resident above his/her waist as the resident is very strong and behaviours include grabbing the flesh of his/her inner thigh causing bruising and injury. RPN #S124 indicated the tilt is applied for comfort and rest periods.

The current physician order for the physical devices is as follows: requires a seat belt, table top and tilt while in his wheelchair for positioning and comfort. Staff observed hourly and reposition q2 hours as per policy.

The plan of care for Resident #27 was reviewed indicating under Positioning related to physical limitations, the use of Personal Assistance Services Devices (PASD) including seatbelt and table top to while in wheelchair for positioning, comfort or to provide assistance with activities of daily living (ADLs).
The hard copy health care record includes a consent which concedes that the seat belt, table top and tilt are applied as a form of physical restraint.

Inspector #148 spoke with the home's RPN/RAI Coordinator (backup) who is familiar with the resident and knowledgeable of the home's programs. She agreed that Resident #27 is unable to remove the physical devices, as described. She indicated that at one time the resident was very active and would attempt to get out of his/her wheelchair but was at risk of falling and injury to self. The belt and table top were put in place to restrict the resident's movement out of the chair and reduce injury. The use of the tilt may be for comfort and positioning. When asked by the Inspector, the RPN/RAI Coordinator (backup)was unable to identify if an assessment of alternatives to restraining were

considered at the time of their implementation or anytime thereafter. In review of the devices, the RPN/RAI Coordinator (backup)agreed that when the resident's wheelchair is tilted, the resident is not at risk for sliding out of the chair. She further agreed that the belt, when applied, maintains the resident's safety, whereby the table top may or may not be required.

The home has not ensured that the restraining of Resident #27, has been included in the plan of care whereby the significant risk to the resident or other person is identified, that alternatives to restraining the resident have been considered, that the method of restraining is reasonable and the least restrictive of such reasonable methods and that the physician has ordered or approved the restraining.

Resident #31 was observed on several occasions to be seated in a wheelchair with lap belt, table top and tilt applied. It was confirmed by the writer and staff who are responsible for the resident's care, that the resident is unable to both physically and cognitively release any of the three physical devices.
Inspector #148 spoke with the unit RPN #S124, who indicated that the lap belt is used to maintain the resident from sliding out of the wheelchair and injuring him/herself. RPN #S124 indicated that the table top, which buckles at the back of the wheelchair, was initially implemented to restrict the resident's access to the lap belt. The RPN was not clear to the table tops current purpose and indicated the tilt is applied for comfort and rest periods.

The current physician order for Resident #31's physical devices is as follows: secure lap belt, table top and tilt when seated in wheelchair for positioning and safety. Staff observed hourly and reposition q2 hours as per policy.
The plan of care for Resident #31 was reviewed indicating under Risk for falls, the use of Personal Assistance Services Devices (PASD) including seatbelt for positioning, comfort or to provide assistance with activities of daily living (ADLs).

A documented consent, which concedes to the use of the seat belt, table top and tilt, could not be provided.

Inspector #148 spoke with the home's RPN/RAI Coordinator (backup), who is familiar with the resident and knowledgeable of the home's programs. She agreed that Resident #31 is unable to remove the physical devices, as described. She indicated that the seat belt was initiated due to a fall risk, as the resident would attempt to leave the chair and falling incurring risk to self. The resident no longer attempts to leave the chair but the belt

assists in maintaining posture so that the resident does not slide out of his/her chair. The RPN/RAI Coordinator (backup)indicated that the description of the table tops initial usage, by RPN #S124, may be correct. Currently, the RPN/RAI Coordinator (backup) believes the table top to be on for comfort and positioning of the resident's arms. She suspects the tilt is in place for comfort and rest periods. When asked by the Inspector, the RPN/RAI Coordinator (backup) was unable to identify if an assessment of alternatives to restraining were considered at the time of their implementation or anytime thereafter. In review of the devices, the RPN/RAI Coordinator (backup) agreed that when the resident's wheelchair is tilted, the resident is not at risk for sliding out of the chair. She further agreed that the belt, when applied, maintains the resident's safety, whereby the table top may or may not be required.

The home has not ensured that the restraining of Resident #31, has been included in the plan of care whereby the significant risk to the resident or other person has been identified, that alternatives to restraining the resident have been considered, that the method of restraining is reasonable and the least restrictive of such reasonable methods.

The Inspector spoke to the home's DOC to review both Resident #27 and Resident #31. The DOC indicated that the home is currently reviewing the minimizing of restraints program. [s. 31. (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 prior to the use of a physical device, under section 31 of the Act, the licensee has identified the significant risk to the resident or another person would suffer serious bodily harm if not restrained, alternative to restraining have been considered, the method of restraining is reasonable and the least restrictive of methods to address the risk identified, an order or approval is in place for the restraining and a consent by the resident or SDM has been obtained giving authority to restraint, to be implemented voluntarily.

WN #4: 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 had his or her personal items labeled within 48 hours of admission and of acquiring, in the case of new items.

During the course of an inspection the following unlabeled personal care items were observed by inspector #556:

In the shared bathroom of room #188 the inspector observed an unlabeled tooth brush and an unlabeled hair brush on the bathroom counter.

In the shared bathroom of room #312 the inspector observed two unlabeled denture cups on the bathroom counter.

In the shared bathroom of room #163 the inspector observed three identical unlabeled white toothbrushes on the bathroom counter.

In the shared bathroom of room #188 the inspector observed an unlabeled toothbrush and an unlabeled hair brush on the bathroom counter.

In the shared bathroom of room #349 the inspector observed an unlabeled toothbrush, and two unlabeled black combs on the bathroom counter.

In the SPA room on the Gladstone Unit the inspector observed 2 unlabeled combs and an unlabeled safety razor.

In an interview PSW #S132 stated that all resident personal items such as hair brushes, combs, toothbrushes, and razors are to be labeled by the PSW's on the unit. PSW #S132 further stated if an unlabeled personal item like a toothbrush or a comb is found in a shared bathroom it is thrown out and replaced.

In an interview the DOC stated that the home has a policy related to the labeling of personal items, and it is the expectation that when the PSW's find unlabeled items they are to label them with a marker. [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 monitoring occurs to ensure that every resident has his or her personal items labeled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that all staff at the home receive training in the home's policy to promote zero tolerance of abuse and neglect of residents, annually.

In accordance with LTCHA 2007, s.76(1), (2)3. And (4) and O. Regulation 79/10, s.218, all staff at the home shall receive training in the long term care home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities and annually thereafter.

Inspector #148 reviewed the training provided to four staff members involved in an alleged incident of abuse and neglect in February 2015 (Critical Incident #2873-000001-15). Of the four staff members, the home could not demonstrate that RPN #S137 and RPN #S138 had received annual training related to the home's abuse policy. RPN #S137 could not recall her last training of the home's abuse policy. RPN #S138 was not available to be interviewed by the Inspector, however, the DOC indicated that RPN #S138 may not have been provided annual training due to extended and frequent periods of leave. [s. 76. (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 receive annual training of the long term care home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #6: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the infection prevention and control program required under subsection 86(1) of the Act is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On April 29, 2015 in an interview the DOC stated that there is an infection prevention and control program (IPC) in the home with an interdisciplinary committee that meets quarterly, however the annual review of the IPC program for 2013 or 2014 was not completed. [s. 229. (2) (d)]

2. The Licensee has failed to ensure the implementation of the infection prevention and control program during the administration of medications to residents.

This home has implemented, as part of their Infection Prevention and Control Program,

the Just Clean Your Hands Program which indicates that hand hygiene is to be performed before and after resident contact.

On April 24, 2015, the DOC indicated that the home's implementation of the program has included the review of the accessibility of hand washing stations and hand sanitizer dispensers on each of the units for all moments of care, including medication administration. The DOC indicated that her expectation was that all registered nursing staff wash or disinfect their hands prior to the preparation of medications and after the administration of medications, that hand hygiene be implemented at "all moments of care".

On April 23, 2015 at 11:20 hours on Queens unit, during medication pass observation, Inspector #548 noted that a hand sanitizer pump was located on the side of the medication cart. It was observed by inspector #548 that Resident #49 was administered a prepared medication with a spoon by RPN #S122. RPN S#122 then prepared 12:00 hours medications for Resident #50 and administered the medication to the resident with a spoon. RPN S#122 proceeded to open up a tube of Voltaren Emugel and place a pea size amount of the medication onto her fingertips and applied the medication to Resident's #51 right elbow. RPN S#122 proceeded to start the preparation of medications for another resident.
RPN S#122 was not observed to perform hand hygiene before and after resident contact.

On April 24, 2015 the DOC indicated that it was the expectation that the registered practical nurse to have washed or disinfected her hands between each administration and to have put gloves on to apply the Voltaren Emugel to Resident #51.

It was observed during the administration of medications, the preparation and administration of medications, that RPN S#122 did not disinfect or wash her hands. It is noted that RPN S#122 continued the practice of not disinfecting or washing of her hands as she prepared and administered medications to other residents on the unit. [s. 229. (4)]

3. The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control Program.

It was noted on a tour of the home that an infection control cart containing personal protective equipment (PPE) was located outside the door of a two specified rooms, however there was no signage indicating what precautions were to be taken when

providing care to the residents residing in the specified rooms.

A review of the health care records for both residents indicated one resident had a diagnosis of extended spectrum betalactamase (ESBL) resistance, and the other resident had a diagnosis of ESBL and vancomycin-resistant enterococci (VRE).

A review of the home's policy #InfC2, entitled Additional Infection Control Precautions, with a revision date of September 2014 stated one of the elements of additional precautions includes the posting of signage outside the room of the resident with the infection.

In an interview RPN #S101 stated that both Residents are on contact precautions and there is supposed to be a sign posted outside the room to make staff aware of what type of precautions to take when providing care to the resident.

In an interview the ADOC stated it is expected that when a resident is diagnosed with an infection a sign with the type of precautions is supposed to be posted on the door outside the room to advise the staff what type of precautions are to be used and what PPE is required.

In an interview the DOC stated that it is the RPN on the unit who is responsible for posting the signage outside the resident's room, and the Charge Nurse is responsible to check and ensure that everything is in place. [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 the implementation of the infection prevention and control program during the preparation and post administration of medications to residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On April 24, 2015, Inspector #592 observed one isolation cart containing protective personal equipment at the entrance of a specified room which was shared by two residents.

During an interview on April 24, 2015 with PSW S#126 and PSW S#130, they both told inspector #592 that the isolation cart was for Resident #047 in bed 1. Both indicated that Resident #047 was in contact precautions for (VRE) and that staff were required to wear gloves and gowns when entering resident's room.

During an interview on April 27, 2015 with RPN S#130, she told inspector #592 that contact precautions were in place for Resident #047 as a result of being diagnosed with Clostridium Difficile (C-DIFF). She further indicated that she would need to confirm the information in the Resident's Health Care Records for clarification as she was unsure.

Upon a revision of the documentation in the written plan of care for Resident #047, Inspector #592 and RPN S#130 were unable to found the documentation for the purpose of the use of the contact precautions for Resident #047.

During an interview on April 27, 2015 with RN S#119, she told inspector #592, that Resident #047 was diagnosed with (VRE) approximately one month ago. She further told inspector #592 that Resident was diagnosed previously with (C-DIFF) several months ago and has been on contact precautions on and off due to poor hygiene practice. She indicated that the diagnosis of (VRE) should have been documented in the written plan of care for Resident #047. In addition she indicated that the documentation in the care plan

is usually triggered in the point of care which will make the staff aware of the planned care for residents but in this case no documentation was done. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there is a written plan of care for Resident #055 that sets out the planned care for the resident.

It was noted during a tour of the home that an infection control cart containing personal protective equipment (PPE) was located outside the door of Resident #055's room although there was no signage indicating what type of precautions were required when providing care to the resident.

A review of Resident #055's health care record indicated a diagnosis of extended spectrum betalactamase (ESBL) resistance with an onset specified date , however the Resident's plan of care did not include the (ESBL) resistance, nor provide any direction to staff as to what care or precautions were required for the resident related to (ESBL) resistance.

In an interview RPN #S101 stated that Resident #055 is on contact precautions due to a wound infected with (ESBL). RPN #S101 further stated that the (ESBL) resistance is supposed to be on the resident's care plan.

In an interview the Assistant Director of Care (ADOC), she stated it was expected that when a resident is diagnosed with an infection the information is added to the Resident's care plan and would include the precautions required when providing care to the resident. [s. 6. (1) (a)]

3. 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.

The Resident #19 was admitted to the home on a specified date in February 2014. The resident has several diagnoses including, unspecified dementia.

On April 22, 2015 during an interview with a family member, the family indicated that the resident had expressed concern that he/she was being retired to bed early in the evening. The family member indicated that Resident #19 is usually put into bed around 20:30 hours and that his/her preference has always been to go to bed after 22:00 hours in the evening. It is noted that the family member is Power of Attorney for the Resident #19.

During record review the current Kardex specifies that the resident's preference is to be placed in bed at 21:00 hours.
On April 24, 2015 during interviews with RPN S#122 and S#125 both indicated that the Resident #19 is put into bed between 19:00- 19:30 hours each evening and that resident watches television until he/she falls asleep around 21:30 hours. Both staff indicated that this is the usual routine for the resident. RPN S#125 indicated that she is not sure what is documented in the care plan regarding the resident's preference on retiring for bed.

On April 24, 2015 PSW S#121 indicated that she knows Resident #19 well and knows his/her bedtime routine. She indicated that the resident is placed in bed between 19:30 hours and 20:00 hours each night. She further added that the resident is asked each evening if he/she would like to go to bed and the resident is agreeable to retire around 19:30 hours. PSW S#121 indicated that the resident is put into bed and then watches television until 22:30-23:00 hours each night. She further indicated that she has access to the resident's plan of care and that she is not aware that the care plan indicated that the resident's preference is to be put to bed at 21:00 hours.

On April 24, 2015 RPN S#122 indicated that the Resident #19 has had a declined in his/her health status and does takes naps throughout the day and she is aware that the resident is being put to bed at around 19:30 hours. RPN S#122 indicated that the resident watches television and goes to sleep after 21:30 hours. She further added that when the resident was newly admitted (February 2014) the care plan met the resident preferences and needs for bedtime routine. RPN S#122 indicated that the resident has had decline in health status, naps more and the resident's bedtime routine has changed. She confirmed that the care plan should have been updated with clear directions to reflect the resident's current needs.

On April 24, 2015 during an interview the DOC indicated that the Kardex provides the necessary information that directs the care to be provided by the PSWs for a resident. The DOC indicated that the expectation is for the care plan to reflect resident needs and preferences and when there are changes the care plan should be updated accordingly. The DOC indicated that all of the staff have access to the care plan and it is expected that staff are aware of the information in the care plan as the care plan provides clear directions to staff and others who provide care to residents.

During record review it is noted the POA attended the annual care conference on a specified day in February 2015. It is noted there is no documentation pertaining to the

change in the resident's bed time routine needs. [s. 6. (1) (c)]

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

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee shall ensure that there is a written policy in place to promote zero tolerance of abuse and neglect and at minimum the policy shall contain an explanation of section 24 to make mandatory reports and set out the consequences for those who abuse or neglect residents.

The policy titled Zero tolerance of Abuse and Neglect, #A11, was identified by the Executive Director to be the policy to promote zero tolerance of abuse and neglect of residents as required by section 20 of the Act.

A review of the policy indicates the following as the explanation of section 24:
"Section 24(1) of the LTCHA requires certain persons, including the home and certain staff members to make immediate reports to the Director where there is a reasonable suspicion that certain incidents occurred or may occur."

The statement related to section 24, within the policy, does not clearly define or explain what "certain incidents" are to be reported. The explanation also limits the intent of section 24, whereby a person with reasonable grounds, shall immediately report to the Director under the Act.

In addition, the policy does not set out the consequences for those who abuse or neglect residents. The policy speaks to staff only and indicates that staff are to fully cooperate with the home's investigation. [s. 20. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1.The licensee did not ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

During the day shift, on a specified date, PSW #S127 observed Resident #54 having difficulty passing a bowel movement, the PSW determined that the resident was in discomfort and unwilling to attend the lunch meal. The PSW approached the unit RPN #S 138 with her concerns related to Resident #54, specifically the PSW indicated to the RPN that the resident required the RPN to assess and provide disimpaction. The PSW reports that the RPN did not approach the resident for assessment and that the RPN indicated that RPNs do not perform disimpaction. The resident continued to be in discomfort and on the third approach from the PSW, the RPN provided the PSW with a suppository for the PSW to provide the resident. The PSW, did not provide the resident with the suppository but rather massaged and couched the resident with effect and the resident was able to pass the bowel movement over the course of 45 minutes. The PSW's report indicates that the RPN did not provide an assessment of the resident needs or provided intervention, as appropriate.

On the same date, PSW #S127 reported the incident to unit RPN #S137 at the beginning

of the evening shift. RPN #S137 reported the incident to the evening supervisor, RN #S140, who then called the DOC at home. The DOC reports that RN #140 shared with her the name of the resident and that care was not provided related to bowel management. The DOC attempted to speak with RPN #S137, but was not successful. The DOC reports that she initially felt the complaint may be malicious and asked that the home's Human Resource Manager follow up on the following day.

The home's documented investigation data, as provided to the Inspector, indicates that the Human Resource Manager, conducted several interviews of staff on the second, third and fourth day following the incident, including an interview with PSW #S127 on the second day. A report from the Territorial Abuse Advisor who conducted further investigative tasks for this incident, indicates the complaint was filed on the first day following the incident. The Director, under the LTCHA, was notified of the incident four days after the incident, as reported via the Critical Incident System by the home's DOC.

Upon discussion with the home's Executive Director and DOC, in addition to what is described above, it was confirmed that the home began their investigation days prior to informing the Director, the conclusion of which determined that RPN #S138 neglected the care of Resident #54. The content of the home's investigation indicates that at minimum, reasonable grounds to suspect neglect were confirmed by the home on the second day after the incident, however the Director was not notified until four days after the incident.

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

Findings/Faits saillants :

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

During observations on Tuesday, April 21, 2015, Inspector #148 observed three female residents, Resident #33, #34 and #36, with long facial hair on chin, neck and/or along the jaw line. The length of facial hair provided indication that grooming of facial hair had not been provided for some time.

On Wednesday April 22, 2015, and Thursday April 23, 2015, Inspector #148 observed Resident #33 and #34 with the same length of facial hair visible. Resident #36 was observed to have had much of her facial hair removed; staff indicated that the resident had a bath that morning and was provided with a trim to facial hair.

The plans of care for all three residents indicates that each resident requires some level of assistance for bathing and grooming, neither of the three plans of care provided direction for the provision of facial hair removal.

Inspector #148 spoke to each resident, Resident #33 and #34 were able to answer questions about their facial hair and both indicated that if offered to them they would have the facial hair removed. `PSW S#114 and S#115 indicated that facial hair for men is routinely maintained during the evening care, whereby facial hair for women is monitored and care provided on bath days. Inspector confirmed that all three residents are scheduled for two bath/showers each week. Resident #33 was scheduled for a bath on Friday and Tuesday on the day shift and Resident #34 was scheduled for a bath on Sunday and Wednesday on the evening shift.

Three female residents were observed with long facial hair indicating that individualized personal care for facial hair was not provided. [s. 32.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a written response is provided to the Residents' Council within 10 days of having received a concern or recommendation from the Residents' Council.

Inspector #148 interviewed the Chair of the Residents' Council to review the function of the Council. The Chair indicated that a written response, to concerns or recommendations made by the Council, is provided at the next council meeting. The Life Enrichment Coordinator, who is the assistant to the Residents' Council, indicated that when a concern or recommendation is identified at the Council meetings, she will use the form titled "Response to Resident Council" to document the concern or recommendation then forward the form to the appropriate manager. The response from the manager will be provided to the Council at the next monthly meeting.

During the Residents' Council meeting held on February 17, 2015, it was identified by the Council that the home's air temperature had been cold. The Response to Resident Council form indicates that the concern was identified on February 17, 2015, and sent to the Environmental Services Manager on March 2, 2015. The ESM provided a written response on March 16, 2015, the same date as the March Residents' Council meeting.

The licensee has not ensured that a written response is provided to the Residents' Councils within 10 days of being advised of concerns or recommendations. [s. 57. (2)]

WN #12: 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. (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).

Findings/Faits saillants :

1. The licensee did not ensure that the use of a physical device to restrain a resident under s.31 of the Act is documented and, without limiting the generality of this, all requirements of s.110(7) of the Regulations.

Resident #27 was observed on several occasions to be seated in a wheelchair with lap belt, table top and tilt applied. It was confirmed by the writer and staff who are responsible for the resident's care that the resident is unable to both physically and cognitively release any of the three physical devices.

Resident #31 was observed on several occasions to be seated in a wheelchair with lap belt, table top and tilt applied. It was confirmed by the writer and staff who are responsible for the resident's care that the resident is unable to both physically and cognitively release any of the three physical devices.

As described by WN #3, related to s. 31(2) of the Act, it was determined that, at

minimum, the lap belts used for Resident #27 and Resident #31 are in place to prevent the risk of the resident(s) sliding out of their wheelchair and sustaining injury and that neither resident are able to release themselves from this physical device. The lap belts, at minimum are used to restraint the identified residents.

When asked by the Inspector, the RPN/RAI Coordinator (backup)could not provide documentation to support that alternatives to restraining were considered and why those alternatives were inappropriate for either Resident #27 or #31.

Documentation maintained by the PSWs, within the Point of Care (POC) of the electronic health care records, were reviewed for the period of April 11 to April 23, 2015. The documentation maintained does not ensure that the time of application and all monitoring, as required by s.110 of the Regulations, is clearly documented.

This is exampled by the documentation of Resident #27, whereby in POC the PSWs are asked to document PASD use of seatbelt, table top and padded ½ bed rails within one follow up question. On April 13, 2015, the documentation indicates that the first time of application of a physical device is at 14:49 hours, there are an additional six checkmarks noted at the same time of day, suggesting a potential 6 hours pass prior to a device being released, with the next application of a physical device at 22:33 hours, there are six additional checkmarks with no indication that a physical device was released after this pass of time. Due to the question set out, that provides the guidance for PSW documentation, it is unclear if one or more physical devices are applied and if any physical devices were released or the resident repositioned during the time of application. It was confirmed that the usual daily routine for Resident #27 is to be up in the dining room for breakfast in his/her wheelchair with lap belt and table top applied. There is no indication that this routine varied on April 13, 2015.

Similar examples for both Resident #27 and #31 were reviewed with both the RPN/RAI Coordinator (backup)and the home's DOC. In discussion with Inspector #148, neither the RPN/RAI Coordinator (backup)and DOC would provide for or demonstrate that current documentation practices meet the requirements of s.110(7), specifically related to the consideration of alternatives, the type of device and time of application, hourly monitoring and all releases of the device and repositioning provided. [s. 110. (7)]

Issued on this 6th day of May, 2015

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

Original report signed by the inspector.