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

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Inspection de soins 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
Dec 1, 2016	2016_219211_0023	013533-16	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

JOELLE TAILLEFER (211), MEGAN MACPHAIL (551), 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): September 19, 20, 21, 22, 23, 26, 2016.

During this inspection Log # 019670-16 was completed related to allegation of resident's abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Operation Manager, Director of Care, Environmental Manager, Dietitian, Activity Director, RAI Coordinator, Acting Human Resource Officer, Staff Scheduler, Registered Nurses (RN), Registered Practical Nurses (RPN), Behavioral Supports of Ontario (BSO), Personal Support Workers (PSW), residents and family members.

The inspectors also conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures related to Restraints & Abuse, staff work routines and schedules, observed resident rooms, resident common areas, Medication Carts, and the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

15 WN(s)
9 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required under subsection 8 (3) of the Act.

Sarsfield Colonial Home is a 46 bed home.

According to the Staff Scheduler #120, the RN shifts are 0600 -1400 hours (day), 1400-2000 hours (evening) and 2000-0600 hours (night).

According to the Ontario Regulation 79/10, the following are the exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required under subsection 8 (3) of the Act:

s. 45. (1) 1, for the home with a licensed bed capacity of 64 beds or fewer,

i. A registered nurse who works at the home pursuant to a contract or agreement between the nurse and the licensee and who is a member of the regular nursing staff may be used,
ii. In the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met,

A. A registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of

the licensee and a member of the regular nursing staff is available by telephone, or
B. A registered practical nurse who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone.

Ontario Regulation 79/10 section 45 (2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a Registered Nurse from getting to the long-term care home.

According to the Long-Term Care Homes Act, 2007 s. 8 (4), during the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations.

A review of the staffing schedules (from June 18-September 23, 2016) indicated there was no evidence that at least one RN who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home for specific dates, over and above the required DOC coverage hours of 24 hours/week:
June 18, 19, 22, 23, 24 and 28, 2016: for all the shifts from 1400-1800 hours
June 27, 2016: from 1000-1400 hours
July 6, 2016: from 1400-200 hours
July 8, 2016: 1400-1800 hours
July 14, 2016: from 0600-1000 hours
July 31, 2016: from 1400-1800 hours
August 2, 4, 10, 11 and 24, 2016: for all the day shifts from 0600-1400 hours
August 28, 2016: for the day and evening shifts from 0600-2100 hours

The inspector and Staff Scheduler #120 reviewed each of the above dates and it was confirmed there were no unforeseen emergencies.

The DOC stated that in the absence of an RN working in the home she was either working additional hours onsite as an RN or as a DOC supervising the RPN assigned to replace the RN, or made herself available by telephone. From the inspection it was reported that an agency RN worked on the identified shifts for three dates in 2016. There were no emergency reported on these dates.

A compliance order is being issued because as a result of the absence of a Registered

Nurse, who is a regular nursing staff member and familiar with the residents that reside in the long-term care home, potentially poses a risk to resident safety and affects every resident living in the home given the high number of identified absences. [s. 8. (3)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to resident #010 and #011 related to their skin and wound care.

Resident #010 was admitted in the home on an identified date and diagnosed with cognitive impairment and other medical health issues.

The health care record was reviewed specifically related to skin and wound.

Resident #010's current plan of care indicated the following:
• resident has incontinent,
• has incontinence product,
• to check and change the resident's incontinence product every two hours and as needed,
• to provide pericare after each incontinence, and
• to apply protective cream to perineum.

Review of the current resident's written plan of care which was updated on an identified date, however it did not indicate that the resident was at risk for altered skin integrity problems.

Review of resident 010's progress notes for a period of four months identified the following skin issues:

• On an identified date, resident #010 had a pressure sore to a specified area. Barrier cream was applied and the staff were to continue to monitor for further breakdown.
• One month later, resident #010 exhibited redness to the specified area but there were no open lesions at that time. Barrier cream was applied to the skin area to help prevent further breakdown.
• Three months later, a PSW reported to the registered staff that resident #010 had redness to the same area with no skin breakdown and barrier cream had been applied.

It was noted during the review of the resident's health care record that the Skin Check's sheets completed by the PSWs during resident #010's bath indicated that the resident exhibited the reddened area for five specified dates.

An interview on September 22, 2016 with the RN #101 revealed that the resident had a identified stageable ulcer. RN #101 indicated he/she was informed two days ago that the resident's continence product rubs on their skin when it is wet. RN #101 stated in her progress notes on an identified date, that the resident #010 had redness to a specified skin area. The resident's current written care plan does not reflect the resident's skin integrity issue.

An interview on September 22, 2016 with RN #101 indicated that the PSWs have the responsibility to complete a visual head to toe skin assessment on bath days by completing a form titled "Appendix 1: Skin Check" at every bi-weekly bath/shower and to communicate changes to resident's skin integrity to the registered nurses.

An interview on September 22, 2016 with the RN #101 confirmed that the resident's written plan of care does not set out clear directions to staff and others who provide direct care to the resident who have developed periodic alteration in skin integrity over a period of time. [s. 6. (1) (c)]

2. Resident #011's current written plan of care did not indicate that the resident had a

identified stageable wound to a skin area.

Resident #010's altered skin integrity was triggered during the revision of the resident's census record and the most recent of the Minimum Data Set (MDS-MR) on an identified date.

Resident #011 was admitted in the home on an identified date and diagnosed with multiple medical health issues. Resident #011's health care record indicated he/she has a current identified stageable wound to a specified skin area.

Review of resident #011's health care records and progress notes identified the following skin issues:

• On an identified date, the PSW reported that the resident had a identified wound to a specified skin area. The RPN applied a daily unspecified cream to the area.
• One month later, the resident complained of two sores on an identified skin area. There are two identifiable wound areas. The areas have no signs or symptoms of infection present. The areas were cleansed with normal saline and a dressing was applied.
• Two days later, the resident's skin area was altered. The area was cleansed and the prescribed medication was applied. It was noted that the resident had been putting an identified product to the area. We will continue to monitor and have the doctor assess the area for further plan of care.
• The next day, the resident had two wounds on the specified areas. The wound was cleansed with normal saline and dressing was applied.

Review of the Skin Check's sheet for a specified period of 2 months, indicated that the same wound was identified three days before the other health care record documentation..

The quarterly review of the resident's Minimum Data Set (MDS) care needs dated one month after the first sign of altered skin integrity, indicated the resident has a specified stage wound.

The resident's current plan of care identified interventions for toileting, personal care and hygiene which included the monitoring and assessment of any open skin.

An interview on September 21, 2016 with PSW #106 revealed that the resident is continent but has had occasional altered skin integrity areas for the past nine months.

PSW #106 stated that the resident has a current wound to an skin area that started approximately one month ago. PSW #106 stated that barrier cream and a little protective product is applied to the skin area.

An interview on September 21, 2016 with the RN #101 confirmed that the resident's written plan of care did not set out clear direction to staff and others who provide direct care to the resident who has developed a identified stage wound to his/her skin area. The resident's plan of care does not specif that the resident has altered skin condition and what interventions are being provided. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to resident #010 and #011 related to their skin and wound care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas 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.

On September 19, 2016, the Floor 1 Utility Room door was observed to be ajar at 1000

hours with a white cloth lodged between the door and the door latching mechanism. Inspector #655 was able to enter the utility room and observed the following inside an unlocked cabinet: detergent germicide deodorizer, surface cleaner and disinfectant, anti-perspirant spray, and an air wick aerosol spray.

During an interview on September 19, 2016, PSW #123 indicated that the Utility Room door is to be locked at all times. PSW #123 removed the white cloth from the door in order to lock. PSW #123 stated that she thought the cloth was likely put there by another staff member who was having to go in and out of that room because it was a busy time.

During an interview on September 23, the DOC indicated that the Utility Room is a non-residential area due to contents of the room (i.e. storage of chemicals). For this reason, the DOC indicated that the Utility Room door is expected to be locked at all times.

On September 19, 2016, Inspector #655 observed the third floor Activity Department Storage room door to be closed but unlocked. Inspector #655 opened the door and observed a bottle of nail polisher remover sitting on the lower shelf inside the storage room.

The same door was again observed to be closed but unlocked on September 21, 2016 and on September 26, 2016. On both occasions, there was nail polish remover on the lower shelf inside.

During the initial tour and interview with the Environmental Manager #107 on September 19, 2016, he indicated that the Activity Department Storage room door on the third floor is normally closed and locked.

During an interview on September 26, 2016, RPN #122 indicated that the Activity Department Storage room door should be locked at all times; and that it is a non-residential area.

On September 19, 2016, a staff and non-residential bathroom located on second floor next to the nurse station office was observed to be closed but unlocked. Inspector #655 was able to enter the bathroom. The same bathroom door was observed to be closed but unlocked on September 26, 2016.

On September 19, 2016, Inspector #655 was able to enter a staff and non-residential bathroom located on second floor next to the nurse station office. The non-residential

bathroom was observed to be closed but unlocked. Since the area is a non-residential bathroom, it should be locked. The same non-residential bathroom door was observed to be closed but unlocked on September 26, 2016.

During an interview on September 26, 2016, PSW #119 indicated that this room is a staff bathroom and is not intended for resident use.

On September 23, 2016, the staff bathroom on the third floor was observed to be closed but unlocked. Inspector #655 was able to enter the third floor staff bathroom. Since the area is considered a non-residential bathroom, it should be locked.

During an interview on September 23, 2016, the DOC indicated that these bathrooms are intended for staff and visitor use; and are non-residential areas, not intended for resident use. The DOC indicated that most of the staff bathrooms are kept locked at all times; but acknowledged that one of the staff bathrooms does not lock properly at this time. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On September 19, 2016, Inspector #655 observed there to be white stains and dried debris on the seat of the walker belonging to resident #016. On the same day, Inspector #655 also observed stains and a heavy amount of dried debris on the seat belt and arms of the wheelchair belonging to resident #016. Resident #016's walker and wheelchair were still unclean on September 21 and on September 22, 2016. On those days, Inspector #655 observed that there was also dried debris on the frame of resident #016's wheelchair, and on the wheel spokes.

During an interview on September 21, 2016, PSW #102 indicated that resident walkers and wheelchairs are on a cleaning schedule, and should be cleaned at least once a week by night staff. PSW #102 referred to a form titled "HCA/PSW Night Cleaning Schedule". PSW #102 indicated the form identifies when each residents equipment is to be cleaned; and further indicated that staff are required to document that the required cleaning was completed using this form.

In a policy document provided by DOC #100, titled "Night PSW Cleaning schedule", it is indicated that resident wheelchairs and walkers "are to be washed thoroughly once a week".

Upon review of the "HCA/PSW Night Cleaning Schedule" form, Inspector #655 observed initials next to resident #016's walker/wheelchair for the day of September 17, 2016 only. On September 22, 2016, RN #101 indicated that a staff members initials would signify that resident #016's walker and wheelchair had been cleaned; and that where there is no

initial, it would indicate that the equipment has not been cleaned.

The "HCA/PSW Night Cleaning Schedule" form for an identified week in 2016, shows only a line crossed out under resident #016's section titled "walker/wheelchair schedule. The "HCA/PSW Night Cleaning Schedule" form for two identified weeks in 2016, has no signature indicating that resident #016's walker/wheelchair was cleaned.

During an interview on an identified date, resident #016 indicated that his/her wheelchair only gets cleaned occasionally. During an interview on September 22, 2016, PSW #110 acknowledged that the wheelchair belonging to resident #016 was unclean. [s. 15. (2) (a)]

2. On an identified date, resident #002 indicated to Inspector # 551 during an interview, that his/her room and bathroom are unclean.

During a follow-up interview two days later, resident #002 indicated to Inspector #655 that the cleanliness of his/her bathroom is the primary concern. Resident #002 indicated that his/her bathroom is not cleaned every day, and that it does not smell good.

On September 21, 2016, Inspector #655 observed that there were yellow stains on the toilet, around the seat area, and down the base. There was a faint urine-like odour at this time. Inspector #655 observed dried, yellow stains on the toilet in the bathroom of resident #002 on: September 22, September 23, and September 26, 2016. [s. 15. (2) (a)]

3. On Monday, September 19, 2016, Inspector #655 noted a strong offensive, urine-like, odour upon entering resident #017s bathroom. Inspector #655 also observed a dried film on the bathroom tile surface which covered a large area of the floor.

During an interview on September 22, 2016, Housekeeper #108 acknowledged that there is an odour in the bathroom of resident #017 at times.
During the same interview, Housekeeper #108 indicated to Inspector #655 that she is the only official housekeeper on staff; and that she typically works four week days per week plus every other weekend, for a total of ten days in a two week period. She indicated that in her absence, other environmental staff will assist with housekeeping duties.

Inspector #655 reviewed the housekeeping schedule for the period in September 2016 and noted that on an specific day in 2016, there was no housekeeping staff scheduled to work. Housekeeper #108 confirmed that she did not work on that identified day, when the

bathroom of resident #017 was observed to have a strong urine-like odour and unclean floors.

During an interview on September 22, 2016, the Environmental Services Manager acknowledged that there is an issue with odours of urine in the bathroom of resident #017.

During an interview on September 26, 2016, the Environmental Services Manager indicated to Inspector #655 that when housekeeping staff are off on an identified day of the month, he will provide approximately 3 hours of housekeeping services himself. The Environmental Services Manager acknowledged that he does not clean all resident bathrooms on those days. [s. 15. (2) (a)]

4. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

On September 19, 2016, Inspector #211 observed that residents #011, #010 and #013 have loose raised toilet seats in their bathrooms when touched.

On September 21, 2016, observation and interview with PSW #106 revealed that the raised toilet seat on the toilet in the bathroom of resident #010 was tighten, secure and safe.

PSW #106 observed that resident #011's raised toilet seat was loose on the toilet in his/her bathroom. The PSW stated that the raised toilet seat was presently safe and secure on the toilet after she tightened the button in the front of the seat.

PSW #106 observed that the raised toilet seat on the toilet of resident #013's's bathroom was loose when touched. PSW #106 stated that the mechanism to tighten the raised toilet seat on the toilet must be broken since she can't secure the seat on top of the toilet.

An interview with the Environment Manager on September 21, 2016, revealed that the raised toilet seat on the toilet of resident #011 needed to be tightened again since it was still slightly loose. The Environment Manager was able to tighten and secure the raised toilet seat on the toilet of resident #011.

The Environment Manager revealed that he tried to repair resident #013's raised toilet seat but the above equipment need to be replaced. The Environment Manager stated

that he presently think that resident #013's railed toilet was safer since he fixed the seat with a screw. He asked the DOC to order extra raised toilet seat to replace the one in resident #013's bathroom.

The Environment Manager confirmed that the above raised toilet seats were not safe and secure when they are loose or broken. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following:
-that the residents' wheelchair and residents' bathroom are kept clean and sanitary, and
-that the residents' raised toilet seats on the toilet are safe and secure, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

On September 19, 2016, a tour of the home was conducted, and it was noted that there is one dining room on the lower level of the home that serves as the sole dining room for the home. As such, residents eat their meals at a first or second seating and access the dining room by the elevator.

A resident-staff communication and response system (call bell) was not located in the dining room.

The maintenance manager confirmed that there was no call bell in the dining room. He stated that staff would be use the phone located in the back corner of the dining room as a pager if assistance in the dining room was required. [s. 17. (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 the dining room is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining by a physical device is included in the plan of care.

Resident #010 was admitted to the home on an identified date. On two separate occasions in 2016, the resident was observed sitting in his/her wheelchair with a specified seat belt applied.

On an specified day, resident #010, told the inspector that the belt was to prevent him/her from falling.

The resident stated that he/she did not like wearing the belt but was following the rules. Resident #010 was unable to physically or cognitively release the belt.

A review of the progress notes indicated that on the day of the resident's admission to the home, a wheelchair was provided. The progress notes entries on three identified dates, indicated that resident #010 used a seat belt when seated in his/her wheelchair. On two identified dates, the progress notes stated that the resident had removed the belt and transferred himself/herself out of the wheelchair. Several progress note entries indicated that the seat belt was applied to discourage resident #010 from self-

transferring.

It was noted that a PASD/Restraint Monitoring form was initiated on a specified date in 2016. No record of PASD/Restraint Monitoring was found from an identified month in 2015 to an identified month in 2016. The most recent coding of the Minimum Data Set (MDS) assessment indicated that resident #010 did not use a trunk restraint, a limb restraint or a chair that prevents rising.

On September 22, 2016, the DOC stated to Inspector #551 that the resident wore the specific belt to deter him/her from self-transferring and that the seat belt acted to restrain the resident as he/she could not release it.
The home's policy titled Restraint Reduction Program, last reviewed August 31, 2016, states that if a restraint is being considered, the RN will initiate an "Initial Restraint Assessment". The resident's health care record was reviewed, and an assessment for the initiation of a restraint was not found. Under step three: restraint application, the form directs the RN to update the care plan.

The written plan of care was reviewed, and there is no indication that #010 wears the specific seat belt. [s. 31. (1)]

2. The licensee has failed to ensure that the restraint plan of care included an order by the physician or the RN in the extended class.

Resident #010 was admitted to the home in an identified year. On two specified days in 2016, the resident was observed sitting in his/her wheelchair with a front closing seat belt applied.

On a specified day in 2016, resident #010, told the inspector that the belt was to prevent him/her from falling.

The resident stated that he/she did not like wearing the belt but was following the rules. Resident #010 was unable to physically or cognitively release the belt.

The resident's health care record from the time of admission was reviewed, and no order from a physician or RN in the extended class was found.

The DOC stated that the resident wore the front closing belt to deter him/her from self-transferring and that the seat belt acted to restrain the resident as he/she could not

release it. The DOC stated that there should be an order for the use of the seat belt.

The home's policy titled Restraint Reduction Program, last reviewed August 31, 2016, states that if a restraint is being considered, the RN will initiate an "Initial Restraint Assessment". The resident's health care record was reviewed, and an assessment for the initiation of a restraint was not found. Under step three: restraint application, the form directs the RN to obtain a doctor's order indicating the type, reason and duration for the restraint. [s. 31. (2) 4.]

3. The licensee has failed to ensure that the restraint plan of care included the consent of the resident's SDM.

Resident #010 was admitted to the home in an identified year. According to his/her health care record, the resident has a SDM.

On two identified days in 2016, the resident was observed sitting in his/her wheelchair with a specific seat belt applied.

On a specified day in 2016, resident #010, told the inspector that the belt was to prevent him/her from falling.

The resident stated that he/she did not like wearing the belt but was following the rules. Resident #010 was unable to physically or cognitively release the belt.

The DOC stated that the resident wore the specific belt to deter him/her from self-transferring and that the seat belt acted to restrain the resident as he/she could not release it. The DOC stated that there should be consent from the SDM for the use of the seat belt.

The home's policy titled Restraint Reduction Program, last reviewed August 31, 2016, states that if a restraint is being considered, the RN will initiate an "Initial Restraint Assessment". The resident's health care record was reviewed, and an assessment for the initiation of a restraint was not found. Under step three: restraint application, the form directs the RN to obtain consent or refusal for the application of the restraint from the resident's SDM.

The resident's health care record was reviewed, and there is no consent from the resident's SDM the use of a seat belt. [s. 31. (2) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the restraining by a physical device is included in the plan of care, that the restraint plan of care included an order by the physician or the RN in the extended class and to ensure that the restraint plan of care included the consent of the resident's SDM, 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

Resident #010's pressure ulcer was triggered during the revision of the resident's census

record on an identified day in 2016.

Resident #010 was admitted in the home on an identified date and diagnosed with cognitive impairment and other medical health issues.

Review of resident #010's progress notes for a period of four months identified the following skin issues:
• On an identified date, resident #010 has a pressure sore to an identified skin area. Barrier cream was applied to the area and the staff is to continue to monitor for further breakdown.
• three months later, a PSW reported to the registered staff that resident #010 had redness to an identified area with no skin breakdown and barrier cream has been applied.
• One month later, resident #010 had redness to the identified skin area but there were no open lesions at that time. Barrier cream was applied to the skin area to help prevent further breakdown.

It was noted during the review of the resident’s health care record that the Skin Check’s sheets completed by the PSWs during resident #010’s bath indicated that the resident had reddened areas to the unspecified skin area for five specified dates.

An interview on September 22, 2016 with RN #101 revealed that the resident has altered skin integrity redness areas identified at a certain stage and he/she was informed two days ago through the report that the resident’s continence product rubs on the skin when it is wet. RN #101 stated in her progress notes on an identified date in 2016, that the resident #010 has redness to an identified area and the resident did not received 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.

Interview on September 22, 2016 with RN #101 indicated that the PSWs have the responsibility to complete a visual head to toe skin assessment on bath days by completing a form titled "Appendix 1: Skin Check" at every bi-weekly bath/shower and to communicate changes to resident’s skin integrity to the registered nurses. The RN #101 stated the home has a new hard updated copy of the Skin and Wound Care Program implemented in 2016, but the new clinically appropriate assessment instrument that is specifically designed for skin and wound assessment in hard copy form version “Titled “Appendix B: Pressure Ulcer/Wound Assessment Record was not used for resident #010.

The DOC confirmed that a new updated hard copy version for Skin and Wound Care Program was implemented in 2016. The nurses did not use the clinically appropriate assessment instrument that is specifically designed for skin and wound assessment for residents #010. [s. 50. (2) (b) (i)]

2. Resident #011 was admitted in the home on an identified date, and diagnosed with multiple medical health issues.

Review of the resident's progress notes on the following days related to his/her skin indicated:
• On an identified date in 2016, the PSW reported that the resident has an identified wound to a skin area. The resident's daily cream applied to area by RPN.
• One month later, the resident complained of two sores on the identified skin areas. There are two specified wound areas. The open areas have no signs or symptoms of infection present. The areas were cleansed with normal saline and a dressing was applied.
• Two days later, the resident's skin area is red and irritated. The area was cleansed and the prescribed medication was applied. It was noted that the resident had been applying his/her own product to the area. We will continue to monitor and have the doctor assess the area for further plan of care.
• the next day, the resident has two specified wound areas to the identified area. The wound was cleansed with normal saline and dressing was applied.

Review of the resident's sheets titled "Appendix 1: Skin Check" which are completed by the PSWs for three identified months in 2016, indicated that one of the identified months in 2016, the resident's skin developed specified wound areas to the identified area. Interview with PSW #106 on September 21, 2016, revealed that the resident has a current specified wound to the identified skin area that started on an identified month in 2016.

Interview with RN #101 on September 21, 2016, revealed that the resident has a identified stage wound to the identified area.

The RN #101 stated the home has a new hard updated copy of the Skin and Wound Care Program implemented in 2016, but the new clinically appropriate assessment instrument that is specifically designed for skin and wound assessment in hard copy form version "Titled "Appendix B: Pressure Ulcer/Wound Assessment Record was not used for

resident #011.

The DOC confirmed that a new updated hard copy version for Skin and Wound Care Program was implemented in 2016. The nurses did not use the clinically appropriate assessment instrument that is specifically designed for skin and wound assessment for residents #011. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietician who is a member of the staff of the home.

The resident #011's progress notes on an identified date in 2016, indicated that the resident had a identified wound to a specified skin area.

The quarterly review of the resident's Minimum Data Set (MDS) care needs dated on a specified month in 2016, indicated the resident has a identified stage wound.

An interview with RN #106 on September 21, 2016, revealed that the resident was not referred to the registered dietician (RD) when the resident developed the identified Stage wound to the specified skin area for the two identified months in 2016.

The home's policy and procedure titled "Skin and Wound Care Program" indicated the registered staff is to complete two hard copy forms; "Appendix F: Pressure Ulcer Tracking Form" and "Appendix G: Weekly Assessment of wound/Dietician". Once the above forms completed, the registered staff are to send the forms to the Registered Dietician (RD) for review.

The above home's policy and procedure indicated that the registered dietician will follow these instructions:
1. Complete nutritional and hydration risk assessment within 7 days of receiving Appendix F and G from the registered staff.
2. Recommend/order appropriate diet, supplements and hydration strategies
3. Make recommendations to physician including: albumin, blood monitoring, and vitamins/minerals.
4. Do weekly assessment of wound healing, using the Appendix G completed by the registered staff on weekly assessment.

An interview with the RD on September 22, 2016, revealed she was not aware of the

new hard copy titled "Skin and Wound Care Program: Policies and procedure implemented in 2016. The RD stated she did not receive the Appendix F and G from the registered staff as indicated in the new skin and wound care program. The RD also revealed that she was not aware of resident #011's identified Stage wound on the skin area and she did not complete an assessment for this resident. [s. 50. (2) (b) (iii)]

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 #010 and #011 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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, and
to ensure that resident #011 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietician who is a member of the staff of the home, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #014 was assessed and actions were taken when the resident experienced weight changes of: 5 percent (%), or more, over one (1) month; 7.5%, or more, over three (3) months; 10%, or more, over 6 months.

Resident #014 was admitted to the home on a identified date. His/her diagnosis includes a history of cognitive impairment and other health care issues.

Resident #014 was fed with an identified feeding procedure. In an identified date, he/she began to consume nutritional supplement orally. One month later on two identified months, his/her feeding procedure was decreased, and the oral intake of the supplement was increased. On an identified month, the supplement was decreased from a specified amount per hour for identified hours twice daily to a lower amount per hour for an identified hours twice daily, and the oral intake of the supplement was increased from two different amounts at two different times.

On an identified month in 2016, a different nutritional supplement, was ordered to be consumed orally at specific times per day with two different amounts, and he/she continued to receive 250ml water via the identified feeding procedure twice daily. A referral was sent for the resident to be assessed by a Speech and Language Pathologist in an identified year. In the assessment on an identified day in 2016, the RD noted that the resident consumed an identified texture of solids orally and chose to only eat one meal per day, and required encouragement to do so.

Resident #014's weight on a identified month in 2016 was identified at a certain kg as per the coding of section K of the Minimum Data Set (MDS) assessment completed for the Assessment Reference Date (ARD) of the identified month.

Following the implementation of resident #014 consuming all of the supplement orally, instead of some enterally on the identified month in 2016, his/her weight declined from 5.2kg between two identified months, a loss of 7% in 1 month. This also represented a loss of 9.4% in 3 months.

A review of his health care record indicates that resident #014's identified month in 2016 weight and corresponding weight changes (a loss of 7% in 1 month between two identified months and 9.4% in 3 months) were not assessed and actions were not taken by any staff member.

On an identified date in 2016, the RD charted that resident #014's weight was stable between two identified months. The weight loss between the two previous months were not assessed.

The following month in 2016, the RD charted resident #014 had lost 2.1kg in 1 month. At this time, resident #014's weight was at a specified kg and represented a loss of 11.1% in a 6 month period. A review of his health care record indicates that resident #014's significant weight loss over a 6 month period was not assessed and that actions were not taken. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. The licensee has failed to ensure that actions were taken in response to a weight change of: 5%, or more, over one month; 7.5%, or more, over three months.

Resident #017 was admitted to the home in 2016. His diagnosis include cognitive impairment and another health issue.

Between a period of two months, resident #017's weight declined 6.8%. The resident experienced another weight loss of 6.8% between the following two months.

The resident's initial weight loss between the two identified months was not assessed until the following month by which time he/she had lost 13.9% between his/her admission to the next 3 month period.

On that last month period, resident #017's weight was assessed by the RD. No actions were taken to address the weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 residents #014 was assessed and actions were taken when the resident experienced weight changes of: 5 percent (%), or more, over one (1) month; 7.5%, or more, over three (3) months; 10%, or more, over 6 months, and
to ensure that actions were taken in response to resident #017's weight change of: 5%, or more, over one month; 7.5%, or more, over three months, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure where drugs are stored should be kept locked at all times, when not in use.

On September 19, 2016, Inspector #655 observed a medication cart to be unlocked and unattended outside an identified resident's room at 1018 hours. Inspector #655 was able to open the medication cart drawer at that time and observed several medications including diphenhydramine, acetaminophen, and potassium chloride inside. The medication cart remained unlocked and unattended for six minutes. There were no staff members or residents in the area during the time of this observation. At 1024 hours, RN #101 was observed locking the medication cart only after Inspector #655 informed the RN that it was unlocked. Interview with RN # 101 on September 19, 2016, acknowledged that the medication cart should have been locked.

On September 26, 2016, Inspector #655 observed RPN #122 leave a medication cart unlocked and unattended several times during a medication pass. The medication cart was observed to be unlocked and unattended at 1216 hours, 1220 hours, 1249 hours, and 1300 hours while RPN #122 had walked down the second floor hallway in the direction of the resident lounge. There was a resident seated on a wheelchair beside the unlocked medication cart on that day at 1216 hours.

During an Interview on September 26, 2016, RPN # 122 acknowledged that the medication cart should be locked at all times and the reason was not mentioned.
The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use. [s. 130. 1.]

2. The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On September 22, 2016, Inspector #551 observed Environmental Manager #107 unlocking and accessing the medication room on Floor 2.

During an interview on September 22, 2016, RPN #105 indicated that there is only one medication room, and that it is located on Floor 2. RPN #105 indicated that the following individuals have access to the medication room: the nurse on duty, Director of Care (DOC) #100, Environmental Manager #107, and Acting Human Resources Officer #120.

During an interview on September 23, 2016, Environmental Manager #107 indicated that he has a key for every room in the home, including the medication room.

During an interview on September 23, 2016, RN #101 indicated that there is a spare medication room key which the Acting Human Resources Officer #120 uses to access the medication room as needed.

During an interview on September 23, 2016, DOC #100 indicated that access to the medication room had been restricted following a previous inspection. However, DOC #100 indicated that the Environmental Manager #107 and Acting Human Resources Officer #120 still have access to the medication room. Environmental Manager #107 and Acting Human Resources Officer #120 do not dispense, prescribe, or administer drugs in the home.

The licensee has failed to ensure that access to the medication room is restricted to persons who may dispense, prescribe, or administer drugs in the home. [s. 130. 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 where drugs are stored should be kept locked at all times, when not in use, and to ensure where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure for the purpose of paragraph 6 of subsection 76 (7) of the Act, that all staff who provide direct care to resident received the skin and wound care training, annually.

Review of the training sheet titled "Basic Skin Care/Wound Prevention" dated September 15, 2015, indicated that five out of thirty-eight staff who provide direct care to the residents received the above training.

Interview with RN #106 on September 21, 2016, stated the DOC started a new skin and wound program in June 2016, but the hard copy forms titled Appendix B, F, and G were not used for resident #010 and #011.

An interview with the Registered Dietician on September 22, 2016, stated that she did not know that there was a new Skin and Wound Program and nor did she receive the training.

An interview with the DOC revealed that all the registered staff received the new hard copy version of the Skin and Wound Program. The DOC stated that the registered staff were informed to sign the form to certified that they read and understand the content of the new Skin and Wound Program for 2016. However, the DOC stated she still did not receive all the certified sheets signed by the registered staff for 2016.

An interview with the Acting Human Resource Officer confirmed that 13 per cent of all staff who provide direct care to residents received the skin and wound care training in 2015. [s. 221. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure for the purpose of paragraph 6 of subsection 76 (7) of the Act, that all nurse received the skin and wound care training, annually, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Minutes from the Residents' Council meetings were reviewed, and it was noted that concerns or recommendations were brought forward, including the following:

January 2016:
- Residents requested specific menu items at lunch/supper meals
- Residents concerned about co-residents wandering into other residents' room and residents calling out at night

February 2016:
- Same concerns expressed at the January 2016 meeting

April 2016:
- Residents who eat at the second sitting were finding it too long in between meals
- Concerns about changes to the PSW routines

May 2016:
- Same concerns expressed as at the April 2016 meeting

July 2016:
- Resident s requested specific brunch menu items

August 2016:
- Same concerns expressed as at the July 2016 meeting

On September 23, 2016, the Activity Director and Assistant to the Residents' Council stated that following the Residents' Council meeting, she informs head of the relevant department of any concerns or recommendations brought forward by the Residents' Council. She stated that next to the recommendation or concern on the meeting minutes, there is blank column for the relevant staff member to provide a written response to the concern or recommendation to the Residents' Council. She stated that she has not received a written response in quite some time. If the written response is received, it is shared at the next Residents' Council meeting. No written responses to the above concerns were found in the Resident's Council binder managed by the Assistant to the Council. [s. 57. (2)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 Family Council, at least every three months after recruitment occurred in December 2015.

Review of the Family Council binder and an interview with the Activity Director confirmed that the last Family Council meeting occurred on August 26, 2015.

An interview with a member of the Family Council on September 23, 2016, revealed that the licensee never consulted with the Family Council since the new recruitment of family members in December 2015.

An interview with the Activity Director on September 23, 2016, revealed that the home has four Family Council members. The Activity Director stated that the home was able to recruit extra members during Christmas time in 2015; however no Family Council meeting was set up.

An interview with the Administrator on September 23, 2016, revealed that the licensee had not had a family council meeting since August 26, 2015 and has not consulted the existing family council's members regularly, at least every three months. [s. 67.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 copies of inspection reports from the past two years for the long-term care home were posted in the home, in a conspicuous and easily accessible location.

On September 19, 2016 a tour of the home was conducted, and it was noted that inspection reports from 2015 were in a black plastic slot attached to the wall. No 2016 inspection reports were found.

On September 23, 2016, it was noted that inspection reports had been moved and were posted on a cork board in a plastic sleeve. Four inspection reports were posted (2016_346133_0014, 2016_284545_0005, 2016_346133_0001 and 2015_346133_0045).

A review of the home's compliance history shows that in the past two years, the home was inspected on twelve occasions. Seven of the twelve inspection reports were not posted.

On September 23, 2016, the Administrator told Inspector #211 that she was under the impression that the reports were posted as per the legislative requirement. [s. 79. (3) (k)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

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 did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

The Administrator stated that it was the responsibility of the Assistant to the Residents’ Council to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results, and was under the impression that she had.

According to the Activity Director and Assistant to the Residents’ Council, the 2015 satisfaction survey was sent out in January 2015. The Assistant stated that she was not aware of the legislative provision to seek the advice of Residents’ Council in developing and carrying out the satisfaction survey, and in acting on its results, and had not done so. [s. 85. (3)]

2. The licensee did not make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

The Administrator stated that it was the responsibility of the Assistant to the Residents’ Council to present the compiled results of the satisfaction survey to the Residents' Council, and was under the impression that this had been done around May 2015.

The Assistant stated that she did not make available the results of the 2015 satisfaction survey to the Residents' Council.

The Residents' Council meeting minutes for 2015 were reviewed, and there is no indication that the results were made available to the council. [s. 85. (4) (a)]

WN #15: 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 did not 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.

The Assistant to the Residents' Council stated that improvements made through the quality improvement program are not shared with the Residents' Council. She stated that if they were, it would be documented in the meeting minutes. The meeting minutes for 2016 were reviewed, and there is no indication that quality improvements were communicated. [s. 228. 3.]

Issued on this 4th day of January, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOELLE TAILLEFER (211), MEGAN MACPHAIL (551), MICHELLE JONES (655)
Inspection No. / No de l'inspection :	2016_219211_0023
Log No. / Registre no:	013533-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 1, 2016
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
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:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

This plan shall include all recruiting and retention strategies and the home's staffing plan to address the backup coverage for managing absenteeism for Registered Nurses.

This plan must be submitted in writing by December 9, 2017 to:
Megan MacPhail LTCH Inspector by fax :613-569-9670.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required under subsection 8 (3) of the Act.

Sarsfield Colonial Home is a 46 bed home.

According to the Staff Scheduler #120, the RN shifts are 0600 -1400 hours (day), 1400-2000 hours (evening) and 2000-0600 hours (night).

According to the Ontario Regulation 79/10, the following are the exceptions to

the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required under subsection 8 (3) of the Act:

s. 45. (1) 1, for the home with a licensed bed capacity of 64 beds or fewer,

i. A registered nurse who works at the home pursuant to a contract or agreement between the nurse and the licensee and who is a member of the regular nursing staff may be used,
ii. In the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met,

A. A registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, or
B. A registered practical nurse who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone.

Ontario Regulation 79/10 section 45 (2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a Registered Nurse from getting to the long-term care home.

According to the Long-Term Care Homes Act, 2007 s. 8 (4), during the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations.

A review of the staffing schedules (from June 18-September 23, 2016) indicated there was no evidence that at least one RN who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home for specific dates, over and above the required DOC coverage hours of 24 hours/week:

June 18, 19, 22, 23, 24 and 28, 2016: for all the shifts from 1400-1800 hours
June 27, 2016: from 1000-1400 hours
July 6, 2016: from 1400-200 hours
July 8, 2016: 1400-1800 hours
July 14, 2016: from 0600-1000 hours
July 31, 2016: from 1400-1800 hours
August 2, 4, 10, 11 and 24, 2016: for all the day shifts from 0600-1400 hours
August 28, 2016: for the day and evening shifts from 0600-2100 hours

The inspector and Staff Scheduler #120 reviewed each of the above dates and it was confirmed there were no unforeseen emergencies.

The DOC stated that in the absence of an RN working in the home she was either working additional hours onsite as an RN or as a DOC supervising the RPN assigned to replace the RN, or made herself available by telephone. From the inspection it was reported that an agency RN worked on the identified shifts for three dates in 2016. There were no emergency reported on these dates.

A compliance order is being issued because as a result of the absence of a Registered Nurse, who is a regular nursing staff member and familiar with the residents that reside in the long-term care home, potentially poses a risk to resident safety and affects every resident living in the home given the high number of identified absences. [s. 8. (3)] (551)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 24, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 1st day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joelle Taillefer

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