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
Jun 23, 2017	2017_619550_0015	007616-17	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

JOANNE HENRIE (550), LINDA HARKINS (126), LISA KLUKE (547)

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): May 15, 16, 17, 18, 19, 23, 24, 25, 26, 29, 30, 31, June 1, 2017.

This inspection included a follow-up inspection to a compliance order related to 24 hour nursing care under log #000291-17 and a compliance order related to resident-staff communication and response system under log #005519-17.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, General Manager, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Dietician, Food Service Supervisor (FSS)/RAI Coordinator, the Activity Director, the Activity Assistant, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), a Cook, the president of the family council, the Human Resources person, several family members and several residents.

In addition, the inspectors reviewed resident health care records, policies related to medication administration, continence assessment, infection control, staffing, maintenance and resident council minutes. Inspectors observed resident care and services, staff and resident interaction, and meal services.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
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.

- **22 WN(s)**
- **14 VPC(s)**
- **4 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 there was at least one Registered Nurse (RN)

who is an employee of the licensee and a member of the regular nursing staff, on duty and present in the home at all times.

This inspection was a follow-up inspection for compliance order #001 that was issued to the home on December 1, 2016, under inspection #2016_219211_0023 with a compliance date of February 24, 2017.

Inspector #550 reviewed the registered nursing staff schedules for the period of February 25 to May 28, 2017 and noted the following:
-March 27, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours,
-March 28, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours,
-April 15, 2017 there was not an RN scheduled for five of the eight hour day shift; from 0600 to 1100 hours and for the full evening shift; from 1400 to 2200 hours,
-April 16, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours,
-April 20, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours,
-April 21, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours,
-May 9, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours,
-May 18, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours,
-May 20: there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours and,
-May 21, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours.

Ontario Regulation 79/10 section 31. (3) (d) requires the licensee to have a written staffing plan that includes a back-up plan for nursing and personal care staffing that addresses situation when staff, including the staff who must provide the nursing coverage required under subsection 8. (3) of the Act, cannot come to work.

As per Ontario Regulation 79/10, section 45 (1) 1 indicates for homes 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 me 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 nurse and 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.

Sarsfield Colonial home is a 46 bed long-term care facility located in a rural community.

During an interview with the Human Resource person staff #113 on May 30th, 2017, she indicated that for all the above ten shifts there was not a registered nurse available to cover those shifts and that these ten shifts were not shifts that would be covered under an ''emergency situation''. She told the inspector that when a Registered Nurse (RN) calls sick, they will call their roster of available RNs by seniority. If this fails, they will offer overtime to the RN on-site and as a last resort, they will offer the shift to a RPN with the DOC or a RN from the home being on call. She further indicated that the roster of Registered Nurses is limited as their part-time RNs have other employment and are available for specific shifts only. They currently have four RNs on call for the day and evening shifts and two available for the night shift.

On Monday March 27, the RN who was scheduled for the day shift called in sick. The night RN called the roster of RN offering the shift with no success. A RPN covered the shift. No other back-up staffing options was planned or available. Therefore, no RN worked on March 27, 2017 from 0600 to 1400 hours.

On Tuesday March 28, the day full time RN who is also the ADOC was scheduled to replace the DOC as she was away on vacation, leaving the day shift not covered by an RN. The Human Resource person staff #113 indicated there was only one RN available to whom she could offer the shift to as the others were either not available or do not work the day shift. The available RN declined the shift and a RPN covered the shift. No other back-up staffing options was planned or available. Therefore, no RN worked on March 28, 2017 from 0600 1400 hours.

On Saturday April 15, the evening RN was authorized time off and because there was no RN to cover that shift, the regular day RN was scheduled to work from 1100 to 2100 hours to cover part of both shifts and a RPN was covering the day shift from 0600 hours until she arrived at 1100 hours. The regular day RN came in to work at 1100 hours but left at 1400 hours as she was sick. There was one RN available to call to replace this shift but he declined and a RPN covered the shift with the DOC being on call. No other back-up staffing options was planned or available. As a result, there was no RN scheduled to work from 0600 to 1100 hours on days and no RN available to work from 1400 to 2200 hours on evening.

On Sunday April 16, the evening RN was authorized time off and because there was no RN to cover that shift, the regular day RN was scheduled to work from 1100 to 2100 hours to cover part of both shifts but ended up calling sick. A RPN was covering the day shift from 0600 hours until she arrived at 1100 hours with the DOC being on call. As there was no RN available to call to offer the shift to from 1100 to 2100 hours, the full time evening RN was offered overtime and she covered the evening shift from 1400 to 2200 hours. Therefore, no RN worked on April 16 from 0600 to 1400 hours.

On Thursday April 20, the regular full time day RN was sick. The roster of RN was called offering the shift but no one was available. A RPN covered the shift. No other back-up staffing options was planned or available. Therefore, no RN worked on April 20 from 0600 to 1400 hours.

On Friday April 21, the regular full time day RN was still sick. There was no RN available to call to replace as they were either scheduled or not available. No overtime was offered and a RPN covered the shift. No other back-up staffing options was planned or available. Therefore, no RN worked on April 21 from 0600 to 1400 hours.

On Tuesday May 9, the regular day RN who is also the ADOC was scheduled to work as the DOC as the DOC was away on leave. The Human Resource person staff #113 had

no documentation indicating that the home attempted to replace this shift and to whom it was offered. A RPN covered the shift. Therefore, no RN worked on May 9 from 0600 to 1400 hours.

On Thursday May 18, the regular day RN who is also the ADOC was scheduled to work as the DOC was away on leave. The Human Resource person staff #113 had no documentation indicating that the home attempted to replace this shift and to whom it was offered. A RPN covered the shift. Therefore, no RN worked on May 18 from 0600 to 1400 hours.

On Saturday and Sunday May 20 and 21, the scheduled RN was approved vacation time. The Human Resource person staff #113 had no documentation indicating that the home attempted to replace these shifts and to whom it was offered. A RPN covered both shifts with the DOC being on-call. Therefore, no RN worked on May 20 and 21 from 0600 to 1400 hours.

During an interview with the General Manager and the Human Resource person staff #113 on May 30th, 2017, they indicated to the inspector that even if they did not have a RN on-site, they believed they were still compliant as the DOC or a RN from the regular staff was either on call or onsite. They were not aware that when the DOC works in the capacity of the DOC, she cannot be considered to be a RN on duty and present in the long-term care home. They also believed that when a RN called in sick or there was no RN available to cover a shift, this was considered an emergency situation.

On May 31, 2017, during an interview, the Administrator indicated to inspectors #550 and #547 that she was not aware that the previous Compliance Order required her to prepare, submit and implement a plan for achieving compliance therefore she did not prepare or submit a plan. She indicated that the home's current back-up staffing plan includes strategies such as:
-Call the roster of RNs
-Offer 12 hour shifts, overtime
-Schedule 2 RPNs with a RN or the DOC on call.

She indicated that although the DOC currently works 56 hours per two weeks, she is not asked to replace RN shifts or change her shift to ensure the RN coverage as part of their current back-up plan. Furthermore, she indicated that the home currently does not use an agency for registered staff replacement.

It was identified that for the period of February 25 to May 28, 2017, there were eleven shifts where there was not a registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present in the home. The home's back-up staffing plan was not followed.

The scope and severity of this non-compliance was reviewed. The fact that there was not a solid back-up staffing plan to deal with emergency situations, plus the licensee's ongoing non-compliance poses a risk to residents' safety and affects every resident living in the home. [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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On August 21, 2012, a notice was issued to Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada titled "Adult Hospital Beds:

Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (referred to as Health Canada Guidance Document). In the notice, it is written that this Health Canada Guidance Document is expected to be used "as a best practice document".

The Health Canada Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the Health Canada Guidance Document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision making. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003).

This document provides necessary guidance in establishing a clinical assessment for residents where bed rails are used. It is recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including, but not limited to, the residents right to participate in the care planning process, the residents medical needs, sleep habits and sleep environment, resident comfort in bed, and potential safety risks posed by using any type of bed rail. The document further indicates that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

The Food Services Supervisor/ RAI coordinator reported during an interview with Inspector #126 on May 19, 2017 that resident #023 was found hanging out of her bed a few weeks earlier and that she had reported this to the Director Of Care (DOC) and General Manager via email on April 21, 2017 at the change of shift from day to evening shift.

On May 24, 2017 Inspector #547 observed resident #023's bed. The bed had two rotating assist bed rails which are half rails that were placed in the center on either side

of the bed. The head of the bed had a sign to indicate two rails up.

On May 22, 2017 Inspector #547 interviewed the General Manager regarding what the home did after becoming aware of this incident for resident #023 on April 21, 2017. He indicated that the resident's bed and rails were verified and all were properly tightened, and that nursing staff were to have heightened monitoring of the resident. He indicated that he met with the DOC on their usual Monday meetings, and reviewed that they had to increase their monitoring of the resident. The General Manager further indicated that his only formal bed assessments, is to verify the bed frames and bed rails with the mattresses, to ensure that they are in functioning order. He stated that this verification is completed every two weeks. The General Manager also stated that he was not familiar with the Health Canada Guidance Document or the companion document that provides guidance for the clinical assessment of residents when bed rails are used.

The DOC indicated to the inspector that she recalled having a meeting with the General Manager early in May, 2017. DOC retrieved the EMAIL sent by the FSS/RAI coordinator in the home on April 21, 2017 at 1428 hours. This message was sent to the DOC and the General Manager in the home. The EMAIL stated "resident #023 was yelling help but staff were still in report, resident #023 was hanging out of the bed, the resident's entire torso and head were on floor with only the legs in bed against the other bed rail. I am not sure if the bed rail can be moved, if so to move this rail beside the resident's head/torso to avoid this". The DOC further indicated that the resident was not re-assessed after this incident, and that the monitoring for this resident had not been heightened.

Inspector #547 reviewed resident #023's health care records that indicated the resident now had two full rails used in bed that the resident uses to assist staff when turning and repositioning in bed. The resident's documented care conference in 2016 indicated the resident was high risk of falls and utilized a Personal Safety Aid (PSA) and two side rails. A physical restraint consent form for the resident had documented consent from the resident's SDM for two full bed rails and co-signed by the DOC. It was further noted that the resident resided on a specific floor at the time of this consent and annual care conference.

On May 30, 2017 the DOC indicated that the resident was later moved to another floor according to the room transfer binder in the office. The DOC indicated that in her note book she discussed this incident with the General Manager, however they did not assess the resident's need for these half bed rails upon the resident's move to another floor or implement any further changes to the resident's monitoring or plan of care.

The home's policy and procedure provided to the inspection team titled Bed Rails policy effective date November 25, 2007 last revised June 6, 2013, was reviewed by the DOC. This policy indicated when a resident is identified at risk of falling out of bed or getting up alone and falling, side rails may be used as determined by the nursing assessment. The home's procedure indicated that all beds will be equipped with two side rails.

Over the course of this inspection, it was noted by the inspection team that the majority of residents were in beds that had two bed rails in place, thus the non-compliance described above is widespread and presents the potential for actual harm to residents without any resident assessment for rails use and his or her bed systems evaluated in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, to minimize risk to these residents. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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, allows calls to be cancelled only at the point of activation and clearly indicates when activated where the signal is coming from.

This inspection was a follow-up inspection to compliance order #001 that was issued to the home on March 8, 2017, under inspection #2017_548598_0005 with a compliance date of May 12, 2017. This inspection was part of the home's Resident Quality Inspection.

On May 31, 2017, Inspector #550 observed the newly installed system for the call bell in the dining room on the lower level of the home. On the lower level there is the home's main dining room, the kitchen, the hairdresser salon and the administration office. The inspector observed a strobe light on the ceiling in the hallway at the entrance of both dining room doors. Once inside the dining room, the inspector observed that on the wall opposite the kitchen there was a red push button next to a telephone on the wall. Under the push button there was a sign in French and English indicating:

IN CASE OF EMERGENCY
Pick-up handset, press PAGE and CALL OUT "NURSE STAT DINING ROOM"
Also press the switch to activate Emergency lights

Inspector #550 pressed on the emergency button to activate a call while inspector #547 went on the 2nd floor unit. Inspector #550 observed that the two strobe lights on the ceiling in the hallway on the lower level were activated but no sound was heard in the dining room or on the lower level. Inspector # 547 confirmed to inspector #550 that there was no indication on the 2nd floor resident to staff communication system panel that a call had been placed in the dining room. No sound was heard either.

During an interview, the General Manager indicated to inspectors #547 and #550 that he thought that because their current resident to staff communication and response system was old, it was grandfathered. The Administrator and the General Manager indicated that the telephone and the strobe lights are not connected to each other nor are they connected to the home's current resident to staff communication system. The telephone page when activated is heard on every floor. To place a call for assistance, a person has to read the sign on the wall, page staffs using the page function on the telephone,

announce that a nurse is required in the dining room and then press on the red button to activate the strobe lights on the lower level. Once the page is completed and the handset of the telephone is replaced, there is no further audible indication of a call for assistance, in any area of the home. The page does not repeat, there is no continuous call. The strobe lights on the lower level are only seen if in the hallway and keep going on until the red button is pressed again to cancel the lights. There is no other ongoing indication anywhere in the home to signal that a call for assistance has been made in the dining room. The strobe lights do not notify nursing staff on the resident care units of the call for assistance.

Therefore, to activate a call from the dining room, this implicates a two-step process. The first step is to page the nurse, as per the written directions, to the dining room by the use of the telephone and the second step is to press the red emergency button. Once the nurse is paged and the handset of the telephone is replaced, the call is ended at that time. Although the strobe lights will go on until the red button is pressed again to deactivate the lights, they can only be seen from the lower level of the home as they are not connected to the home's primary call bell system panel.

It was determined by both inspectors that the resident-staff communication and response system in the dining room on the lower level:

- Can be easily seen on the wall in the dining room. It cannot be easily accessed and used by persons with physical disabilities (that hinder them from reaching that far up) as it is mounted approximately 5 feet from the floor. Staffs are aware of its location and how to use it. The inspector was not able to observe visitors using the system during the visit.
- Is on at all times;
- The call for assistance cannot be cancelled only at the point of activation in that there is no continuous call to be cancelled. A resident to staff communication system has to be a one step process with a continuous call until it is deactivated. The current system in the dining room is a two-step process and it is not a continuous system. When the handset of the telephone is replaced after the page is completed, the page is automatically cancelled. If activated, the strobe lights remain on until they are deactivated by someone.
- Is available in every area accessible by residents. The dining room is an area that is highly used by residents for meals and some activities.
- It does not clearly indicate where the signal is coming from. The set up requires the user of the system (the phone) to clearly verbally indicate where the signal (page) is coming from. If during an emergency situation, the person cannot speak or forgets to

announce the location where the assistance is required when paging, there is no way for the nurse to know where the help is needed. And, giving the assumption that the person followed through with the second step, which is to push the red button to activate the strobe lights, the lights are only visible when in the hallway next to the dining room on the lower level of the home. There is no way for staffs anywhere else in the home to see the strobe lights and be informed that a call for help has been placed from the dining room.
- The paging system is audible to staff.

The home's compliance history, scope and severity were reviewed. A Voluntary Plan of Correction was issued in March 2015 under inspection # 2015_225126_0012 and in December 2016 under inspection # 2016_219211_0023. A Compliance Order was issued in March 2017 under inspection # 2017_548592_0005. The fact that the home's resident-staff communication and response system in the lower level dining room cannot be easily accessed and used by residents, it does not allow calls to be cancelled only at the point of activation and it does not clearly indicates when activated where the signal is coming from as well as the licensee's ongoing non-compliance this poses a risk to residents' safety and affects every residents living in the home. [s. 17. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Findings/Faits saillants :

1. The licensee has failed to comply with section 71. of the regulation in that the home failed to ensure that the home's menu planning includes the following:

1. The home's menu cycle, includes menus for regular, therapeutic and texture modified diets for both meals and snacks. O. Reg 79/10, s. 71 (1) b.

On May 15, 2017, during the lunch dining observation, Inspector #126, noted that there was only one choice of pureed texture for the meal, no alternative were available. On May 15, 2017, during an interview, the Cook indicated to Inspector #126 that there was one choice of pureed texture for the meal and it was fish. He indicated that there was no

alternate choices for residents on pureed texture diet. On May 19, 2017, during an interview, the FSS indicated to Inspector #126 that there was one choice of pureed texture diet for the three meals and that it was always like that.

The three weeks menus cycle were reviewed by inspector #126 and it was noted that there was one choice for the pureed texture diet at each meal and no alternatives was offered. It was also noted that there was no afternoon snacks documented on the menu for all residents. Also, on the menu, it was noted that the evening snack for residents on pureed texture diet did not include any choices.

2. Each resident is offered a minimum of three meals daily. O. Reg 79/10, s. 71 (3) a.

Resident #013 was admitted to the home with multiple diagnoses. Upon admission, the resident was weighed at a specified weight range.

During a review of the resident's health care records, inspector #550 noted documented a continuing gradual weight loss for six specific months.

Documentation in the progress notes by the R.D. and the registered staffs since the resident's admission, indicated that this resident's continuous gradual weight loss and refusal to eat was known by the healthcare team.

The inspector reviewed the daily food and fluid intake record for the resident for twenty three specific days. It was noted documented that during that period of time, the resident refused breakfast on four of the twenty three days. There was no documentation for two of the twenty three days. On a specific day it was documented "A" meaning absent from the dining room, as per the R.D. The progress notes were reviewed and there was no indication that a tray was provided or offered to the resident on any of those days.

Lunch: It was documented that the resident refused lunch on eight of the twenty three days. There was no documentation on two of the twenty three days. There was documentation in the progress notes that the resident was provided with a tray on one specific date but not on any of the other dates.

Supper: It was documented that the resident refused supper on twelve of the twenty three days. There was documentation in the progress notes that the resident was provided with a tray on two specific days but not on any of the other dates.

During an interview with the home's R.D. and RN #100 on May 24, 2017, they indicated to the inspector that the home does not offer trays to the resident when he/she refuses to come to the dining room for meals as they do not want the resident to make a habit of eating in his/her room; they want to promote social interaction. Furthermore, the R. D. indicated that the resident is not provided with any snacks at a.m. collation even when he/she does not eat his/her breakfast as the home only provides liquids to the residents at that time. The resident is provided with cookies at pm collation and 1/2 a sandwich at bedtime. She indicated that although the resident enjoys sandwiches, they do not want to give him/her a sandwich between meals because they fear the resident will not want to eat his/her meals. The R.D. indicated that other than a specific supplements which the resident refused because of bothersome side effects and pudding, they have not tried other options including fortified foods, or other types of supplements because of budget restrictions.

The scope and severity of this non compliance was reviewed. The fact that the home's menu cycle does not include menus for therapeutic and texture modified diets for both meals and snack plus the fact that resident #013 who is identified has having a continuous gradual weight loss is not offered three meals per day at a minimum poses a potential risk for actual harm to those residents. [s. 71.]

Additional Required Actions:

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

WN #5: 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 in the

home are equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff.

On May 15, 2017, inspector #547 observed the Pantry room door to be unlocked and unattended by any staff members from 0850 to 0900 hours and at 1330 hours. This Pantry room is located on the home's lower level across from the home's kitchen and two doors away from the home's only elevator. The elevator is frequently used on a daily basis by residents to access the main dining room. The room contained several shelving units with packages of dried foods. It was also observed to have a freezer room door that was not locked, and accessible to residents in the home to enter.

On May 15, 2017 Inspector #547 observed the clean utility room door on the first floor to be unlocked. This utility room is located off the central sitting area near the elevator. Inside this room, clean linens and plug in devices were accessible. RPN #101 was at the medication cart outside this room and indicated to inspector #547 that this clean utility room was never locked as staff go in and out of this room all day long. She further indicated that the clean utility room was not always supervised, and that this was not a residential area. PSW #102 indicated that this door was not locked.

On May 16, 2017 Inspector #547 observed the Pantry door to be opened and unlocked again. This door was kept open with a metal hook attached to the back of the Pantry door and to the shelving unit on the inside of this room. Inspector #547 was able to open the freezer door and enter this room. This room was not supervised by any staff members.

On May 17, 2017 Inspector #547 observed the Pantry door to be open and unlocked. The cook staff #103 indicated to inspector #547 that this Pantry room was not locked during the day as kitchen staff were in and out all day long. The cook staff #103 indicated he would lock this door after the dinner meal when they are done preparing food for the day. The cook staff #103 confirmed that this room was not always in his line of sight while he was in the kitchen, and that it was not supervised. Inspector #547 noted a sign outside the Pantry door that indicated "keep door closed and locked at all times".

The Administrator indicated to inspector #547 on this same day, that the Pantry room is a non-residential area and that it is supposed to be kept closed and locked as identified on the sign on the door, for residents' safety.

On May 18, 2017, inspector #547 observed that the clean utility door on the first floor was unlocked at 1350 hours while resident #005 was seated outside this room. Inspector

#547 interviewed RN #100, the acting Director of Care (DOC) that day. She indicated that this clean utility door had a locking mechanism on the door. RN #100 indicated that the clean utility rooms were not residential areas in the home and further indicated that this door was likely not locked as resident #005 was able to unlock the deadbolt style lock. RN #100 indicated that she would make a work order to the maintenance department to have this locking mechanism changed to one that the resident cannot unlock. [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 the doors to the pantry room and the clean utility rooms are equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On May 16, 2017, during the resident observation, inspectors observed the following equipment to be in disrepair:

Resident #005: when inspector #550 activated the call bell at the resident's bedside, the dome light over the bedroom door lite up but there was no audible sound.
Resident #006: when inspector #550 activated the call bell at the resident's bedside, the dome light over the bedroom door lite up but there was no audible sound.
Resident #028: inspector #547 observed that the activation button on the call bell cord at the resident's bedside was missing and there was a metal pin inside the button. When the inspector pushed on the metal pin the call bell was not activated. On May 25, 2017, twelve days later, inspector #550 observed the call bell at bedside for this resident and noted that it was in the same state of disrepair.

On May 29, 2017, during an interview with the General Manager, he indicated to inspectors #550 and #547 that the maintenance person does a verification of the call bell system every two weeks at the same time as he does the verification of the bed systems. Although there was documentation on the bed system verification, he was unable to provide documentation for the last verification of the call bell system.

On May 31, 2017, the Administrator indicated to inspector #550 and #547 during an interview that as part of the Joint Health and Safety Committee workplace monthly inspections, the maintenance person is required on a monthly basis to do a verification of the call bell system in the home. He has to verify each call bell to ensure that the call bell is working, the cord is intact, the electric panel fixture is in working order and document this on the Joint Health and Safety Committee workplace monthly inspection checklist. She provided inspector #550 with last the call bell inspection check list which was dated March 2017. She indicated that the General Manager and the maintenance person were probably not aware of this procedure further indicating that the maintenance person was new in the home.

As evidenced above, the licensee failed to ensure that the call bell system in the home was kept in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the call bells in the home are kept in a good state of repair, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has specifically failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, (a) mouth care in the morning and evening, including the cleaning of dentures and (b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth.

Resident #006:
On May 17, 2017 resident #006 indicated to Inspector #550 that the Personal Support Staff (PSW) provide dental care daily to the resident.

Inspector #547 reviewed resident #006's health care records that indicated the resident was admitted with several medical diagnoses. The resident's plan of care related to personal hygiene identified an inability to do care related to physical impairment. PSW staff are to maintain oral hygiene for the residents daily as per the home's mouth care

standard currently in effect. This mouth care standard identified cleaning of teeth in the morning and evening.

Resident #006 indicated to Inspector #547 on May 26, 2017 that staff use a toothette swab to brush his/her teeth and that he/she would prefer they used a toothbrush.

PSW #108 and #114 indicated that PSW staff use a toothette swab and mouth wash to provide resident #006's mouth care morning and evening. PSW #114 indicated that she was not aware of any process to use a toothbrush for resident's that have their own teeth in the home, and has usually used a toothette swab and mouthwash for resident's mouth care.

Resident #034:
On May 17, 2017 resident #034's teeth were observed by Inspector #547 to be soiled with debris that the resident was picking at with his/her right hand. The resident said that he/she brushes his/her own teeth when he/she can and requires to be set up by PSW staff to do this.

Inspector #547 reviewed resident #034's health care records that indicated the resident was admitted with several medical diagnoses including physical impairment. The resident's plan of care related to dental care indicated PSW staff are to clean resident's teeth every morning and evening.

Resident #034 indicated to inspector #547 on May 26, 2017 that staff use a toothette swab to brush his/her teeth and that he/she would prefer to use a toothbrush and thought he/she could do this if they set him/her up.

PSW #108 indicated that PSW staff use a toothette swab and mouth wash to provide the resident mouth care morning and evening as the resident was not able to brush his/her own teeth. PSW #108 further indicated that they use a toothette swab and mouthwash as the resident clenches down on his/her teeth preventing them from being able to get the toothbrush inside his/her mouth.

Resident #039:
Resident #039's health care records reviewed and identified the resident was admitted to the home with several medical diagnoses including cognitive impairment. Resident #039's plan of care indicated the resident's personal hygiene is to be completed by one PSW staff. Resident #039 is identified as having a denture plus own teeth and required

to be supervised and assisted to brush teeth every morning and evening.

On May 17, 2017 Inspector #547 observed the resident with foul smelling breath and soiled teeth that were brown, with food matter stuck between the teeth. Resident #039 indicated to inspector #547 that if only he/she could have a tooth brush, that he/she could finally brush his/her teeth.

On May 18, 2017 Inspector #547 interviewed the resident’s Substitute Decision Maker (SDM) who indicated resident #039 often had soiled teeth and bad breath. The SDM further indicated that resident #039 informed him/her recently that the resident’s gums were sore as the staff had not brushed his/her teeth.

Inspector #547 reviewed the documented flow sheets for a specific period of time for resident #039’s dental care. These flow sheets indicated the following mouth care legend coding: TB for tooth brushing, D/C as denture cleaning, M/C as mouth care with toothette swabs. Resident #039 documentation on these flow sheets as M/C mainly as twice daily and occasionally documented as D/C. No documentation of dental care provided to the resident's teeth (TB) or dentures care (D/C) for the resident’s denture twice daily during this period.

On May 29, 2017 PSW #108 and #115 indicated to inspector #547 that resident #039 required to have his/her teeth brushed for him/her as the resident no longer seems to understand how to brush on his/her own. Resident #039’s dental care was provided with toothette swabs and mouthwash to wash.

During an interview, RN#100 indicated to inspector #547 that the resident's in the home that have their own teeth have a toothbrush and toothpaste provided to them by the home, unless they purchase their own. Residents with dentures have another style of brush to be used, and toothette swabs with mouthwash to cleanse their palates. RN #100 showed Inspector #547 the home's storage room that is locked and accessible when PSW staff request supplies that contained several packaged toothbrushes, paste, mouth wash and indicated that she had recently had to re-order toothette swabs in the home as they had run out.

During an interview on May 30, 2017, the DOC indicated to inspector #547 that resident’s who have their own teeth should have these teeth brushed with a toothbrush and if they have dentures, they are to have the dentures brushed with a denture brush and soaked overnight with cleaning tablets. Toothette swabs and mouthwash is only to

be used for residents that do not have any teeth to provide mouth care to their palates and gums and this would be specifically identified in the resident's plan of care. The DOC further indicated that the dentist can provide dental spacers to aid in brushing residents' teeth as required for resident's needs that are provided from the dentist and that this would need to be evaluated for resident #034. (547) [s. 34. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #006, #034 and #039 receive mouth care in the morning and evening, including the cleaning of dentures and the physical assistance or cuing to brush their teeth, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

On May 23, 2017, resident #039's Substitute Decision Maker (SDM) indicated to inspector #547 that he/she had to complain to the nurse in the home last week about the resident's toenails. He/she was having difficulty finding comfortable shoes for the resident, as the resident's toenails had over grown over the top of the toes, and were curled under the toes on both feet.

Inspector #547 and the resident's SDM observed the resident's toenails on May 23, 2017 and noted them to be trimmed to the edge of the resident's toes. SDM indicated the resident's toenails had improved from last week as they were no longer curled over the top of the toes.

RPN #101 indicated to inspector #547 that toenail care is provided by the PSWs during bath care unless they have foot care services arranged, or complex nails that PSW staffs are unable to trim. When a resident requires a registered nursing staff to trim their nails, the PSW staff is to call the registered nursing staff into the tub room during the resident's bath to trim the resident's toenails at that time.

Inspector #547 interviewed PSW #102 responsible for bathing residents over the last week. She indicated that she recalled the resident's toenails were trimmed last week by RN #100. The residents on the bath list identified as FC for foot care, are to be done by the foot care nurse that comes to the home. Resident #039 was on the regular bath list, and PSWs are responsible to trim finger nails and toenails.

RN #100 indicated to inspector #547 that the toenail care procedure is to be reviewed by the home. Many PSWs do not do this task with baths as they believe it is to be done by the registered nursing staff. She was under the impression that only complex nails, or residents with diabetic nails, are to be flagged on bath days by the PSW staff to trim their toenails. RN #100 indicated that she was not made aware of resident #039's toenails status until the residents SDM informed her last week. RN #100 indicated she was required to trim the residents toenails as they were very long and uncomfortable for the resident. [s. 35. (1)]

2. The licensee has failed to ensure that the resident receive fingernail care, including the cutting of fingernails.

Resident #039 was observed on five specific days, by inspector #547 to have brown matter embedded in the resident's long fingernails.

Inspector #547 reviewed resident #039's health care records. The resident was admitted to the home with several medical diagnoses including cognitive issues. The Minimum Data Set (MDS) assessments completed by the FSS/RAI coordinator quarterly indicated the resident had responsive behaviours and resisted care almost daily that was not easily redirected. Resident#039 required total assistance for personal hygiene including nail

care.

On May 23, 2017, inspector #547 spoke to the resident's SDM, who indicated that he/she wished the nursing staff would simply trim the resident's fingernails short to prevent dirt from getting stuck inside them.

PSW #105 indicated that during baths, resident #039 refused to allow her to clean or cut his/her nails. The resident did however allow them to place both hands in the bath water as the resident's fingernails are often dirty.

PSW #102 who is now the bath PSW and indicated that resident #039 usually does not allow the staff to clean his/her nails with the wooden cuticle sticks. She did not know to report the cleaning issue to registered nursing staff but if the resident needed to have the nails trimmed, and refused, then they asked the registered nursing staff for assistance.

On May 26, 2017, PSW #109 indicated to inspector #547 that the home's process for nail care was that resident's finger nails and toenails are cleaned and trimmed as required during baths. PSW #109 further indicated that nail care is documented on the bath skin check sheet. Inspector #547 reviewed this bath skin check sheet, which indicated that resident #039 had his/her nails cleaned only on one specific date. There was no documented dates of nail trimming of either finger or toe nails on this skin check sheet for the other days.

On May 26, 2017 RN #100 indicated to Inspector #547 that she was not made aware of any issues related to cleaning or the cutting of resident #039's fingernails or toenails related to refusing care as part of the resident's responsive behaviours. Resident #039 often places his/her hands inside the brief that makes it very important to clean the resident's fingernails for sanitary purposes. She will ask a staff member to attend to the resident's fingernails, to soak them, clean and trim them short and that she would update the resident plan of care related to these behaviours. [s. 35. (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 resident #039 receives fingernail and foot care services, including the cutting of fingernails and toenails, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence care and bowel management program provide for strategies to maximize the resident's independence, comfort and dignity, including equipment, supplies, devices and assistive aids.

During the course of the RQI, it was identified that resident #011 was not assessed after the removal of a specific equipment and became subsequently incontinent of urine.

Inspector #550 requested the home's continence and bowel management program and was provided with two policies; ''Bowel and Bladder Continence Care /

Assessment/Monitoring'', revised July 25, 2016 and ''Bowel and Bladder Continence Care / Toileting Program'', revised October 18, 2016. The inspector reviewed the program and noted that the program did not provide for strategies to maximize the resident's independence, comfort and dignity, including equipment, supplies, devices and assistive aids.

During an interview on May 31, 2017, the DOC identified the two above policies as the home's continence care and bowel management program. She further indicated that their current program does not provide for strategies to maximize the resident's independence, comfort and dignity, including equipment, supplies, devices and assistive aids. [s. 51. (1) 4.]

2. The licensee has failed to ensure that the resident who is incontinent receive an assessment that:
• includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and
• is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

During a review of resident #011's health care records, it was documented that this resident was admitted with a specific type of equipment in place . It was also documented on a specific date that the resident remove the equipment and that it was not re-installed as the resident was voiding appropriately. On a specific date the resident returned to the home from a hospital stay with a specific type of equipment to assist the resident with a specific condition. It was documented on another specific date that the resident had removed the equipment and it was then discontinued by the physician at the home the following day as the resident was voiding properly.

During an interview on May 29, 2017, RN #100 indicated to the inspector that they do continence assessment upon a resident's admission and they will do another one when there is a change in the resident's condition. She indicated that a continence assessment was not done when the resident specific equipment was removed and it was determined that the resident was incontinent because the resident's spouse previously told the RN the resident was incontinent at home therefore the RN did not think that the resident had a potential of being continent.

During an interview with the DOC on May 30, 2017, she indicated to the inspector that a

continence assessment should have been completed when resident #011's specific type of equipment was removed and the resident determined to be incontinent as this was considered a change in the resident's continence status. [s. 51. (2) (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 home's continence and bowel management program provide for strategies to maximize the resident's independence, comfort and dignity, including equipment, supplies, devices and assistive aids and that resident #011 receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Resident #039 was admitted to the home with several medical diagnoses including dementia. The resident's current assessment documented the resident as resisting care almost daily, and not easily redirected. Resident #039's current plan of care indicated the resident had specified interventions related to dementia for toileting, bathing and personal hygiene.

The resident's plan of care further identified the resident as having history of a specified infection and altered skin integrity related to excoriated skin.

During the course of this inspection, resident #039 was observed on several occasions to have brown matter embedded in the resident's fingernails as identified in WN # 9.

PSW #102 and #109 and RPN #101 indicated to inspector #547 that the resident often had responsive behaviors of resisting care related to hygiene and finger nail care and placing his/her hands inside the brief after he/she has had a bowel movement and playing with feces.

Resident #039's progress notes were reviewed between the period of nineteen days, and noted three instances when it was documented that the resident was discovered picking at his/her feces after being incontinent. The resident's progress notes also identified reddened/ excoriated buttocks on a daily basis during this period of time. RPN #101 documented that this redness/excoriated buttocks may be related to frequent incontinence of loose stools in this period of time.

This behavior was not identified in the resident's current plan of care, related to bowel continence, specialized approach for hand and nail hygiene or bathing care requirements. It was further noted that no strategies had been developed and implemented to mitigate these behaviors when the resident was picking at his/her own feces or any referral to Behavior Support Ontario (BSO) related to these behaviors was identified. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that strategies are developed and implemented to respond to resident #039's responsive behaviours, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On May 30, 2017, during an interview with the Activity Director, it was determined that the home does not have a formal family council in the home. The current practice is that the Director of Activity organizes and leads meetings three times per year with some family members where they discuss issues in the home that families may have but there are no terms of references and no president to this committee. The Director of Activity indicated that family members are invited to attend those meetings through the "Residents/Family Newsletter" but they do not convene semi-annual meetings to advise resident's families and persons of importance to the residents of their right to establish a Family Council.

During an interview on May 31, 2017, the Administrator confirmed that the home currently does not have a formal Family Council. She indicated that the families are invited to attend meetings three times per year to discuss issues they may have. She further indicated that the home does not organize semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council. [s. 59. (7) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that semi annual meetings are organized to inform residents' families and persons of importance to residents of their right to establish a Family Council, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. he licensee has failed to ensure that the daily and weekly menus were communicated to residents.

On May 15, 2017, at lunch time, it was noted by Inspector #126 that the daily menu was communicated to residents by being posted on the wall, beside the main dining room but the weekly menu was not communicated to residents.

During the course of this inspection, Inspectors #547 and #550 had observed that the daily menu was communicated to the residents but that the weekly menu was not communicated to the residents.

On May 18, 2016, the RD indicated to Inspector #126 that weekly menu were not posted/communicated to residents. [s. 73. (1) 1.]

2. The licensee has failed to ensure that there was a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

On May 15, 2017, during the lunch meal observation, it was observed by inspector #126 that residents' likes and dislikes were not documented on the resident's diet sheet that was posted beside the servery.

On May 15, 2017, during an interview, the Cook indicated to inspector #126 that there was a list on the wall that indicated the residents' diet, tea and coffee but it did not include the likes and dislikes of each resident. On that day, the meat for the pureed texture diets was fish and the Cook indicated that there was no alternate choice for residents on pureed texture diet. He further said that he was serving the fish to all the residents on a pureed textured diet without knowing if those residents liked the fish or not.

On May 15, 2017, during an interview, the FSS indicated to inspector # 126 that the RD is responsible to complete the initial assessment for likes and dislikes of the residents. She indicated that this information is kept in the care plan/kardex of each resident in their health care records. The FSS indicated that because it was a small home, they usually knew what the residents' likes and dislikes are. [s. 73. (1) 5.]

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

On May 15, 2017, during lunch time, residents #009, #027, #030 and #032 were observed to be sitting at the same table and were served their entree, main course and desserts at the same time. All these residents either required assistance with feeding or required to be fed by staff.

On June 7, 2017, the FFS provided the current plan of care of the four above residents. In the plan of care there was no indication that those residents required to be served all courses at the same time. [s. 73. (1) 8.]

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 weekly menus are communicated to the residents, a process is in place to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences and that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs, to be implemented voluntarily.

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. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The Licensee of a long-term care home has failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

As per LTCHA, 2007, S. O. 2007, c. 8, s. 79 (3), the required information for the purpose of subsection (1) is:
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of the residents;
(g) notifications of the long-term care home's policy to minimize the restraining of the residents, and how a copy of the policy can be obtained; and
(k) copies of the inspection reports from the past two years for the long-term care home.

On May 15, 2017 Inspector #547 conducted the initial tour of the home for the resident quality inspection and observed the following information was not posted in the home:
- the home's policy to promote zero tolerance of abuse and neglect of residents
- the long-term care home's policy to minimize the restraining of residents as well as information about how a copy of the policy can be obtained.
- copies of the inspection reports from the last two years.

On May 18, 2017 Inspector #547 reviewed the requirements for information to be posted in the home with the Administrator, and she indicated that they had just removed the inspection reports to update them. When they returned the inspection reports, she removed all the 2015 inspections, as she thought she only required the previous year (2016) and the current year (2017) reports. The Administrator further indicated that the policies for Zero Tolerance of Abuse and Restraints are not currently posted in the home as she was not aware this was required. The Administrator indicated that the Human Resources staff member is now in charge of postings in the home, and will ensure that all the required information is posted in the home. [s. 79. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents, the home's policy to minimize the restraining of residents as well as information about how a copy of the policy can be obtained and copies of the inspection reports from the last two years are posted in the home, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols required under O. Reg. 79/10, s. 114 (2) were:
(a) Developed, implemented, evaluated and updated in accordance with evidence-based practices.

O. Reg. 79/10, s. 114 (2), requires the licensee to ensure that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs.

The home's pharmacy is Classic Care Pharmacy and they require the homes they are affiliated, to follow their policies.

This relates to the issue of signing Medication Administration Record (MAR) before the medication is administered and on two occasions, the medication was signed but not administered to the resident.

The home's Classic Care Pharmacy policy and procedure for Administering Routine Medications #4.2 last revised November 2015 was revised by inspector #547. It was observed documented that each medication is individually inspected and verified for correctness against the resident's MAR sheet verifying competence, safety and authority and then the medication that has been verified is administered to the resident as ordered. Each medication is initialed as administered on the MAR in the correct boxes, date and time, upon administration.

Upon review of the home's medication incident reports for a specific period of time, the following three incidents were identified:

1. Resident #028 who was required to have a monthly medication administered as routine medication for a specific diagnosis on a specific date but did not receive this routine medication until it was delivered at the home by the pharmacy a few days later. It was noted that RN #100 signed the Medication Administration Record (MAR) on the specific day the medication was to be administered, however the medication was not administered to resident #028 until a later date. This incident report identified that RN #100 signed the MAR prior to preparation and verification of the medication.
2. Resident #008 was required to have routine medication on two specific dates. This medication was signed for in the MAR but not administered to the resident.

These registered nursing staff members did not follow the home's policy for administration of routine medications, and the residents were then not provided with their medication as ordered.

This incident is related to the issue of administering a controlled substance to a resident as a PRN medication and not documenting this administration in any records in the home.

The home's Classic Care Pharmacy policy and procedure for Administering PRN Medications #4.4 last revised November 2015, indicated that when PRN medication are administered, detailed information about the dose is documented. The dose of the PRN medication is documented, recording the date and time, medication name and strength,

dosage administered, reason for administration, and signature of administering person. This procedure further stated that PRN medication is initialed as administered on the MAR immediately after administration and the effectiveness/outcome of the administered PRN medication is documented.

3. Resident #044 was administered a PRN medication of Hydromorphone injection on March 8, 2017. This medication was not documented in the resident's MAR or the controlled substance tracking form as having been administered by the administering registered staff.

This registered nursing staff member did not follow the home's policy for administering PRN medication of a controlled substance, posing a risk for medication error to this resident as no record of any administration or effectiveness/outcome of the PRN medications was documented. [s. 114. (3) (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 medication administration policies are implemented in the home, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to resident #008 and resident #028 in accordance with the directions for use specified by the prescriber.

As part of the medication observation, inspector #547 reviewed the home's medication incident reports.

Resident #028 was not provided with a specific medication as prescribed. This medication was required for a specified diagnosis and it was not provided to the resident on the date it was to be administered to this resident.

Resident #008 was not provided with a specific medication as prescribed on two occasions. It was indicated that the registered nursing staff involved on each occasion did not read the medication details and missed administering this medication to the resident. This medication is used to reduce exacerbation of a specific chronic condition.

These medication incidents identified that drugs were not administered to these residents in accordance with the directions for use specified by the prescriber. [s. 131. (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 resident #008 and #028 are administered their medications in accordance with the directions or use specified by the prescriber, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's SDM, if any.

On May 26, 2017 RN #116 indicated to Inspector #547 that when a medication incident occurs in the home, the registered nursing staff have to complete a medication incident report form. RN #116 indicated that they have to report this incident to the SDM, the pharmacy, physician, DOC, and RN in charge if completed by the RPN. Once this document is completed, the DOC is then provided the incident report form and reviews the information and then manages with the nursing staff member involved and keeps a records in her office.

Upon review of the home's medication incident reports for four incidents that occurred in the last six months completed by registered nursing staff in the home. This report identified that the incident shall be reported to Resident/Power of Attorney (POA), Pharmacy Service Provider, Attending physician, Director of Care, Prescriber, Medical Director and RN (EC) and to indicate the date and time it is reported.

It was noted that the resident/POA were not made aware of these medication incidents involving residents in the home.

On June 1, 2017 the DOC indicated that upon review of the four medication incidents for residents reviewed in the home, that no resident/ POA were documented as being informed. The DOC further indicated that she will have to review the process for completing a medication incident report with registered nursing staff in regards to who these incidents must be reported to as identified in the home's process. [s. 135. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all medication incidents involving a resident and every adverse drug reaction are reported to the resident and the resident's SDM, if any, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as of January 1, 2011, the DONPC work regularly in that position on site for at least the following amount of time per week:
1. In a home with 19 licensed beds or fewer, at least 4 hours
2. In a home with 20 to 29 licensed beds, at least 8 hours
3. In a home with 30 to 39 licensed beds, at least 16 hours
4. In a home with 40 to 64 licensed beds, at least 24 hours
5. In a home with 65 or more licensed beds, at least 35 hours

Note: In a home with more than 39 licensed beds, a DONPC who is attending a meeting or training related to his or her position as a DONPC is considered to be working on site at the home as long as he or she is available by telephone.

Sarsfield Colonial Home is a 46 bed long-term care facility, therefore required to have a DONPC on site for at least 24 hours per week.

For the purpose of this report, the DONPC is also referred to as the Director of Care (DOC).

On May 15, 2017, inspector #550 was informed by the Human Resource person staff #113 that the DOC was away on leave and was not expected to return until May 24,

2017. She further indicated that RN #100/Assistant Director of Care (ADOC) was replacing the DOC. On May 23, 2017, the Human Resource person staff #113 indicated to the inspector that the DOC's leave was extended until May 31, 2017. On May 29, 2017, the DOC returned to work as per her regular schedule.

Inspector #550 reviewed the staffing schedule for registered staff including the ADOC's schedule for the period of February 25 to May 28, 2017. It was then determined that the DOC had been on an approved leave since May 8, 2017. The inspector observed documented on the schedule that the ADOC staff #100 was scheduled to replace the DOC on the following dates for the following weeks:
Week of May 8 to 14: May 9 and 11 for a total of 16 hours,
Week of May 15 to 21: May 18 for a total of 8 hours,
Week of May 22 to 28: May 25 for a total of 8 hours.

The above findings were reviewed with the Administrator on May 31, 2017. She confirmed that during her leave, the DOC was not attending a meeting or training. She also confirmed that during this leave, the home did not have a DOC on site and present in the home for 24 hours per week for the following weeks:
Week of May 8 to 14: missing 8 hours,
Week of May 15 to 21: missing 16 hours, and
Week of May 22 to 28: missing 16 hours. [s. 213. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a DOC on site for a minimum of 24 hours per week, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On May 17, 2017, from 0815 to 0915 hours, inspector #550 observed the breakfast meal service in the first floor television lounge. At the time of this observation, there were ten residents in the lounge. During the course of the service, the inspector observed PSW #114 making toasts for the residents, putting butter and jam on the toasts, plating the food, pouring beverages, serving the residents their meal and beverages and taking croissants from the stainless steel food pan with her bare hands and placing them on the plates. PSWs #102 was observed feeding a residents who required to be fed, removing the dirty dishes after and then went to help another resident to eat without washing her hands. Both PSWs were also observed providing assistance to residents who required some assistance. Both PSWs were moving from one task to another and from one resident to another during the entire meal service without washing their hands. The inspector observed that there was no sink with running water and soap and no alcohol-based hand rub dispensers in the television lounge for the staff to use to wash their hands.

During an interview, PSW #102 indicated to inspector #550 that there was no alcohol-based hand rub dispensers or sink in the television lounge available to staffs to wash their hands.

Inspector #550 reviewed the home's hand hygiene program provided by the Director of Care. Document titled "Best Practices for Hand Washing Sarsfield Colonial Home", revised May 29, 2013, on page 2 of 7, under "Indications and Moments for Hand Hygiene", it was documented:

A hand hygiene indication is the reason why hand hygiene is necessary at given moment. There might be several hand hygiene indications in a single care. Sequence or activity:

The third bullet indicated:
• Before preparing, handling or serving food or medications to the resident.

The fifth bullet indicated:
• After contact with a Resident or items in their immediate surroundings, when leaving the

resident's room.

On page 4 of 7, under Hand Hygiene Products and Agents, it was documented: Alcohol-based Hand Rub (ABHRs):

The second bullet indicated:
• Easily accessible ABHR has showed that more people practice hand washing compared to traditional hand washing. It's faster and has been showed to be more effective than washing with soap and water when hands are not visibly soiled.

The third bullet indicated:
• When visible soil is present and running water is not immediately available, use disposable towels followed by ABHR's then go to the nearest utility to do soap and water washing.

During an interview on June 1, 2017, the Director of Care and the Administrator indicated to the inspector that the staff were expected to use the alcohol-based hand rub dispenser located on the wall across the hall from the entrance to the television lounge to wash their hands. The Administrator further confirmed that disposable towels were not available for staff to clean their hands with when they were visibly soiled. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program by following the home's hand hygiene program, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote resident #023's right to be afforded privacy in treatment and in caring for the resident personal needs.

On May 23, 2017 Inspector #547 observed PSW's #106 and #107 at 1353 hours providing care to resident #023 by changing the resident's brief while in bed and the PSWs had not drawn the privacy curtains around this resident's bed. Resident #023 resides in a shared bedroom with three other residents that were also present in the room at this time. This room was equipped with privacy curtains for each resident bed area for resident privacy.

Resident #024 that shares this room had a curtain drawn, but a two foot gap at the head level that was directly facing resident #023's bed at this time. Resident #042, who also resides in this shared room got out of bed, and was walking towards the Inspector and the Inspector turned him/her around, and redirected him/her from going to the shared bathroom at this time as that would have had him/her walk directly across the open curtain area for this resident's bed, as his/her bed is located next to the shared bathroom.

Inspector #547 interviewed resident #024 on May 24, 2017, who sleeps in the next bed near resident #023. The resident indicated that he/she did see resident #023 the day before when the staffs were changing his/her brief, as it always happens, and that he/she did not like this and often has to turn away towards the window. Resident #024 indicated that it is terrible, and cannot understand why they do not use the curtains. Inspector #547 then interviewed resident #023 who indicated that PSW staff never pull the curtains while providing his/her care, and that's just the way it was.

Interview with PSW #107 and she indicated that they should have pulled both curtains for this resident, in this shared bedroom, as anyone could have come in as the Inspector did or other residents in this shared room.

Interview with PSW #106 indicated that he had drawn the curtains between the residents, he did not notice the two foot gap for resident #024's bed facing resident #023's bed. He also did not identify the need to draw any other curtain for this resident. He indicated that he did not think of this curtain at the time of providing the resident's care.

On May 24, 2017 the Administrator indicated to Inspector #547 that she has made sure that every resident had the privacy curtains required for care and for privacy, especially in these shared bedrooms of four residents. She indicated that she would follow up with the staff in a meeting for the importance of using the privacy curtains in each resident's shared room for their privacy. [s. 3. (1) 8.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 70. Dietary services
Every licensee of a long-term care home shall ensure that the dietary services component of the nutrition care and dietary services program includes,
(a) menu planning;
(b) food production;
(c) dining and snack service; and
(d) availability of supplies and equipment for food production and dining and snack service. O. Reg. 79/10, s. 70.

Findings/Faits saillants :

1. The licensee has failed to ensure that the dietary services component of the nutrition care and dietary services program includes, (d) availability of supplies and equipment for food production and dining and snack service.

Inspector #550 observed on May 17, 2017, the meal service for the activity ''breakfast in bed'' on the first floor from 0815 to 0915 hours. This activity occurs two times per week on each floors; Sundays and Wednesdays.

During the course of that meal service, the inspector observed that the residents were served breakfast in the television lounge on each of their respective floors and were served their breakfast meal using disposable dishes except for the cutlery and the cups. The cold cereals were served in a 10 oz white foam bowl, the main course was served on a paper plate, the cold liquids in a plastic disposable glass and pureed fruits in a small clear plastic disposable dish.

On June 9, 2017, during an interview, the FSS indicated to the inspector that they are using disposable dishes for the activity ''breakfast in bed'' because this meal service takes more time than the usual meal service and the kitchen staff would not have time to wash all the dishes in time for the next meal service which starts at 1100 hours. Furthermore she indicated that the risk for injury to a resident would be lower when using disposable dishes than when using regular porcelain dishes if a resident was to drop the dishes. [s. 70. (d)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

On May 15, 2017 Inspector #547 toured the home's three tub rooms. These tub rooms were not locked and accessible to residents. Inside these tub rooms there was a cabinet located next to the tub by the windows that contained a bottle of "Ecolab Mikro-Quat" cleaning solution labelled with a tag to say for bath use only and for disinfection of nail instruments. These cabinets were noted to be equipped with a keyed locking mechanism that was not locked.

Inspector #547 reviewed the Material Safety Data Sheet (MSDS) for Mikro-Quat cleaner/disinfectant to be considered a hazardous product to residents in the home.

On May 23, 2017 Inspector #547 discussed this cleaning product with the home's General Manager, who indicated that these cabinets in the tub rooms are supposed to be kept locked as they contain bathing and cleaning products. [s. 91.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,

(a) Hand hygiene

In accordance with LTCHA, 2007, S.O. 2007, c. 8, s. 76. (1), the licensee shall ensure that all staff in the home have received training as required by this section.

For the purpose of section 76. (4) of the Act, the licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

As per O. Reg. 79/10, s. 219. (1), the intervals for the purpose of subsection 76 (4) of the Act are annual intervals.

Over the course of the Resident Quality Inspection, on June 1, 2017, inspector #550 reviewed the home's annual training in infection prevention and control, more specifically on hand hygiene.

During an interview, the DOC indicated to the inspector that staffs receive training on hand hygiene during health and safety week and that the last training was done the week of November 28 to December 2016.

The inspector requested and was provided with the education training on hand washing by the Human Resources person, staff #113. The education was provided in the form of a 5 minute video on hand hygiene and then a quiz was given to the attending employees to ensure their comprehension. The Human Resources person staff #113 indicated that at the time that the training was provided in 2016, there were a total of fifty three employees in the home. It was observed documented that forty two of the fifty three employees (79%) did not attend the training on hand washing in 2016. The DOC and Human Resources person indicated that many of their staffs were not working during that week, therefore they did not attend the training. [s. 219. (4) (a)]

Issued on this 18th day of July, 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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE HENRIE (550), LINDA HARKINS (126), LISA KLUKE (547)
Inspection No. / No de l'inspection :	2017_619550_0015
Log No. / Registre no:	007616-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 23, 2017
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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_219211_0023, CO #001;

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 revise their current back-up nursing staffing plan to ensure that it complies with O. Reg 79/10, s. 45.

The reviewed nursing staffing plan shall include:

-detailed strategies for when the Registered Nurse who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work,
-a definition of emergency situations as per O. Reg. 79/10, s. 45 (2)., and,
-strategies for emergency situations when the back-up plan fails 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.

Grounds / Motifs :

1. The licensee has failed to ensure that there was at least one Registered Nurse (RN) who is an employee of the licensee and a member of the regular nursing staff, on duty and present in the home at all times.

This inspection was a follow-up inspection for compliance order #001 that was issued to the home on December 1, 2016, under inspection #2016_219211_0023 with a compliance date of February 24, 2017.

Inspector #550 reviewed the registered nursing staff schedules for the period of

February 25 to May 28, 2017 and noted the following:
-March 27, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours,
-March 28, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours,
-April 15, 2017 there was not an RN scheduled for five of the eight hour day shift; from 0600 to 1100 hours and for the full evening shift; from 1400 to 2200 hours,
-April 16, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours,
-April 20, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours,
-April 21, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours,
-May 9, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours,
-May 18, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours,
-May 20: there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours and,
-May 21, 2017 there was not an RN scheduled for the eight hour day shift; from 0600 to 1400 hours.

Ontario Regulation 79/10 section 31. (3) (d) requires the licensee to have a written staffing plan that includes a back-up plan for nursing and personal care staffing that addresses situation when staff, including the staff who must provide the nursing coverage required under subsection 8. (3) of the Act, cannot come to work.

As per Ontario Regulation 79/10, section 45 (1) 1 indicates for homes 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 me 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 nurse and 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.

Sarsfield Colonial home is a 46 bed long-term care facility located in a rural community.

During an interview with the Human Resource person staff #113 on May 30th, 2017, she indicated that for all the above ten shifts there was not a registered nurse available to cover those shifts and that these ten shifts were not shifts that would be covered under an ''emergency situation''. She told the inspector that when a Registered Nurse (RN) calls sick, they will call their roster of available RNs by seniority. If this fails, they will offer overtime to the RN on-site and as a last resort, they will offer the shift to a RPN with the DOC or a RN from the home being on call. She further indicated that the roster of Registered Nurses is limited as their part-time RNs have other employment and are available for specific shifts only. They currently have four RNs on call for the day and evening shifts and two available for the night shift.

On Monday March 27, the RN who was scheduled for the day shift called in sick. The night RN called the roster of RN offering the shift with no success. A RPN covered the shift. No other back-up staffing options was planned or available. Therefore, no RN worked on March 27, 2017 from 0600 to 1400 hours.

On Tuesday March 28, the day full time RN who is also the ADOC was scheduled to replace the DOC as she was away on vacation, leaving the day shift not covered by an RN. The Human Resource person staff #113 indicated there was only one RN available to whom she could offer the shift to as the others were either not available or do not work the day shift. The available RN declined the shift and a RPN covered the shift. No other back-up staffing

options was planned or available. Therefore, no RN worked on March 28, 2017 from 0600 1400 hours.

On Saturday April 15, the evening RN was authorized time off and because there was no RN to cover that shift, the regular day RN was scheduled to work from 1100 to 2100 hours to cover part of both shifts and a RPN was covering the day shift from 0600 hours until she arrived at 1100 hours. The regular day RN came in to work at 1100 hours but left at 1400 hours as she was sick. There was one RN available to call to replace this shift but he declined and a RPN covered the shift with the DOC being on call. No other back-up staffing options was planned or available. As a result, there was no RN scheduled to work from 0600 to 1100 hours on days and no RN available to work from 1400 to 2200 hours on evening.

On Sunday April 16, the evening RN was authorized time off and because there was no RN to cover that shift, the regular day RN was scheduled to work from 1100 to 2100 hours to cover part of both shifts but ended up calling sick. A RPN was covering the day shift from 0600 hours until she arrived at 1100 hours with the DOC being on call. As there was no RN available to call to offer the shift to from 1100 to 2100 hours, the full time evening RN was offered overtime and she covered the evening shift from 1400 to 2200 hours. Therefore, no RN worked on April 16 from 0600 to 1400 hours.

On Thursday April 20, the regular full time day RN was sick. The roster of RN was called offering the shift but no one was available. A RPN covered the shift. No other back-up staffing options was planned or available. Therefore, no RN worked on April 20 from 0600 to 1400 hours.

On Friday April 21, the regular full time day RN was still sick. There was no RN available to call to replace as they were either scheduled or not available. No overtime was offered and a RPN covered the shift. No other back-up staffing options was planned or available. Therefore, no RN worked on April 21 from 0600 to 1400 hours.

On Tuesday May 9, the regular day RN who is also the ADOC was scheduled to work as the DOC as the DOC was away on leave. The Human Resource person staff #113 had no documentation indicating that the home attempted to replace this shift and to whom it was offered. A RPN covered the shift. Therefore, no RN worked on May 9 from 0600 to 1400 hours.

On Thursday May 18, the regular day RN who is also the ADOC was scheduled to work as the DOC was away on leave. The Human Resource person staff #113 had no documentation indicating that the home attempted to replace this shift and to whom it was offered. A RPN covered the shift. Therefore, no RN worked on May 18 from 0600 to 1400 hours.

On Saturday and Sunday May 20 and 21, the scheduled RN was approved vacation time. The Human Resource person staff #113 had no documentation indicating that the home attempted to replace these shifts and to whom it was offered. A RPN covered both shifts with the DOC being on-call. Therefore, no RN worked on May 20 and 21 from 0600 to 1400 hours.

During an interview with the General Manager and the Human Resource person staff #113 on May 30th, 2017, they indicated to the inspector that even if they did not have a RN on-site, they believed they were still compliant as the DOC or a RN from the regular staff was either on call or onsite. They were not aware that when the DOC works in the capacity of the DOC, she cannot be considered to be a RN on duty and present in the long-term care home. They also believed that when a RN called in sick or there was no RN available to cover a shift, this was considered an emergency situation.

On May 31, 2017, during an interview, the Administrator indicated to inspectors #550 and #547 that she was not aware that the previous Compliance Order required her to prepare, submit and implement a plan for achieving compliance therefore she did not prepare or submit a plan. She indicated that the home's current back-up staffing plan includes strategies such as:
-Call the roster of RNs
-Offer 12 hour shifts, overtime
-Schedule 2 RPNs with a RN or the DOC on call.

She indicated that although the DOC currently works 56 hours per two weeks, she is not asked to replace RN shifts or change her shift to ensure the RN coverage as part of their current back-up plan. Furthermore, she indicated that the home currently does not use an agency for registered staff replacement.

It was identified that for the period of February 25 to May 28, 2017, there were eleven shifts where there was not a registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present in the

home. The home's back-up staffing plan was not followed.

The scope and severity of this non-compliance was reviewed. The fact that there was not a solid back-up staffing plan to deal with emergency situations, plus the licensee's ongoing non-compliance poses a risk to residents' safety and affects every resident living in the home. (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee is ordered to:

1. Establish and implement a process for that when bed rails are used, that the resident is to be assessed for the need of these bed rails in accordance with prevailing practices;

2. Establish and implement a process for when bed rails are used, that the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize the risk of resident entrapment, taking into consideration all potential zones of entrapment;

3. The resident is followed by an interdisciplinary team for assessment of the ongoing need and use for these bed rails, including quarter or half rails. This interdisciplinary team is to be consulted before the decision to add/change the style of bed system, bed rails or mattress used for residents; and

4. Ensure that the above assessments and reassessments are documented including the names of team members participating in the assessment, the results of the assessment, and the recommendations for these residents in relation to their bed system and rails.

Grounds / Motifs :

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

On August 21, 2012, a notice was issued to Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (referred to as Health Canada Guidance Document). In the notice, it is written that this Health Canada Guidance Document is expected to be used "as a best practice document".

The Health Canada Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the Health Canada Guidance

Document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision making. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003).

This document provides necessary guidance in establishing a clinical assessment for residents where bed rails are used. It is recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including, but not limited to, the residents right to participate in the care planning process, the residents medical needs, sleep habits and sleep environment, resident comfort in bed, and potential safety risks posed by using any type of bed rail. The document further indicates that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

The Food Services Supervisor/ RAI coordinator reported during an interview with Inspector #126 on May 19, 2017 that resident #023 was found hanging out of her bed a few weeks earlier and that she had reported this to the Director Of Care (DOC) and General Manager via email on April 21, 2017 at the change of shift from day to evening shift.

On May 24, 2017 Inspector #547 observed resident #023's bed. The bed had two rotating assist bed rails which are half rails that were placed in the center on either side of the bed. The head of the bed had a sign to indicate two rails up.

On May 22, 2017 Inspector #547 interviewed the General Manager regarding what the home did after becoming aware of this incident for resident #023 on April 21, 2017. He indicated that the resident's bed and rails were verified and all were properly tightened, and that nursing staff were to have heightened monitoring of the resident. He indicated that he met with the DOC on their usual

Monday meetings, and reviewed that they had to increase their monitoring of the resident. The General Manager further indicated that his only formal bed assessments, is to verify the bed frames and bed rails with the mattresses, to ensure that they are in functioning order. He stated that this verification is completed every two weeks. The General Manager also stated that he was not familiar with the Health Canada Guidance Document or the companion document that provides guidance for the clinical assessment of residents when bed rails are used.

The DOC indicated to the inspector that she recalled having a meeting with the General Manager early in May, 2017. DOC retrieved the EMAIL sent by the FSS/RAI coordinator in the home on April 21, 2017 at 1428 hours. This message was sent to the DOC and the General Manager in the home. The EMAIL stated "resident #023 was yelling help but staff were still in report, resident #023 was hanging out of the bed, the resident's entire torso and head were on floor with only the legs in bed against the other bed rail. I am not sure if the bed rail can be moved, if so to move this rail beside the resident's head/torso to avoid this". The DOC further indicated that the resident was not re-assessed after this incident, and that the monitoring for this resident had not been heightened.

Inspector #547 reviewed resident #023's health care records that indicated the resident now had two full rails used in bed that the resident uses to assist staff when turning and repositioning in bed. The resident's documented care conference in 2016 indicated the resident was high risk of falls and utilized a Personal Safety Aid (PSA) and two side rails. A physical restraint consent form for the resident had documented consent from the resident's SDM for two full bed rails and co-signed by the DOC. It was further noted that the resident resided on a specific floor at the time of this consent and annual care conference.

On May 30, 2017 the DOC indicated that the resident was later moved to another floor according to the room transfer binder in the office. The DOC indicated that in her note book she discussed this incident with the General Manager, however they did not assess the resident's need for these half bed rails upon the resident's move to another floor or implement any further changes to the resident's monitoring or plan of care.

The home's policy and procedure provided to the inspection team titled Bed

Rails policy effective date November 25, 2007 last revised June 6, 2013, was reviewed by the DOC. This policy indicated when a resident is identified at risk of falling out of bed or getting up alone and falling, side rails may be used as determined by the nursing assessment. The home's procedure indicated that all beds will be equipped with two side rails.

Over the course of this inspection, it was noted by the inspection team that the majority of residents were in beds that had two bed rails in place, thus the non-compliance described above is widespread and presents the potential for actual harm to residents without any resident assessment for rails use and his or her bed systems evaluated in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, to minimize risk to these residents. (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 21, 2017

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2017_548592_0005, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee is ordered to ensure that the call bell system in the lower level dining room:

-is easily accessible to all residents
-allows the calls to be cancelled only at the point of activation, and,
-clearly indicates when activated where the signal is coming from.

Grounds / Motifs :

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, allows calls to be cancelled only at the point of activation and clearly indicates when activated where the signal is coming from.

This inspection was a follow-up inspection to compliance order #001 that was issued to the home on March 8, 2017, under inspection #2017_548598_0005

with a compliance date of May 12, 2017. This inspection was part of the home's Resident Quality Inspection.

On May 31, 2017, Inspector #550 observed the newly installed system for the call bell in the dining room on the lower level of the home. On the lower level there is the home's main dining room, the kitchen, the hairdresser salon and the administration office. The inspector observed a strobe light on the ceiling in the hallway at the entrance of both dining room doors. Once inside the dining room, the inspector observed that on the wall opposite the kitchen there was a red push button next to a telephone on the wall. Under the push button there was a sign in French and English indicating:

IN CASE OF EMERGENCY
Pick-up handset, press PAGE and CALL OUT "NURSE STAT DINING ROOM"
Also press the switch to activate Emergency lights

Inspector #550 pressed on the emergency button to activate a call while inspector #547 went on the 2nd floor unit. Inspector #550 observed that the two strobe lights on the ceiling in the hallway on the lower level were activated but no sound was heard in the dining room or on the lower level. Inspector # 547 confirmed to inspector #550 that there was no indication on the 2nd floor resident to staff communication system panel that a call had been placed in the dining room. No sound was heard either.

During an interview, the General Manager indicated to inspectors #547 and #550 that he thought that because their current resident to staff communication and response system was old, it was grandfathered. The Administrator and the General Manager indicated that the telephone and the strobe lights are not connected to each other nor are they connected to the home's current resident to staff communication system. The telephone page when activated is heard on every floor. To place a call for assistance, a person has to read the sign on the wall, page staffs using the page function on the telephone, announce that a nurse is required in the dining room and then press on the red button to activate the strobe lights on the lower level. Once the page is completed and the handset of the telephone is replaced, there is no further audible indication of a call for assistance, in any area of the home. The page does not repeat, there is no continuous call. The strobe lights on the lower level are only seen if in the hallway and keep going on until the red button is pressed again to cancel the lights. There is no other ongoing indication anywhere in the home to signal that

a call for assistance has been made in the dining room. The strobe lights do not notify nursing staff on the resident care units of the call for assistance.

Therefore, to activate a call from the dining room, this implicates a two-step process. The first step is to page the nurse, as per the written directions, to the dining room by the use of the telephone and the second step is to press the red emergency button. Once the nurse is paged and the handset of the telephone is replaced, the call is ended at that time. Although the strobe lights will go on until the red button is pressed again to deactivate the lights, they can only be seen from the lower level of the home as they are not connected to the home's primary call bell system panel.

It was determined by both inspectors that the resident-staff communication and response system in the dining room on the lower level:

- Can be easily seen on the wall in the dining room. It cannot be easily accessed and used by persons with physical disabilities (that hinder them from reaching that far up) as it is mounted approximately 5 feet from the floor. Staffs are aware of its location and how to use it. The inspector was not able to observe visitors using the system during the visit.
- Is on at all times;
- The call for assistance cannot be cancelled only at the point of activation in that there is no continuous call to be cancelled. A resident to staff communication system has to be a one step process with a continuous call until it is deactivated. The current system in the dining room is a two-step process and it is not a continuous system. When the handset of the telephone is replaced after the page is completed, the page is automatically cancelled. If activated, the strobe lights remain on until they are deactivated by someone.
- Is available in every area accessible by residents. The dining room is an area that is highly used by residents for meals and some activities.
- It does not clearly indicate where the signal is coming from. The set up requires the user of the system (the phone) to clearly verbally indicate where the signal (page) is coming from. If during an emergency situation, the person cannot speak or forgets to announce the location where the assistance is required when paging, there is no way for the nurse to know where the help is needed. And, giving the assumption that the person followed through with the second step, which is to push the red button to activate the strobe lights, the lights are only visible when in the hallway next to the dining room on the lower level of the home. There is no way for staffs anywhere else in the home to see the strobe

lights and be informed that a call for help has been placed from the dining room.
- The paging system is audible to staff.

The home's compliance history, scope and severity were reviewed. A Voluntary Plan of Correction was issued in March 2015 under inspection # 2015_225126_0012 and in December 2016 under inspection # 2016_219211_0023. A Compliance Order was issued in March 2017 under inspection # 2017_548592_0005. The fact that the home's resident-staff communication and response system in the lower level dining room cannot be easily accessed and used by residents, it does not allow calls to be cancelled only at the point of activation and it does not clearly indicates when activated where the signal is coming from as well as the licensee's ongoing non-compliance this poses a risk to residents' safety and affects every residents living in the home. (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 22, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. Menu planning

Order / Ordre :

The licensee shall ensure that menu planning includes:
1. Menus for texture modified diets for both meals and snacks
2. The meal menu shall include alternative pureed choices of entrees, vegetables and desserts at lunch and dinner
3. The snack menu shall include a pureed snack option in the afternoon and evening
4. Offering each resident a minimum of three meals daily

Grounds / Motifs :

1. The licensee has failed to comply with section 71. of the regulation in that the home failed to ensure that the home's menu planning includes the following:

1. The home's menu cycle, includes menus for regular, therapeutic and texture modified diets for both meals and snacks. O. Reg 79/10, s. 71 (1) b.

On May 15, 2017, during the lunch dining observation, Inspector #126, noted that there was only one choice of pureed texture for the meal, no alternative were available. On May 15, 2017, during an interview, the Cook indicated to Inspector #126 that there was one choice of pureed texture for the meal and it was fish. He indicated that there was no alternate choices for residents on pureed texture diet. On May 19, 2017, during an interview, the FSS indicated to Inspector #126 that there was one choice of pureed texture diet for the three meals and that it was always like that.

The three weeks menus cycle were reviewed by inspector #126 and it was noted that there was one choice for the pureed texture diet at each meal and no alternatives was offered. It was also noted that there was no afternoon snacks documented on the menu for all residents. Also, on the menu, it was noted that the evening snack for residents on pureed texture diet did not include any

choices.

2. Each resident is offered a minimum of three meals daily. O. Reg 79/10, s. 71 (3) a.

Resident #013 was admitted to the home with multiple diagnoses. Upon admission, the resident was weighed at a specified weight range.

During a review of the resident's health care records, inspector #550 noted documented a continuing gradual weight loss for six specific months.

Documentation in the progress notes by the R.D. and the registered staffs since the resident's admission, indicated that this resident's continuous gradual weight loss and refusal to eat was known by the healthcare team.

The inspector reviewed the daily food and fluid intake record for the resident for twenty three specific days. It was noted documented that during that period of time, the resident refused breakfast on four of the twenty three days. There was no documentation for two of the twenty three days. On a specific day it was documented "A" meaning absent from the dining room, as per the R.D. The progress notes were reviewed and there was no indication that a tray was provided or offered to the resident on any of those days.

Lunch: It was documented that the resident refused lunch on eight of the twenty three days. There was no documentation on two of the twenty three days. There was documentation in the progress notes that the resident was provided with a tray on one specific date but not on any of the other dates.

Supper: It was documented that the resident refused supper on twelve of the twenty three days. There was documentation in the progress notes that the resident was provided with a tray on two specific days but not on any of the other dates.

During an interview with the home's R.D. and RN #100 on May 24, 2017, they indicated to the inspector that the home does not offer trays to the resident when he/she refuses to come to the dining room for meals as they do not want the resident to make a habit of eating in his/her room; they want to promote social interaction. Furthermore, the R. D. indicated that the resident is not provided with any snacks at a.m. collation even when he/she does not eat his/her

breakfast as the home only provides liquids to the residents at that time. The resident is provided with cookies at pm collation and 1/2 a sandwich at bedtime. She indicated that although the resident enjoys sandwiches, they do not want to give him/her a sandwich between meals because they fear the resident will not want to eat his/her meals. The R.D. indicated that other than a specific supplements which the resident refused because of bothersome side effects and pudding, they have not tried other options including fortified foods, or other types of supplements because of budget restrictions.

The scope and severity of this non compliance was reviewed. The fact that the home's menu cycle does not include menus for therapeutic and texture modified diets for both meals and snack plus the fact that resident #013 who is identified has having a continuous gradual weight loss is not offered three meals per day at a minimum poses a potential risk for actual harm to those residents. (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 18, 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 23rd day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Henrie

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