Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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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
Sep 14, 2016	2016_290551_0022	013532-16	Resident Quality Inspection

Licensee/Titulaire de permis

458422 ONTARIO LIMITED
220 EMMA STREET CORNWALL ON K6J 5V8

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

SANDFIELD PLACE
220 EMMA STREET CORNWALL ON K6J 5V8

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

MEGAN MACPHAIL (551), ANGELE ALBERT-RITCHIE (545), MICHELLE JONES (655)

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): August 22, 23, 24, 25, 26 and 29, 2016.

The following logs were inspected concurrently: 005720-14 (hospitalization related to an attempt of self harm), 025425-16 (an allegation of resident neglect), 025506-16 (concerns about the care of a resident) and 022460-16 (concerns about the care of a resident).

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), a Nurse Practitioner, a Restorative Care Worker, an Activation Worker, a Housekeeper, the Housekeeping and Laundry Supervisor, the Registered Dietitian, the Director of Activation, the Director of Care (DOC) and the Administration.

During the course of the inspection, the inspectors(s): interviewed residents and family members, toured resident and non-resident home areas, reviewed health care records, completed resident observations, completed staff interviews, reviewed select policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **17 WN(s)**
- **7 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls when a resident has fallen.

The home's clinically appropriate instrument that is specifically designed for falls is a Falls Incident Report. The Falls Incident Report has several sections including details, injuries, factors, witnesses, actions notes and signatures. The Falls Incident Report prompts the staff member to also complete a Falls Risk Assessment Tool (FRAT) and a Fall Incident Analysis.

Throughout the course of the inspection, resident #007 was observed ambulating in his/her wheel chair with a front closing seat belt applied. A review of the health care record indicates that resident #007 had four (4) falls in a seventeen (17) day period. No injuries were reported.

Following one of resident #007's falls on a specified date, a Falls Incident Report was not completed; only a Fall Incident Analysis was. [s. 49. (2)]

2. On a specified date, resident #013 fell while walking in the hallway and sustained superficial abrasions. A review of the health care record indicated that a Falls Incident Report was not completed; only a Fall Incident Analysis was.

RN #115 stated that a Falls Incident Report is to be completed after each time a resident has fallen, regardless of the outcome to the resident. [s. 49. (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 where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls when a resident has fallen, to be implemented voluntarily.

WN #2: 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:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.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 were kept closed and locked when they are not being supervised by staff.

On August 22, 2016, Inspector #655 observed the door of the janitor closet located on the Ivy Lane resident home area to be closed but unlocked. Inspector #655 entered the janitor closet at that time and observed several cleaning products to be stored on the floor and on shelves in the closet. The products observed at that time included: heavy duty spray and wipe, kling lotion cleanser, spa acrylic cleaner, deep scrub floor finish, liquid drain cleaner, neutral disinfectant, and ultra-low odor stripper.

The same janitor closet door was observed to be closed but unlocked on August 25 and August 29, 2016. There were no staff members observed to be in the immediate area at these times.

During an interview on August 26, 2016, the Administrator indicated that the janitor closets are non-residential areas where chemicals are regularly stored, and that the door should be locked at all times. [s. 9. (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 all doors leading to non-residental areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On August 23, 2016 at 1706 hours, Inspector #545 and #551 observed a medication cart unattended and unlocked in the hallway of the Ivy Lane home area near the dining room while residents were having dinner in that dining room. Staff were busy feeding residents, no registered staff was in view. At 1709 hours, RPN #112 arrived near the medication cart and indicated that she had left to get something in the kitchen and had forgotten to lock the medication cart. She further indicated that while in the kitchen, she was unable to view the medication cart.

Inspector #655 observed a medication cart to be unattended and unlocked on:

August 25, 2016 at 1149 hours in the hallway on Ivy Lane, across from the Courtyard Dining Room;
August 26, 2016 at 1615 hours in the hallway on Ivy Lane outside of room 19; and
August 29, 2016 at 0835 hours in the hallway outside of the Terrace Dining Room.

During an interview on August 25, 2016, RN #104 indicated that the medication cart should be locked at all times, including during medication passes if the nurse is not in the immediate area.

During an interview on August 25, 2016, DOC #114 indicated that it is the expectation that the medication cart remain locked at all times, specifically when the cart is left unattended in the hallway while a staff member who is administering a medication has entered a resident room or dining room.

On August 22, 2016, Inspector #545 observed #001's prescribed cream in a shared washroom. On August 26, 2016, Inspector #655 observed the same prescribed cream in the shared bathroom.

A review of resident #001s medical record showed no indication that this prescribed cream was to be self-administered by resident #001.

During an interview on August 26, 2016, PSW #116 indicated that it is the PSWs who apply the cream for resident #001. PSW #116 explained that this cream does require an order, that it is prescribed, and is considered to be a medication.

During an interview on August 26, 2016, RN #115 also indicated that the cream would be considered a medication and that it is typically stored in the residents' personal bin in their bathroom.

During an Interview on August 29, 2016, the DOC indicated that unless there is an order for self-administration, a cream or ointment that requires a prescription and order should be locked in the medication 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 drugs are stored in an area or medication cart that is secure and locked, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

Findings/Faits saillants :

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

Resident #022 was admitted to the home on a specified date with several complex medical conditions.

In a review of a progress note on a specific date, it was documented that resident #022's spouse informed the RPN on duty that the resident needed his/her mouth assessed. The RPN assessed the resident's mouth and documented that it looked like the resident had a specific condition. The note indicated that the resident's spouse wanted someone to assess and call him/her in the morning with the outcome of the assessment and the treatment plan.

A review of the Communication Book was completed by the Inspector. There was no documentation regarding the resident's need for an assessment of the resident's mouth.

In a review of the physician's orders, a prescription for a specific medication was

received by RN #115 on a specified date.

During an interview with RN #115 on August 26, 2016, she indicated that she was approached by the resident's spouse on a specified date around supper time, and that the spouse informed the RN that he/she had requested, to the RPN on duty on the previous evening, an assessment of the resident's mouth. Resident #022's spouse was told by the RPN on duty that someone would assess in the morning, order a treatment and call with results. RN #115 indicated to the Inspector that the information had not been communicated regarding the need for assessment of resident #022's mouth, therefore treatment was not ordered. The RN further indicated that she contacted the physician and received the order on a specified date, and as the home's pharmacy was closed, the resident's spouse agreed to pick up the prescription at the home's Emergency Pharmacy provider. [Log #: 022460-16] [s. 6. (4) (a)]

2. The licensee has failed to ensure that resident #022's substitute decision maker (SDM) was given an opportunity to participate fully in the development and implementation of the plan of care.

The resident's SDM indicated during an interview that he/she discovered impaired skin on the resident's leg on the evening of a specified date and asked for an assessment and treatment.

In a progress note on a specified date, it was documented that the resident's leg was assessed and a cream was prescribed. There was no documentation regarding communication of the assessment and treatment plan to the resident's SDM.

In a progress note on a specified date, it was documented that the resident's SDM had purchased a medicated cream and had applied it to the resident's leg, and that the spouse was upset when he/she found out that an assessment and treatment had been done and not communicated to him/her. The note further indicated that the registered nurse advised the SDM that he/she should have checked with the registered staff before applying a cream to prevent double application of two different creams.

RPN #108, the home's Wound Champion indicated that it was the responsibility of the RN to contact the resident's family about changes in treatment or medications.

The DOC indicated communication had not been done with the SDM as per the home's expectation. [Log #: 022460-16] [s. 6. (5)]

3. The licensee has failed to ensure that the care set out in the plan of care related to resident #022's skin care was provided as specified in the plan.

In a progress note on a specified date, it was documented that a pressure ulcer was observed on the resident's specified body part and that two specific dressings were applied, one to absorb seepage and one to cover. Two days later, notes indicated that the resident was assessed by the wound care nurse.

During an interview with RPN #108, the home's Wound Champion, she indicated that she was asked to reassess the resident's wound eleven days after its onset and observed that the pressure ulcer had deteriorated. She indicated that the dressing to cover the wound had been applied without the application of the dressing to absorb seepage which had a negative impact on the wound. She further indicated that it was unknown at that time who had changed the dressing, as the dressing change was not due for another twelve days, as it had not been documented in the progress notes or on the dressing itself. She stated that it was the home's practice to initial and date on the actual dressing, and when she changed the dressing this information was not found.

The DOC indicated that care set out in the plan of care related to treatment plan for the pressure ulcer was not provided to resident #022 as specified in the plan. [Log #: 022460-16] [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 staff and others involved in the different aspects of resident #022's care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and compliment each other; to ensure that resident #002's SDM is given the opportunity to participate fully in the development and implementation of the plan of care; and to ensure that the care set out in the plan of care related to the treatment of the resident's impaired skin is provided as specified in the plan, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written hot weather related illness and prevention management plan for the home that meets the needs of residents is developed in accordance with evidence-based practices and is implemented when required to address the adverse effects on residents related to heat.

The home is air conditioned in the following resident areas: the two dining rooms, the sitting room, from the main entry to the fire doors of the corridor to rooms one to twelve, the nurses' station and from the nurses' station to the fire doors of the corridor to rooms eighteen to twenty four. There are four residents rooms in the area of the nurses' station.

The Registered Nurse monitors the heat and humidity in the building in order to determine the humidex, which reflects a perceived temperature, in order for staff to be on heightened alert for symptoms of resident distress. Since July 1, 2016, the humidex was recorded as being thirty (30) degrees Celsius or greater on forty nine (49) occasions. On forty seven (47) of these occasions, the humidex was recorded as being between 30 and thirty three (33) degrees Celsius. The humidex was recorded as being thirty five (35) and thirty seven (37) on one occasion each.

According to the Guidelines for the Prevention and Management of Hot Weather Related Illness in Long-Term Care Homes, humidex levels between 30 and thirty nine (39) degrees Celsius will result in some people feeling uncomfortable and some may begin to present with signs and symptoms of heat related illness.

On July 19, 2012, in a memo to Long-Term Care Home Administrators, the Acting

Director directed long-term care homes to use the most up-dated version of "Guidelines for the Prevention and Management of Hot Weather Related Illness in Long-Term Care Homes (July 2012)", in conjunction with other expert sources of evidence-based practices, as a point of reference in developing or enhancing their own customized hot weather illness prevention and management plans.

According to the Guidelines, understanding and being able to identify the risk factors to LTCH residents is essential to preventing the possible onset of heat related illness and conditions. The Guidelines state that all residents are at risk of heat related illness, and that after completing the risk assessment, it should be determined whether residents are at increased risk during hot weather; or potentially at increased risk during hot weather.

The home's policy titled Prevention of Hot Weather Related Illness (4.1.9) directs Medical/Nursing staff, under Pre-Season Procedures Preparation and Planning, to
1) Complete resident risk assessment for heat related illness.
2) Identify residents who are at a potential or increased risk of heat related illness and communicate
to interdisciplinary team members.
3) Develop heat related interdisciplinary resident care plans.

The health care records of resident #004 and resident #023 were reviewed.

A Heat Risk Assessment was not completed for either of these residents, and the residents are not identified as being at increased risk during hot weather or potentially at risk during hot weather. The plans of care for resident #004 and #023 do not address any risk related to hot weather. [Log #: 025506-16] [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written hot weather related illness prevention and management plan for the home is implemented when required to address the adverse effects on residents related to heat, to be implemented voluntarily.

WN #6: 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 was assessed and his or her bed system was evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices, to minimize the risk to residents.

On August 26, 2016, Inspector #655 observed that a black rail had been added to the bed system of resident #019. During an interview on the same day, resident #019 indicated that he/she brought the black rail from home, and that it was used to transfer in and out of bed.

On August 29, 2016, Inspector #655 observed that the black rail was loose while the head of the bed was slightly elevated, and that the bar was secured to the bed system by only the mattress.

On review of resident's #019 medical records, there was no mention of the black rail in resident #019's plan of care. Inspector #655 was unable to locate any documentation related to a bed system assessment for resident #019.

During an interview on August 29, 2016, the DOC provided Inspector #655 with a policy document titled "Bed Rails" and indicated that this policy applied to the black rail that was added to the bed system of resident #019. In the document titled "Bed rails", it stated that "maintenance and monitoring of the bed, mattress, and accessories such as resident/caregiver assist items should be ongoing".

During an interview on August 29, 2016, the Administrator indicated to Inspector #551 that this resident received a brand new bed system after the Resident Quality Inspection that was conducted in 2015. The Administrator indicated to Inspector #551 that because the bed system was new and had been assessed by the manufacturer as safe, there had been no assessment of resident #019's bed system since it was put in place before the black rail was added to the bed system. [s. 15. (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 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 the risk to residents, to be implemented voluntarily.

WN #7: 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #022 who was exhibiting altered skin

integrity, such as pressure ulcers, was assessed by a registered dietitian who was a member of the staff of the home.

Resident #022 was admitted to the home on a specified date with several complex medical conditions.

According to the most recent RAI-MDS assessment, the resident had an area of skin impairment and was fully dependent on staff for bed mobility and transfers.

RPN #108, the home's Wound Champion indicated that it was the home's practice to refer all resident's with a stage II pressure ulcer to the home's Registered Dietitian (RD), and that it was the responsibility of the registered staff on the unit to make the referral.

In the home's Wound & Skin Care Program, subsection 4.16, revised May 2016, provided by the Director of Care (DOC), it was documented that upon discovering a stage 1 or II pressure ulcer, the interdisciplinary team would refer the resident to the RD for recommendations on supplementation and laboratory investigations. The policy, for a stage III pressure ulcer, indicated to refer the resident to the RD for reassessment of the nutritional plan of care including increased protein intake as tolerated and to arrange for blood work to obtain a pre-albumin level to determine nutritional status and wound healing ability. The DOC indicated that referrals were made by the registered staff by completing a referral note in the home's electronic health record, she further indicated that urgent referrals could be made by email.

In a review of resident #022's progress notes, it was documented that on a specified date, a reddened area was observed on a specific body part. The next day, the Nurse Practitioner assessed the resident's skin and documented that it appeared to be consistent with a healed pressure ulcer and a specific treatment was recommended. Twelve days after the redness was observed, a pressure ulcer, that met the home's criteria for a referral to the RD, was noted. There was no documentation to indicate that a referral to the RD was made.

Nine days later when the pressure ulcer had further deteriorated, the home's wound care nurse asked the RD to assess the resident, and the RD prescribed an oral supplement for a one month period. [Log #: 022460-16] [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that the resident #022 who was dependent on staff for repositioning was repositioned every two hours or more frequently as required

depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

Resident #022 was admitted to the home on a specified date with several complex medical conditions.

According to the most recent RAI-MDS assessment, the resident had an area of skin impairment and was fully dependent on staff for bed mobility and transfers.

In the written plan of care, it was documented that resident #022 was at risk of skin breakdown related to immobility. Staff were directed to assess for proper positioning and teach resident/family/staff proper positioning techniques and to turn and reposition the resident with skin care every two hours.

During observations in the mornings of August 22 and 23, 2016, resident #022 was observed sitting in a standard wheelchair with a pressure relief cushion and a table top on which the resident was resting both arms. After lunch, on both days, the resident was observed lying in bed on his/her side with a pillow along the back of his/her body.

On August 24, 2016, RPN #108, the home's Wound Champion indicated to Inspector #545 that resident #022 required repositioning by staff every two hours due to skin breakdown. She further indicated that the resident was assessed with a pressure ulcer on a specified date, and that in approximately three weeks, the wound had deteriorated and was now at a specified stage.

PSW #100 indicated that the resident was dependent on staff for bed mobility, transfers and repositioning. She indicated that staff got the resident up before breakfast daily, and that he/she was not repositioned until after lunch when the resident went back to bed.

PSW #111 indicated that resident #002 was up in the wheel chair from mid afternoon until he/she was put back to bed in the evening. She indicated that the resident did not require repositioning as he/she did not slide forward in the standard, non-tilt wheelchair. [Log #: 022460-16] [s. 50. (2) (d)]

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 residents who are exhibiting altered skin integrity, such as pressure ulcers, are assessed by a registered dietitian who is a member of the staff of the home; and to ensure that any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to immediately forward any written complaints that were received concerning the care of a resident or the operation of the home to the Director.

During an approximate five month period, the home received thirteen (13) written complaints, in email format, from resident #002's substitute decision maker regarding the care of a resident and the operation of the home.

During an interview with the Director of Care (DOC), she indicated that the written complaints were not forwarded to the Director under the LTCHA as per legislation. [Log #: 022460-16] [s. 22. (1)]

WN #9: 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 had reasonable grounds to suspect that neglect of a resident by the licensee or staff that resulted in harm or risk of harm was immediately reported to the Director.

As per O. Reg 79/10, s, 5. neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident Report (CIR) was submitted to the Director on a specified date under the LTCHA, section 24.

According to the CIR, resident #023's personalized mouth care routine was not followed on a specified date. The CIR states that resident #023's spouse brought this to the attention of RN #118. In an interview with RN #118, who was in charge of the building, she stated that mouth care had not been completed as was the expectation.

Numerous staff were interviewed, and all indicated that staff were expected to follow a personalized mouth care routine daily for resident #023.

The suspected neglect of resident #023 was not reported to the Director immediately; it was not reported until three days later. [Log #: 025425-16] [s. 24. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that where there is no Family Council, the licensee convened semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council.

The Administrator indicated that three times per year, she posted information about families right to establish a Family Council at the entrance of the home. She was unsure of the last time a meeting was convened.

The Activity Coordinator, in the absence of the Assistant to the Residents' Council, indicated that the last time she met with resident's families to discuss their right to establish a Family Council was January 22, 2014. Therefore that has been no semi-annual meetings for two and half years. [s. 59. (7) (b)]

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 67. s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to consult regularly with the Residents' Council, and in any case, at least every three months.

During an interview with the President of the Resident's Council, he indicated that the Administrator did not consult with the Council every three months.

The Activity Coordinator indicated to Inspector #545 that the Administrator had not consulted with the Council in the past year.

The Administrator confirmed that she had not regularly, at least every three months, consulted with the Residents' Council. [s. 67.]

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that a copy of the service accountability agreement entered into between the licensee and a local health integrated network was posted in the home.

On August 22, 2016, the Administrator completed the LTCH Licensee Confirmation Checklist for Admission Processes.

Question 3, c. asking if a copy of the home's service accountability agreement was posted in the home was answered no.

The Administrator stated that this information is not posted in the home in a conspicuous and easily accessible location. [s. 79. (3)]

2. The licensee failed to ensure that the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council, was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements.

During an initial tour of the home on August 22, 2016 the Inspectors were unable to locate the posting of the Residents' Council minutes.

The President of the Residents' Council indicated during an interview with Inspector #545 that the minutes of the June 2016 meeting were typed by the assistant to the Council and posted on the bulletin board by the Dining Room on Ivy Lane. He indicated that there was no meetings in July and August and meetings would resume in September 2016.

RPN #108 indicated that the minutes should be posted on the bulletin board by the Dining Room on Ivy Lane as that was where resident information was usually posted.

The bulletin board was reviewed and the Residents' Council minutes for the June 2016 meeting were not found.

During an interview with the Activity Coordinator, she indicated that the minutes of the Council's meetings had not been posted in the home for many years at the request of a President who was no longer in the home. She further indicated that the current Residents' Council had not been informed of their choice to post or not to post the

minutes of their meetings, that the practice had not been revisited when the current President was elected four years ago. [s. 79. (3) (n)]

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

During interviews with the President of the Residents' Council, and the Activity Coordinator, they indicated that they could not remember if the licensee sought the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

The Administrator indicated that the advice of the Residents' Council had not be sought in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

2. The licensee has failed to make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

In a review of the Residents' Council minutes from September 2015 to June 2016, there was no documentation indicating that the results of the satisfaction survey was made available to the Council.

The Administrator indicated that the survey was delivered to residents and family members in August 2015.

During interviews with the President of the Residents' Council, the Activity Coordinator, and the Administrator, they indicated that the results of the satisfaction survey was not made available to the Council in order to seek the advice of the Council about the survey. [s. 85. (4) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the procedures for addressing incidents of lingering offensive odours were implemented.

Concerns about a urine-like odor and urine on the floor in a specific resident room were brought forward.

On August 24, 2016, Inspector #655 observed discoloration of the floor tiles in a specific shared bathroom. The tiles around the base of the toilet were yellowed.

On August 29, 2016, there was a lingering odor in the room and bathroom of the specific resident room. The floor tile remained discolored around the toilet area in the shared bathroom.

During an interview on August 25, 2016, Housekeeper #101 indicated that there is often a urine-like odor in the specific shared bathroom. Housekeeper #101 showed Inspector #655 a product labelled "Swish Clean and Green Heavy Duty Spray and Wipe". Housekeeper #101 indicated that this was the product that is normally used to clean the bathroom floor tiles in the specific room, and to address odors such as urine.

During an interview on August 24, 2016, the Housekeeping Supervisor indicated that the product to be used where urine has been is called "Aronx 35 bio-enzymatic". The Housekeeping Supervisor indicated that this product is for cleaning the bathrooms and around the toilets, and that it is used to address odours. During an interview on August 25, 2016, the Housekeeping Supervisor indicated that the product called "Swish Clean and Green Heavy Duty Spray and Wipe" is to be used on stubborn stains, but is not to be used to clean areas where urine has been.

On August 25, 2016, the Housekeeping Supervisor was unable to locate the "Aronx 35 bio-enzymatic" cleaner in the janitors closet. On August 25, 2016, Housekeeper #101 indicated that she was not familiar with the product "Aronx 35 bio-enzymatic"; and could not locate it on the housekeeping cart or in the janitors closet. [s. 87. (2) (d)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee has failed to ensure that there were written complaint procedures in place that incorporate the requirements set out in section 101 of O. Reg 79/10 for dealing with complaints as per LTCHA 2007, s. 21.

As per LTCHA 2007, s. 21, every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

The home's Complaint policy titled: Subsection 4.2.10 Complaint - Concern Process, revised: July 2010 was provided to the Inspector by the Director of Care (DOC) upon request for the home's complaints policy.

A review of the Complaints policy demonstrated that the policy did not incorporate the correct requirement set out in section 101 for dealing with complaints.

The complaint procedure did not indicate, as defined by section 22 of the LTCHA, that every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

The home's policy indicated that: The Administrator shall ensure that written complaints are reported to the Ministry of Health and Long Term Care within ten (10) days of receiving the complaint. The Administrator shall submit a copy of the complaint to the MOHLTC with a written report documenting the response the home made to the complaint.

The Director of Care indicated that she was not familiar with the home's Complaint's policy, and would ensure that revisions would include requirement as per legislation. [s. 100.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response was made to the person who made the complaint, indicating:
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief

During an approximate five month period, the home received thirteen (13) written complaints, in email format, from resident #002's substitute decision maker regarding the care of a resident and the operation of the home.

During an interview with the Director of Care (DOC), she indicated that for nine out of thirteen emails written by resident #022's substitute decision maker, a response was not made to the person who made the complaint, indicating what the licensee had done to resolve the complaint, or if the licensee believed the complaint to be unfounded and the reasons for the belief. Log #: 022460-16] [s. 101. (1) 3.]

2. The licensee has failed to ensure that a documented record was kept in the home that included:
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

As noted above, during an approximate five month period, the home received 13 written complaints, in email format, from resident #002's substitute decision maker regarding the care of a resident and the operation of the home

During an interview with the Director of Care (DOC) she indicated that she had received all 13 written complaints from resident #022's substitute decision maker. She indicated that the emails had been printed and kept in a file, however she had not kept a documented record of:
- the type of actions taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- final resolution, if any;
- every date on which any response was provided to the complainant and a description of the response; and
- any response made by the complainant. [Log #: 022460-16] [s. 101. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

2. The system must be ongoing and interdisciplinary.

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Residents' Council.

In a review of the Residents' Council minutes from September 2015 to June 2016, and there was no documentation indicating communication by the licensee about quality improvement initiatives.

The President of the Residents' Council indicated during an interview that there had been no communication about quality improvements.

In an interview with the Administrator, she indicated that she attended the Residents' Council only upon invitation, and that she had not been invited in a long time. She further indicated that she had not communicated to the Residents' Council, quality improvements and utilization review system to accommodations, care, services, programs, and goods provided to the residents. [s. 228. 3.]

Issued on this 14th day of September, 2016

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

Original report signed by the inspector.