Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jul 10, 2015;	2015_225126_0012 (A1)	O-001743-15	Resident Quality Inspection

Licensee/Titulaire de permis

TAMINAGI INC.
05 Loiselle Street CP Box 2132 Embrun ON K0A 1W1

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

SARSFIELD COLONIAL HOME
2861 Colonial Road P.O. Box 130 Sarsfield ON K0A 3E0

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

JESSICA LAPENSEE (133) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date for Compliance Order (CO) #001 has been ammended. The CO was issued as a result of the Resident Quality Inspection ## 2015_225126_0012, Log # O-001743-15, which was conducted in March 2015. The CO was issued pursuant to O. Reg. 79/10, s. 9 (1) 1. iii. which relates to door alarms. The original compliance date for this CO was August 3, 2015. The new compliance date for this CO is September 30, 2015. No other changes have been made.

Issued on this 10 day of July 2015 (A1)

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

Original report signed by the inspector.

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JESSICA LAPENSEE (133) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): March 16, 17, 18, 19, 20, 23, 24, 25, 2015

During this inspection Log# O-1209-14 was completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care/RAI Coordinator, the Environmental Manager, the Food Service Manager, the Dietitian, the Activity Director, several Registered Nurses, several Registered Practical Nurses, several Personal Support Workers, the Administrative Assistant, several residents and several family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

- **11 WN(s)**
- **5 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with 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. (1).
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 stairways and to the outside of the home must be equipped with an audible door alarm as per legislative requirements.

None of the home's resident accessible doors that lead to stairways,including the front door, are alarmed as required.

On March 17, 2015, as Inspector # 126 was arriving to the home and was opening the front door, it was noticed that the front door was locked but not alarmed.

On March 17, 2015, discussion held with the Environmental Manager S#100, indicated that there is no alarm on the door leading to the outside. S#100 indicated that there was an alarm at the front door that was ringing only for residents who were wearing "wanderguard bracelet" and that at this time, the home does not have any bracelet that are functioning. S#100 also indicated that the home will be ordering new "wandergard bracelet " in the future.

On March 27, 2015, telephone discussion with the Administrator, indicated that all the doors leading to the stairway on the resident's units are locked but not alarmed. [s. 9. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (1) in that the licensee did not ensure that the 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.

Resident #04 is diagnosed with bladder disorder and was admitted to the home in the summer of 2014 with an indwelling catheter.

During an interview with Resident #04 on March 25, 2015, Resident # 04 indicated that he/she did not use the toilet for voiding as the catheter was in place for many years. Resident #04 showed the Inspector that a small leg bag was secured in two places on the right leg. The Resident indicated that staff emptied the small bag several times per day.

Upon review of the Resident's RAI-MDS 2.0 assessments since the admission, it was documented that the Resident had no indwelling catheter. In a review of the most

recent Plan of Care, including the KARDEX accessible to the direct care staff, a written plan of care that sets out, planned catheter care for Resident #04; goals the care was intended to achieve; and clear directions to staff and others who provided direct catheter care to the resident, was not found.

The Catheter Care/PSW policy, dated June 11, 2013 was reviewed by the Inspector. On page 1 of 1, it was documented to "assure documentation is done in eNotes and Care Plan.

During interviews with RPN #S115 and RN #S108 on March 25, 2015 they indicated that the Resident had an indwelling catheter in situ, however the written plan of care plan did not indicate as such. Both registered staff stated that the plan of care should provide information that sets out, planned catheter care for Resident #04; goals the care was intended to achieve; and clear directions to staff and others who provided direct catheter care to Resident #04. [s. 6. (1)]

2. The licensee has failed to ensure that the plan of care was reviewed and revised upon the resident's change in care needs due to a decline in health.

Upon review of Resident #08's plan of care on March, 2015 (both hard copy and electronic record), the Inspector observed no updates in the care plan identifying the resident's care needs change for palliative care; oral medications had been discontinued on a specific date in March 2015 and continuous oxygen was prescribed. Progress notes written by the Medical Director on a specific date in October 2014, had indicated that the resident's condition continued to be somewhat precarious, that the resident did not appear to be suffering; he finished by indicating that the resident was on end of life care.

There were numerous progress note entries by the registered staff describing that Resident #08 refused to eat, refused to drink, that as per the POA/SDM, if the resident is sleeping, the resident was not to be woken for meals. As the resident's care needs changed, PSW staff report providing care by repositioning, providing mouth care, with registered staff administering medications to Resident #08 for comfort.

On a specific day in March, 2015, following the interdisciplinary team meeting, palliative measures were discussed and pain medication was ordered by the Medical Director, as well as other palliative comfort measures.

On a specific day in March 2015 during a discussion with the Inspector, the Director

of Nursing and Associate Director of Care both confirmed that Resident #08's plan of care had not been updated to reflect the resident's declining change in health status as of this date, as the palliative measures had just been discussed the day before at the team meeting.

Thus, the existing written care plan does not reflect the resident's change in care needs and does not provide clear directions to staff in regards to end of life comfort measures and palliative care. [s. 6. (1) (c)]

3. The licensee has failed to ensure the responsive behaviour plan of care based on an interdisciplinary assessment of the resident that includes: any potential behavioural triggers and variations in resident functioning at different times of the day was written in the plan of care.

Upon review of Resident #01's health record it was noted that the resident was diagnosed with neurological disease and he/she exhibited verbal abusive behaviour.

During interview with PSW #S102, on March 19, 2015 she indicated that the resident became verbally abusive when staff did not understand what Resident says or when his/her needs were not met immediately; added that Resident also gets mad if staff put on pants for him/her as he/she prefers to wear shorts even in the winter. PSW #S102 stated that the Resident was much calmer when assigned to regular staff. RN #103 indicated that the Resident became impatient when staff did not know how to use the remote control to setup several episodes of a TV program, added that Resident often asked her to set it up in the evening as she is familiar with it.

On specific day in March 2015 PSW #105 indicated that Resident #01 was verbally abusive and got frustrated more in the evening due to fatigue, or when staff did not follow the daily routine.

On specific day in March 2015 during an interview with RN #S108 she indicated that Resident #01's responsive behaviours were worse in the evening, as she felt Resident was sundowning and that it related to the decline in his/her condition. She further stated that the Resident demonstrated racial bias towards certain staff, and could get verbally abusive towards them. RN #S108 indicated that any potential behavioural triggers and variations in Resident #01's functioning at different times of the day were not documented in the resident's plan of care. (545) [s. 6. (1) (c)]

4. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (4) in that

the licensee did not 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
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.

Resident #01 is diagnosed with neurological disease and is wheelchair bound. On March 17, 2015 the Inspector observed extensive bruising to both upper and lower arms, and telfa dressings to both lower arms. When asked cause of altered skin integrity, the Resident indicated the injuries were caused while self-propelling the wheelchair.

In a review of the Skin Care Management - Treatment and Observation Record, it was noted on a specific day in February 2015 that the Resident had "new skin tears to both lower arms from trying to mobilize with wheelchair". Between June and March 2015, multiple skin tears to the Resident's forearms were documented in the progress notes, and treated by cleansing with normal saline and covering with telfa and mefix dressing. In January and February 2015, ointment was prescribed and applied twice daily.

On March 19, 2015 during an interview with RN S#103, she indicated the Resident had eczema to the arms and legs and she believed the tears were caused by the Resident scratching his/her arms.

PSW S#105 indicated on March 20, 2015 that the open lesions and bruises on the Resident's arms were self-inflicted as an attention seeking behaviour, added that the Resident had very sensitive skin.

On March 20, 2014, during interviews with the Physio-Assistant and the Assistant Director of Care (ADOC), they both indicated they were aware that Resident #01 had skin tears to the lower arms and bruising to both lower and upper arms but did not know the cause.

March 20, 2014 the Inspector observed Resident #01 in the wheelchair with a black padded table top in place. In the presence of the Physio Assistant and the ADOC, the Resident demonstrated how his/her upper arms were hitting the back part of the table top and both lower arms were rubbing the sides of the table top each time he/she put the brakes on and off and when he/she self-propelled the wheelchair. They both

indicated that they thought the table top might be too large and possibly be causing injury to the Resident's arms when self-propelling and putting the brakes on and off. The ADOC indicated she was unable to find documentation indicating if the Table Top used by Resident #01 was the one ordered by the Occupational Therapist

During an interview with RN #S108 on March 23, 2015 she indicated that she was aware that the skin tears and bruises on Resident #01's lower and upper arms were caused by the rear fastened table top, added that she had not yet consulted with the Occupational Therapist (OT) to reassess the table top or collaborated with other team members to address the issue. She immediately requested a physician's order for an OT referral.

During an interview with the ADOC on March 25, 2015 she indicated that she had spoken to the Occupational Therapist (OT) who prescribed the Resident's table top one year ago, and he indicated that he had ordered a padded table as a Personal Assistive Service Device (PASD) for positioning. After verifying with their Vendor, the ADOC indicated that the table top the Resident presently used was not the table top prescribed by the OT.

As such, the PSW, the registered staff, the physio assistant, the ADOC and the Occupational Therapist involved in the different aspects of care did not collaborate with each other in the skin care assessment of Resident #01's so that their assessments were integrated, consistent with and complement each other. [s. 6. (4) (a)]

5. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (7) in that the licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During interviews with Resident #01 on March 18, 20, and 23, 2015 the Inspector found communication with the resident difficult to understand due to slurred speech.

Upon review of the Resident's most recent plan of care (January 2015) , it was indicated that staff were to use communication aids; such as an alphabet board, slate, pen, paper or picture board.

PSWs #S105 and #S102 indicated on March 19 and 20, 2015, that they had access to the Resident's Plan of Care. They stated that the Resident was very difficult to understand and they had to be patient when trying to understand requests from

Resident #01 as he/she got frustrated and became angry using abusive language with staff when misunderstood . Both PSWs indicated that no communication aids had been created or implemented, that they had never seen an alphabet board or picture board to assist with communication

During an interview with RN #S108 on March 23, 2015 she indicated that she was able to understand Resident #01 when he/she spoke as she knew him well. She stated that she was not aware of any communication aid ever created to communicate with Resident #01. The Director of care, on the same day indicated that a picture board was placed on the Resident's wall when admitted to the home in February 2014 but that when the television was installed on that wall, the picture board must have been removed. She indicated that the care set out in the plan of care such as using communication aids were not provided to Resident #01 as specified in the plan. [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 1) to ensure there is a written plan of care for Resident # 4 related to indwelling catheter and for Resident # 08 related to end of life care, and that the staff and others involved in the different aspects of care of the resident collaborate with each other and ensure care is provided to Resident #01 as specified in the plan., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The license has failed to ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from.

On March 16, 2015 the dining observation was done in the dining room located in the basement. All residents have their meals in this dining room.

It was observed by Inspector # 126, that the dining room does not have a communication and response system that meet the legislative requirements.

Discussion held with the Assistant Director Of Care (ADOC), indicated that there is no call bell in the dining room and that the staff utilize the telephone to paged for assistance. [s. 17. (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 too ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from., to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

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

On March 17, 2015, Inspector # 126 interviewed the President of the Resident Council who indicated that the licensee does not seek advice of the Resident's Council in developing and carrying out the satisfaction survey.

On March 25, 2015, discussion held with the Administrator and the Activity Director S# 117 who indicated that they did not seek advice of the Residents' Council in developing and carrying out the satisfaction survey of this year. The Administrator indicated they recently conducted a satisfaction survey and the results were going to be share with the Resident's Council at the April 2015 meeting. [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the licensee 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,, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 107 (3) 4 in that the home did not ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident’s health condition.

Upon review of a Critical Incident Report submitted to the Director on a specific day in October 2014, it was noted that Resident #03 was sent to hospital on a specific day in October 2014 with a "noticeable external rotation of the left leg with knee bent and inability to move" after sustaining a fall in the resident's bathroom.

Resident #03 ambulated with the use of 4-wheeled walker, required supervision and set-up help only for transfers, walking in her room, in the corridor and on the unit.

On that specific day in October 2014,it was noted in a progress note that the Resident was heard screaming by staff, was found on the floor in the bathroom. The Resident was complaining of severe pain to the left leg. The Resident was transferred by ambulance to the hospital. It was also noted that the Resident's caregiver contacted the home's staff on that evening to inform that the Resident #03 had a hip fracture and would have surgery on the next day.

During an interview with the Director of Care on March 23, 2015 she indicated that she was aware she did not notify the Director within a one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident’s health condition and for which the resident is taken to a hospital. [s. 107. (3) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition., to be implemented voluntarily.

WN #6: 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 has failed to comply with O.Reg 79/10 s. 110 (7) in that the home did not 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.

2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care

Resident #01 was observed on March 23, 2015 in a wheelchair with a rear fastened table top. The Resident was unable to remove the table top as it was locked at the back of the wheelchair.

Upon review of the Restraint Observation Form it was indicated that Resident #01 had two types of restraints: safety belt and two bed rails for safety. There was no documentation to indicate that a table top with a rear fastened was applied, removed, checked hourly and reassessed for its effectiveness at least every eight hours by a registered staff. In a progress note of a specific date in February 2015, it was noted that a call was made to Shoppers Drug Mart requesting proper size of straps for Resident #01's back fastened Table Top.

During an interview with PSW #S111 on March 23, 2015, she indicated that the table top was fastened at the back of Resident's wheelchair each time he/she was in the wheelchair. PSW #S111 indicated that the Resident required a rear fastened table top to prevent him/her from getting out of the wheelchair, falling and injuring himself/herself. She confirmed that the table top restraint was not monitored hourly and documented on the Restraint Observation Form.

During an interview with RN #S108 on March 23, 2015, she confirmed that staff applied a rear fastened table top each time Resident #01 was in the wheelchair and that it was used as a restraint to prevent falls and ensure safety. She indicated that the Resident's condition was not reassessed and the effectiveness of the restraining evaluated, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

During an interview with the Assistant Director of Care (ADOC) on March 25, 2015 she indicated that she had spoken to the Occupational Therapist (OT) who prescribed the Resident's table top one year ago, and he indicated that he had ordered a padded

table as a Personal Assistive Service Device (PASD). The ADOC indicated that the table top the Resident presently used was not the table top prescribed by the OT and because there were straps, staff applied them daily.

On March 23, 2015 the Director of Care indicated that she was not aware that staff fastened Resident #01's table top at the back of the wheelchair; then added that she was surprised as it was not the home's practice to restrain residents using rear fastened table tops. [s. 110. (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 Resident # 01 table top fastened at the rear under section 31 of the Act is documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply in that the licensee did not ensure that resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act. 2007, c. 8, s. 3 (1).

On March 20, 2015, while reviewing the Emergency Fire Plan it was noted that the home kept three emergency bags at each entrance of the building. In these bags, there was a blue duo tang which include reports with the name, diagnosis and diet of all residents of the home.

Discussion with S#106, indicated that these lists are updated on a quarterly basis and are kept in those bags which are to be used in case of an emergency. Following the discussion, S# 106 removed all the personal health information of the residents out of the duo tang. [s. 3. (1) 11. iv.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's behaviour plan of care is based on an interdisciplinary assessment which includes, but is not limited to: any mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A review of Resident #07's health record and care plan (dated August 2014, with hand dated revisions of Nov 2014 and Jan 2015) related to responsive behaviours indicated the resident had a progressive decline in physical functioning and cognition. Behavioural triggers for responsive behaviors were not identified in the plan of care, nor potential medication effects to observe.

During an interview with Inspector #546, PSW Staff #112 confirmed on March 23, 2015 knowing what triggers Resident #07's had and at what times of her shift. Resident #07 follows Staff #112's approaches and Staff #112 is able to have Resident #07 comply with care, with minimal communication by gently gesturing or persuading. When asked if she shared her information and approaches with others, she reported telling others; the approaches are not documented in Resident #07's plan of care.

Following an admission to hospital for aggressive behaviours and re-evaluation of medications, the resident continued to demonstrate verbal/physical aggression, resistance to treatment and personal care, yelling and wandering related to cognitive impairment. The plan of care was not amended.

Documentation from the end of October 2014 to March 16, 2015 indicated responsive

behaviors such as refusing care, refusing meds, turning on water taps and walking away, refusing to eat, wandering into other residents' rooms, rummaging, being physically aggressive, hitting staff and punching or pinching other residents, smearing feces everywhere in the room and bathroom, breaking objects, yelling, exit seeking.

During an interview with Inspector #546 on March 24, 2015, the ADOC reported that an individualized plan of care was in place for Resident #07 and that there were specific Behavioral Support Ontario(BSO) interventions identified for Resident #07 available for all frontline staff to use. When asked to show the Inspector where these interventions were located as the inspector had not viewed them, the ADOC was unable to locate them in hard copy or electronic copy. The ADOC reported later that Resident #07's plan of care had not been developed post-hospitalization. The ADOC informed the Inspector that the BSO PSW would know all the interventions used with Resident #07 and would be writing the interventions for this resident on March 25, 2014.

During an interview with the Inspector on March 25, 2015, the BSO PSW Staff #114 provided some information about the resident's triggers such as the language barrier and pain, but confirmed that the triggers and interventions recommended by the Royal Ottawa Hospital (ROH) referring nurse and psychiatrist were not documented in the plan of care, adding that the plan of care had not been updated in a long time. Staff #114 confirmed that she would be writing the information down for the ADOC. When asked what was being done about the pain trigger, Staff #114 reported that she thought Resident #07 was receiving an analgesic but that it was not her responsibility.

Thus, the responsive behaviour plan of care is not communicated clearly to all interdisciplinary team members in regards to the patterns, triggers and variations in approaches. [s. 26. (3) 5.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 33 (1) in that the home did not ensure that the resident bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During an interview with Resident #03 on March 17, 2015, indicated that he/she would prefer to get a sponge bath but that the staff "spring" the shower on her/him every week, added that gets really cold and doesn't like it. On March 24, 2015 the Resident indicated to the Inspector that he/she did not want a shower or a bath, that would prefer a sponge bath, and that since the hip surgery does not want to get that area soaked.

Upon review of the Bath List, it was noted that the Resident was scheduled to receive the following on week 1 and week 2:
Week 1:
-Tub bath on Monday at 11:00
-Shower on Thursday at 3:15

Week 2:
-Shower on Monday at 09:00
-Shower on Friday at 10:15

Upon review of the Resident's most recent RAI-MDS 2.0 assessment, it was indicated that the Resident was resistive to care and that the behaviour was not easily altered. The Plan of Care did not include resident's preference related to bathing.

During an interview with PSW #S111 on March 23, 2015 she indicated that Resident #03 did not want to be bathe as the doctor had told him/her not take a tub bath. The PSW stated that a shower was given to the resident very fast as everyone knows

he/she doesn't like it. She added that on the Resident's scheduled bath day, Resident # 03 dresses for breakfast and doesn't tell him/her it is the bath day, to help minimize the anxiety.

On March 24, 2015, PSW #S105 indicated that Resident #03 did not like a shower or a bath. She indicated that since the Resident had the hip surgery last fall, insists that the doctor told him/her the area needed to remain dried. PSW #S105 stated that the Resident becomes anxious if is provided a tub bath, therefore a shower is provided as it can be done faster.

During an interview with the RAI Coordinator on March 24, 2015 she indicated she had completed the RAI-MDS 2.0 assessment in January 2015 and had assessed the Resident as resistive to care, but could not specify to what care. She stated that she was unaware of the Resident's preferred method of choice for bathing, added that the staff had never provided this information to her. [s. 33. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that course by course service was served to the residents at supper time on March 19, 2015.

On March 19, 2015, around 17:03 hours, Inspector # 126 observed 5 residents that were served their main course and desert at the same time.

Discussion with Registered Nurse (RN) S#103, who indicated that it's not usually done and she is not quite sure why it had happened. S#103 indicated that there is no specific reasons why those 5 residents would require their main course and desert at the same time.

Discussion with the Director of Care, indicated residents are supposed to get their meals served one course at a time. At this time, there are no residents in the home that require their main course and desert served at the same time. [s. 73. (1) 8.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information. O. Reg. 79/10, s. 230 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the fire emergency plan is updated at least annually.

On March 20, 2015, Inspector # 126 reviewed the Fire Emergency Plan. It was noted that the plan was not updated since 2011. In the Fire Emergency Plan binder the phone numbers were outdated, the letters of the community agencies/partner facilities and resources that would be involved in responding to the emergency were dated 2009 and 2010.

On March 20, 2015, discussion held with S#106, indicated that she was not aware that the Fire Emergency Plan needed to be reviewed annually.

On March 24, 2015, discussion held with the Administrator, indicated that the Fire Emergency Plan was not updated annually. The Administrator indicated that since that plan was developed, the only change was that the home now has a generator. [s. 230. (6)]

Issued on this 10 day of July 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JESSICA LAPENSEE (133) - (A1)

Inspection No. / No de l'inspection : 2015_225126_0012 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-001743-15 (A1)

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

Report Date(s) / Date(s) du Rapport : Jul 10, 2015;(A1)

Licensee / Titulaire de permis : TAMINAGI INC.
05 Loiselle Street, CP Box 2132, Embrun, ON, K0A-1W1

LTC Home / Foyer de SLD : SARSFIELD COLONIAL HOME
2861 Colonial Road, P.O. Box 130, Sarsfield, ON, K0A-3E0

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : CHANTAL CRISPIN

To TAMINAGI INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

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.

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).

Order / Ordre :

In order to achieve compliance with O. Reg. 79 10, s. 9 (1) 1. iii., the licensee will ensure the following:
a) that all resident accessible doors leading to stairways, and all resident accessible doors that lead to the outside of the home, are equipped with an audible door alarm, and
b) that the door alarms can only be cancelled at the point of activation, which is the door, and
c) that the door alarms be connected to the resident – staff communication and response system (the system), OR
d) that the door alarms be connected to an audio visual enunciator that is connected If the alarms are to the nurses' station nearest to the door and has a manual reset switch at each door.

It must be noted that door alarms cannot self-cancel. A person must have to go to the
door to cancel the alarm.

Until such time that the licensee is in full compliance with O. Reg. 79 10, s. 9 (1) 1. iii,
formalized measures shall be taken to ensure resident safety in light of the lack on alarm
on all applicable doors, which results in an absence of notification to staff if such doors securely after being accessed.

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home must be equipped with an audible door alarm as per legislative requirements.

None of the home's resident accessible doors that lead to stairways,including the front door, are alarmed as required.

On March 17, 2015, as Inspector # 126 was arriving to the home and was opening the front door, it was noticed that the front door was locked but not alarmed.

On March 17, 2015, discussion held with the Environmental Manager S#100, indicated that there is no alarm on the door leading to the outside. S#100 indicated that there was an alarm at the front door that was ringing only for residents who were wearing "wanderguard bracelet" and that at this time, the home does not have any bracelet that are functioning. S#100 also indicated that the home will be ordering new "wandergard bracelet " in the future.

On March 27, 2015, telephone discussion with the Administrator, indicated that all the doors leading to the stairway on the resident's units are locked but not alarmed. (126)

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

Sep 30, 2015(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 10 day of July 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA LAPENSEE - (A1)

Service Area Office /
Bureau régional de services : Ottawa