Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 04, 2015;	2014_266527_0015 (A1)	H-000832-14, H-000699-14	Resident Quality Inspection

Licensee/Titulaire de permis

PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
1090 MORAND STREET WINDSOR ON N9G 1J6

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

SHELBURNE NURSING HOME, DIVISION OF PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
200 ROBERT STREET SHELBURNE ON 000 000

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

KATHLEEN MILLAR (527) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

New Information received. Order rescinded. Director's Referral made.

The number for this Director's Referral is: DRef # 002.

Issued on this 4 day of June 2015 (A1)

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

Original report signed by the inspector.

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

KATHLEEN MILLAR (527) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): July 8, 9, 10, 11, 14, 15, 16, 17, 18, 2014.
The following complaints were inspected concurrently with the RQI:
Log #H-000507-14, H-000699-14, H-000770-14, and H-000809-14

During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Nursing (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Maintenance, Food Services, Housekeeping, residents and family members

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

23 WN(s)
10 VPC(s)
9 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 #19: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

s. 72. (4) The licensee shall maintain, and keep for at least one year, a record of,
(c) menu substitutions. O. Reg. 79/10, s. 72 (4).

Findings/Faits saillants :

1. The licensee did not ensure that all menu items were prepared according to the planned menu.

The Menu Substitution Record was reviewed. Between March and July 2014, 17 menu substitutions occurred due to documented food shortages, late food delivery and fridge mix-ups. In July, the Food Services Manager (FSM) confirmed that most menu substitutions occurred due to staff choosing not to follow the standardized recipes for the planned menu and instead choosing to prepare foods as per their preference and understanding of the menu. The FSM confirmed that staff often did not know where to look for the ingredients. An example, the FSM confirmed that soup substitutions usually occurred due to staff not knowing whether the soup on the menu was canned, frozen or a dry mix and as a result not being able to find the right soup ingredients and substituting with a soup they could easily locate. [s. 72. (2) (d)]

2. The licensee did not ensure that all food and fluids were stored and served using methods which prevent adulteration, contamination and food borne illness.

On a specific date in July 2014 the LTC Inspector noted glasses of fluid pre-poured and left out on the dining room tables prior to meal service. Staff and the Food Services Manager (FSM) confirmed this was a regular practice.

On a specific date in July 2014 a 22.7 kilogram bag of modified food starch was observed being stored in the dietary storage room. The original bag was open with its contents exposed. Dietary staff and the Food Service Manager confirmed that the

storage method was not appropriate.

On a specific date in July 2014 the LTC Inspector noted unlabeled and poorly covered beverage pitchers stored in the kitchen fridge. Two pitchers were loosely covered with a plastic wrap and the third covered with a cracked lid. Dietary staff could not identify the contents, production date and consistency of one pitcher with thickened blue fluids. When asked about the consistency a dietary staff stated that the contents would be re-thickened prior to service. Staff did not discard the pitcher of blue fluid until instructed to do so by the LTC inspector. Another unlabeled pitcher contained a red fluid that staff identified as tomato juice. Staff could not identify whether the juice had been stored in the fridge for long term care residents or residents of the adjacent retirement home. Staff indicated that the juice must have been poured out of the can on Monday, and gets used on Sundays and Mondays weekly. [s. 72. (3) (b)]

3. The licensee did not ensure that records of all menu substitutions were maintained and kept for at least one year.

On a specific date in July 2014, the Food Services Manager (FSM) confirmed that records were not kept prior to March 2014. No previous records of food substitutions were available for review. [s. 72. (4) (c)]

Specifically failed to comply with the following:

s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks; O. Reg. 79/10, s. 77 (1).
(b) the distribution and service of resident meals; O. Reg. 79/10, s. 77 (1).
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and O. Reg. 79/10, s. 77 (1).
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

Findings/Faits saillants :

CO # - 009 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)The following order(s) have been rescinded:CO# 009

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 2. Where, under the program, staff use any supplies with respect to a resident, the supplies are appropriate for the resident based on the resident's condition.

Clinical records for resident #021 were reviewed. The resident was assessed to require pudding-thick fluids due to cognitive deficit and dysphagia. On a specific date in July 2014 the resident was observed during lunch service. The fluid prepared for the resident was too liquid to be considered pudding-thick, posing a risk of choking. The resident was noted to have a wet cough during lunch service.

Dietary staff confirmed that they prepare thickened fluids for four meals at one time for the resident using a quick thickening method of adding 2.25 scoops of starch to one jug of fluid. Dietary staff indicated that the thickened fluids become more runny as they sit in the fridge. The Health Care Aide (HCA) feeding the resident confirmed that pudding-thick fluids provided at meals were often too runny. HCA attempted to re-thicken fluids at point of service by adding more starch, making an unstable, lumpy consistency. No directions for thickening fluids were provided to the HCA. HCA and dietary staff confirmed that they regularly experience problems with thickening fluids.

The LTC Inspector observed the thickener to be a bulk 22.7 kilogram container of modified food starch, without specified clinical use. Dietary staff, the Food Services Manager (FSM) and the General Manager could not provide manufacturer's specifications for the clinical fluid thickening use of the product. The FSM confirmed that the product had been used for clinical purposes without instructions for a year. FSM and staff further confirmed that no training was provided on using the product and no audit of the appropriateness of consistencies was made. Staff did not have the training, instructions or supplies required to produce pudding-thick fluids for Resident #022. [s. 30. (1) 2.]

2. The licensee did not ensure that any actions taken with respect to resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) The MDS Assessments for December 2013, March 2014 and May 2014, and the plan of care identified that resident #001 was on an Incontinent Program. There was no documentation related to a Restorative Bladder Assessment using the Bladder and Bowel Assessment criteria utilized by the home.

B) After reviewing the clinical record for resident #006, there was no evening documentation in the Point of Care (POC) flow sheet in Point Click Care (PCC) on a specific date in July 2014 related to the care provided to the resident. The PSWs confirmed they were short staffed an evening PSW. They also stated they have difficulty finding the time to document care when they don't have the scheduled

number of staff on duty to meet the residents' needs. A review of the home's staffing schedule confirmed one PSW called in sick and was not replaced on the same date in July 2014. The DOC confirmed the home was short staffed a PSW on the evening shift. (527) [s. 30. (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 when staff use supplies, that the supplies are appropriate for the residents' based on their condition, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee did not ensure that the lighting requirements set out in the Table to this section were maintained.

Lighting levels were measured using a Sekonic Handi Lumi portable illumination meter. One resident bedroom, several washrooms, several tub and shower rooms and one corridor were measured.

A) Resident bedrooms were not equipped with any central room fixtures and in order to determine lighting levels, all over bed lights were turned on and window curtains were drawn in room #32. Outdoor conditions were sunny at the time of measurement. Both individual over bed lights were satisfactory at 400 lux for reading levels, however when the meter was held by the centre of the bed, the level dropped to 80 lux and by the foot of the bed, it was 20 lux. The minimum required amount is 215.28 lux in areas where tasks take place such as around the beds, wardrobes and sitting areas.

B) Resident washrooms were not all equipped with the same type of lighting fixtures and lighting levels were quite different depending on the style. Three washrooms with the compact fluorescent spiral bulbs were tested. This included washroom #32 which had a lux of 90 by the toilet and 350 lux over the vanity, washroom #28/29 which had a lux of 110 by the toilet and 520 lux over the vanity and washroom #26 which had two bulbs missing and the lux was 200 over the vanity area. The minimum required level is 215.28 lux over the vanity and toilet areas.

C) Both of the corridors in the home were equipped with flush mounted fluorescent light tubes. The fixtures were spaced 6 to 10 feet apart. Depending on the distance between fixtures and the age of the bulbs, the lux levels ranged from 50 to 185 between fixtures. The meter was held centrally down the long corridor outside room #11 at approximately 30 inches above the floor. The level of the meter did not maintain a consistent and continuous required level of 215.28, but fluctuated between 800 lux (under the light) and 50 lux (between light fixtures at 10 feet apart).

D) The short corridor tub room had a lux of 100 over the tub area. The toilet area in the long corridor tub room was measured at 80 lux. Neither of the tub rooms had lighting levels at the required minimum of 215.28 lux in areas where tasks are performed such as bathing, toileting, dressing and grooming. [s. 18.]

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 lighting requirements set out in the table of r. 18 are implemented and maintained, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

A) Resident #034, #035 and the POAs for residents #003, #005 and #006, stated that it is not unusual for the home to be operating short staffed and can't meet the residents' needs and care requirements. Observed on a specific date in July 2014 that the home was short staffed on evenings by one PSW. Reviewed the home's payroll analysis documents for the pay period ending April 19 to July 12, 2014. The home was short PSW(s) every two week pay period between April 19 to July 12, 2014. The hours short for PSW(s) ranged from the lowest 19.25 hours to the highest of 192 hours in a two week pay period. The RNs, RPNs and PSWs confirmed that the home was short staffed frequently for PSWs. The DOC confirmed they were short staffed PSW(s) during the noted pay periods. Reviewed the home's procedures for replacing PSW shifts. The procedures did not include the process for contacting the Contracted Agency service for PSW replacement. The General Manager confirmed that the home had procedures in place and when they were short a PSW, the registered staff were expected to follow the procedures. Confirmed with the registered staff and the PSWs that they were not aware they could call agency PSWs as part of their procedures for replacing shifts. [s. 8. (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 the organized program of personal support services for the home meets the assessed needs of the residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
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).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an indep

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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that every resident had the right to be afforded privacy in treatment and in caring for his or her personal needs. Resident rooms where ceiling lift tracks were installed had privacy curtains that could not be closed fully around the bed resulting in a lack of privacy for each resident. The entrance to the tub room in the long corridor did not have a privacy curtain that would provide privacy to residents in the tub when the door was opened. [s. 3. (1)]

2. The licensee did not fully respect and promote residents' #013, #014, #031, #032 and #033 right to be afforded privacy in treatment and in caring for their personal needs.

A) In July 2014 the LTC Inspector observed resident #013 being administered insulin into their abdomen by the registered nursing staff, while they were at the main entrance of the home and in full view of all visitors entering the home. The resident's shirt was lifted and the abdomen was exposed. (169)

B) In July 2014 the LTC Inspector observed resident #014 being put into bed using a mechanical lift by PSWs. The resident was yelling at the staff and care was being provided to the resident. The curtains were not pulled around the resident while care was provided. The LTC Inspector observed care being provided to the resident from

the hallway. (169)

C) In July 2014 resident #032 was in the tub room for a bath. The PSW opened the door and did not draw the curtains to ensure the resident had privacy in caring for their personal needs. The LTC Inspector observed the resident up in the chair lift with no clothes on with the door open and no privacy curtains drawn. The PSWs confirmed they forgot to draw the privacy curtains. (527)

D) In July 2014 the LTC Inspector observed resident #031 in the sling of a mechanical lift being transferred from the bed into the wheelchair. Three PSWs were in attendance to assist the resident, the resident's room door was open and no privacy curtains were drawn. The resident was not afforded the privacy in caring for their personal needs. (527)

E) In July 2014 the LTC Inspector observed resident #033 in the sling of a mechanical lift while being transferred from the bed into the wheelchair. Two PSWs were in attendance to assist the resident, the resident's room door was open and no privacy curtains were drawn. The resident was not afforded the privacy in caring for their personal needs. (527) [s. 3. (1) 8.]

3. The licensee failed to ensure that the rights of all residents in the home were promoted including the right to have his or her personal health information kept confidential.

A) On each day of the Resident Quality Inspection (RQI), the inspectors observed and overheard personal health information of various residents being discussed throughout the day. The main nursing station, located at the main entrance does not afford an area for privacy when discussions regarding resident care occur within the interdisciplinary team. During physician rounds, the Doctor and health care team would discuss personal health information for various residents and it was overheard by the inspectors in the Director of Care's office, which was down the hallway. Also, nursing staff would discuss various resident care issues across the nursing station in the hallway, which could also be overheard by the inspectors. Families would also come to the nursing station to discuss care related concerns about residents and this was also overheard by the inspectors throughout the inspection.

The main nursing station, where the residents clinical records were kept does not afford privacy for the health care team to discuss pertinent health related matters without being overheard by visitors entering the home or anyone in the near vicinity.

This was confirmed by visitors and nursing staff. [s. 3. (1) 11. iv.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the written plan of care for residents provided clear directions to staff and others who provide direct care.

A) The plan of care stated that resident #001 needed extensive assistance by one person for dressing. The Minimum Data Set (MDS) assessment from May 2014 identified the resident was totally dependent with one person assisting for dressing. In addition, the plan of care identified the resident needed intermittent supervision with repetitive cues and assistance with personal hygiene. The MDS assessment from May 2014 identified the resident required extensive assistance with one person. The Long Term Care (LTC) Inspector observed staff supervising and cuing the resident when providing care during the month of July 2014. The PSWs confirmed that the written plan of care was confusing. (527)

B) Based on the MDS assessment completed in December 2013, February 2014 and May 2014 the plan of care for resident #006 identified the resident required a medium brief for bladder and bowel incontinence. The resident was also noted as gaining weight at all three assessment periods, however the sizing for the brief for the resident had not changed in the plan of care. The RN, RPNs and PSWs confirmed that the resident required a large brief. The LTC Inspector observed the resident wearing a large brief. The home's Continence Management Program 2014 listing of residents' type and size of incontinence products identified that staff was supplied with a large night brief for resident #006 for all shifts. Staff confirmed they were not aware the plan of care was not updated and confirmed it was unclear. (527)

C) Resident #006 was observed with two-half bed rails up while in bed in July 2014. The plan of care and the document the home refers to as a kardex, which was used by the PSWs, did not provide any direction for the use of the bed rails while the resident was in bed. This was confirmed by the Director of Care and Physiotherapist. (169)

D) Resident #007 was observed in bed in July 2014 with two quarter bed rails in the up position by the head of the bed. The plan of care and the kardex did not identify the use of bed rails or provide any direction to staff when to use them. This was confirmed by the Restorative Aide, Director of Care and Physiotherapist. (169)

E) Resident #002 was observed with quarter bed rail in the up position and a transfer pole on the opposite side of the bed. The plan of care did not identify the use of the bed rail or the transfer pole and did not provide any direction to the personal support workers. This was confirmed by the Restorative Aide, Physiotherapist and Director of

Care. (169) [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care was based on an assessment of the resident's needs.

A) Resident #006 was identified as high risk for falls by the nursing staff, however there were no assessments completed to determine the risk for falls for the past six months. Resident #006 was observed with two half bed rails in the up position while in bed in July 2014. The registered nursing staff and the lack of documentation confirmed there was no fall assessments completed. (169)

B) Resident #007 was observed using two quarter bed rails while in bed in July 2014. The plan of care did not include an assessment of the resident's needs for bed rails. The Restorative Aide, Director of Care and Physiotherapist confirmed an assessment was not completed. (169)

C) Resident #002 was observed with a quarter bed rail in the up position and a transfer pole on the opposite side of the bed in July 2014, while in bed. The plan of care did not include an assessment of the resident's needs. This was confirmed by lack of documentation in the clinical record and interviews with the Restorative Aide, Physiotherapist and Director of Care. (169) [s. 6. (2)]

3. The licensee did not ensure that the care set out in the plan of care was provided as specified in the plan.

A) The MDS assessments completed December 2013, March 2014 and May 2014 identified that resident #001 had the potential ability to restore function related to urinary incontinence. The interventions identified an Incontinent Program for the resident to be toileted before and after meals and at bed time, not to leave the resident unsupervised, to use verbal reminders for urine control, to use a day pad during the day, evening and a brief to sleep. The PSWs, RN and RPNs confirmed they were not aware the resident was on an Incontinent Program and did not know the specific interventions on the plan of care. The PSWs confirmed the resident wears a medium brief, which they check before or after meals and at bedtime, and change if necessary. They stated they only put the resident on the toilet after lunch for a bowel movement and not for urinary continence. There was no documentation on the clinical record related to establishing a urine elimination routine, urinary patterns or toileting regimen. (527)

B) Resident #011 was required to have a dressing change completed weekly. The treatment sheets were reviewed and indicated resident #011 did not receive dressing changes on specific dates in May, June and July 2014. The wound documentation revealed the wound had a history of severe bleeding, clots and a foul odour. The plan of care directs staff to leave the resident when they resist and to try again at a later time. Based on a review of the clinical record and interviews with staff, they did not attempt to complete the dressing change on the following shift or the following day. This was confirmed by the Director of Care.(169)

C) In June 2014 resident #007 was assessed for toileting. The assessment identified the resident needed extensive assistance with the support of one staff; however the plan of care identified the resident needed total assistance by two staff for the entire process of toileting. The PSWs were observed providing total assistance by two staff when toileting the resident. The care provided was contrary to the resident's improvement and potential to restore function to maximum self-sufficiency for toileting as identified in the assessment. The RN, RPNs and PSWs confirmed they where not aware of the improvements noted in the June assessment, and also confirmed the resident was not on a toileting routine. (527)

D) In June 2014 resident #007 was assessed as being high risk for falls and was placed on a Falls Prevention Program. The assessment identified the resident needs extensive assistance with two staff physically assisting to transfer. The plan of care identified the resident needed only one staff to assist for transfers. PSWs were observed transferring the resident with one staff member. The staff confirmed that one staff was required to assist the resident when transferring. The PSWs confirmed they knew the resident was at risk for falls and was on the Falls Prevention Program, but were not aware of what the interventions were on the plan of care. (527)

E) Resident #034 stated that they did not receive assistance to go to bed one evening until very late. The resident was unable to remember the date, however stated it was within the past two weeks. The resident states that they were told that the home was short staffed on evenings and they were unable to assist to bed at the usual time. The resident's choice and preference was to go to bed at a specific time each evening. The staff confirmed that because they were short staffed, resident #034 did not get to go to bed until it was very late.

In July 2014 resident #034 stated they waited fifteen minutes after ringing the call bell for assistance to the toilet. Before getting the assistance to go to the bathroom, the resident was incontinent in their brief. The resident stated they didn't like it and felt

awful. The PSWs confirmed they were not able to assist the resident within a reasonable time as they were short staffed. (527)

F) In July 2014 resident #035 stated they did not receive their bath in the evening. The staff schedule was reviewed and compared to the number of staff that worked, it was identified that the evening shift was short staffed by one PSW. The RPN and PSWs confirmed the resident did not receive their bath because they were short a PSW on the specific evening shift. (527)

G) In July 2014 resident #036 stated that they rang the nursing call bell for assistance to go to the bathroom. The resident stated it took over fifteen minutes for the nurse to respond, which resulted in them being incontinent. The resident stated they felt terrible and felt like a baby, but they were told by staff that the home was short staffed. Confirmed with the PSWs and Registered staff that they were short staffed a PSW on the evening shift, and they were unable to answer the residents' call bell within a reasonable amount of time. (527) [s. 6. (7)]

4. The licensee did not ensure that Resident #022 and Resident #023 were reassessed and the plan of care reviewed and revised at any other time when care set out in the plan had not been effective.

A) Clinical records for Resident #023 were reviewed. The resident consumed an average of 532 millilitres of fluid daily, or 48% of their calculated requirement of 1100 millilitres daily, for three months, from April to July 2014. The resident's plan of care directed staff to push and encourage fluids due to resident being at high nutritional and heat related illness risk as well as at risk for constipation. Fluid interventions were last updated in November 2013. The plan of care was not reviewed and revised when care set out in the plan had not been effective.

B) Clinical records for Resident #022 were reviewed. The Registered Dietitian's (RD) quarterly assessments from September 2013 to April 2014 indicated that the resident experienced ongoing poor fluid intake of 50% to 70% of their calculated fluid intake with no change to hydration interventions. The RD specified to continue with current interventions when the hydration plan of care had not been effective in meeting the resident's fluid goals for seven months. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 003, 004, 005, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The Resident's Council advised the home of concerns at their meetings in February 2014 and they were not addressed in writing until over a month later in March 2014. The Resident's Council advised the home of concerns at their March and May 2014 meetings. As of July 2014, the concerns had not been responded to by the home in writing. There was no documentation of responses in the home's meeting minutes. The home's Residents' Council assistant and the General Manager confirmed the concerns have not been addressed in writing. [s. 57. (2)]

WN #18: The Licensee has failed to comply with LTCHA, 2007, s. 67. s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. The licensee did not ensure that consultation occurred with the Family Council at least every three months.

The Family Council representatives advised that the home does not consult with them at least every three months. The representatives were not able to provide any information related to consultation by the home. The General Manager confirmed that consultation with the Family Council had not occurred at least every three months. [s. 67.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee did not ensure where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home.

On a specific date in July 2014 the Registered Nurse gave the Personal Support Worker (PSW) the key to unlock the medication storage room. The storage room was located on the main floor of the home and the PSW opened the door to look for an item. Observation of the storage room revealed medication was also being stored in the room and the PSW had full access to them. The PSW was an unregulated worker. [s. 130. 2.]

WN #4: 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 residents were not assessed in accordance with prevailing practices to minimize bed entrapment risk to the resident where bed rails were used. Prevailing practices includes but is not limited to a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", developed by the Federal Drug and Food Administration.

According to the Resident Care Coordinator, residents were not evaluated for bed rail use other than to determine if they required assistance with bed mobility or whether bed rails would be used as a restraint. The home did not incorporate the risks of bed rail use in their decision making, especially if the bed did not pass entrapment zones 1 to 4.

A) The bed for resident #006 was observed in July 2014 to have one bed rail elevated. The resident's plan of care did not have any information regarding their need for a bed rail and when it was to be used.

B) The bed for resident #050 was observed in July 2014 to have a therapeutic mattress on the frame and one bed rail elevated. The resident's plan of care identified that the resident was at risk for skin integrity but did not have any information regarding their specialized mattress or their need for a bed rail and why.

C) The bed for resident #051 was observed in July 2014 to have a therapeutic mattress on the frame and one bed rail elevated. The resident's plan of care identified that the resident was at risk for skin integrity but did not have any information regarding their specialized mattress or their need for a bed rail and why.

D) Resident #009 was observed sleeping on a therapeutic air mattress in July 2014 without any gap fillers or bolsters between the elevated assist rails. The resident's plan of care did not have any information about their therapeutic mattress or that they required bed rails. [s. 15. (1) (a)]

2. Where bed rails were in use, steps were not taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident bed systems were assessed for entrapment zone risks in 2011 by a representative from a bed supplier. However, no documentation could be provided to identify which beds were tested for entrapment zones and their status. According to the Restorative Care Coordinator, who was given the task to monitor the beds, many of the beds failed one or more zones of entrapment. In October 2013, another bed safety audit was completed, however the records did not establish who did the audit or the date and the status of all sixty beds. Twenty-four out of the sixty beds passed all four entrapment zones, eight were identified as failing one or more zones of entrapment and the rest of the beds did not have any information as to their status.

According to the Restorative Care Coordinator, many of the beds and mattresses had been replaced between 2011 and October 2013. The most current audit form was not updated and the beds were not re-tested when a change was made to the bed system. The management staff were therefore unable to confirm the safety status of any of the beds.

A) During the inspection, two resident beds identified as "Hill-Rom" beds had elevated bed rails and were ready for use in two resident rooms. Both of these beds also had split rails (zone 5 entrapment risk) attached to the frames. Both sets of bed rails had a large gap within the opening of the rails (zone 1 entrapment risk). No steps had been taken to ensure that the zones would not pose a risk to the residents using the bed rails.

B) Resident #009 was observed sleeping on a therapeutic air mattress with both of their assist rails in the guard or raised position. No bolsters were in place at the time to prevent zone 2, 3 and 4 entrapment risks.

C) The height of the bed rails in two resident rooms were the same as the height of the therapeutic mattresses on the bed frames. Both sets of rails were in the elevated position. The bed rails were not assessed to determine if residents were at risk of possible injury such as rolling over the top of the bed rail or if the resident or staff were able to grab the rail to reposition themselves. In addition, neither of the air mattresses were equipped with bolsters and no accessories were observed on the resident beds that could reduce entrapment between the bed rail and the soft air mattress.

D) All of the beds in three resident rooms had at least one bed rail in the elevated position when residents were out of bed. Bed rails were automatically being left in the raised position throughout the day, regardless of actual assessed need. Residents independently returning to bed that did not pass all four zones of entrapment would be at an increased risk due to the elevated bed rails. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: 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 did not ensure that the home was equipped with a resident-staff communication and response system that was available at every bath location used by residents and was available in every area accessible by residents. An activation station was not available in the short corridor tub room, long corridor tub room (next to the tubs) or in the outdoor courtyard area. [s. 17. (1) (e)]

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 is equipped with a resident-staff communication and response system that, (a) can be easily see, 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., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

**s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

Findings/Faits saillants :

1. The licensee did not ensure resident #011 received a weekly wound reassessment by a member of the registered nursing staff for a wound. In May 2014 the wound was assessed by an RPN, but was not subsequently reassessed for six weeks. The wound was a chronic wound and there was no current assessment of the status of the wound. The Director of Care confirmed the lack of weekly assessments. [s. 50. (2) (b) (iv)]

2. The licensee did not ensure that Resident #009 received reassessment of their wounds. In May 2014 an assessment was completed of the right heel wound. The wound was noted to be 8.5 cm by 3 cm in size. A reassessment had not been completed to date.

In May 2014 an assessment was completed of the left heel wound. The wound was noted to be 4.5 cm by 3.3 cm in size. A reassessment occurred in June 2014 and the wound was noted to be 8cm by 7cm. The assessment was completed approximately one month later and the wound was noted to be worsening.

The buttock wounds were identified initially in June 2014 and there were no assessments completed to date to determine the status of the wounds.

The Director of Care confirmed there were no weekly assessments for any of the wounds. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Specifically failed to comply with the following:

s. 305. (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home. O. Reg. 79/10, s. 305 (3).
2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents. O. Reg. 79/10, s. 305 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that approval of the Director was received prior to the commencement of alterations to the home. A sprinkler system was installed in the home beginning in April 2014 and the Director (via Capital Investment Branch) was not made aware of the project. Awareness of the project became evident when inspectors conducting an inspection on July 7, 2014 noted the incomplete construction of bulk heads around the pipes in resident rooms. [s. 305. (3)]

WN #10: 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. (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).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee did not ensure that residents received 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.

A) Resident #001 had the potential to restore urinary continence as identified in the MDS assessments for the past three quarters. There was no documentation in the resident's health record using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. The RN and RPN confirmed they did not use the Restorative Bowel and Bladder assessment instrument in Point Click Care (PCC). The DOC confirmed that registered staff were expected to use the Restorative Bowel and Bladder assessment instrument.

B) Resident #007 was assessed as having potential to restore function to maximum self-sufficiency for toileting as identified in the MDS assessments from June 2014. There was no documentation in the resident's health record of registered staff using a

clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. The RN and RPN confirmed they did not use the Restorative Bowel and Bladder assessment instrument in Point Click Care (PCC). The DOC confirmed that registered staff were expected to use the Restorative Bowel and Bladder assessment instrument in PCC as outlined in the home's policy.

C) Resident #006 was incontinent. The resident did not receive 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 was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. The resident was admitted to the home in August 2012 and from admission to July 2014, the resident was not assessed using a clinically appropriate assessment instrument designed for assessment of incontinence. The RN and RPN confirmed they did not use the Restorative Bowel and Bladder assessment instrument in Point Click Care (PCC). The DOC confirmed that registered staff were expected to use the Restorative Bowel and Bladder assessment instrument in PCC as outlined in the home's policy.

D) Resident #007 was identified on the plan of care as potentially having the ability to restore function to maximum self-sufficiency for the physical process of toileting. When reviewing the clinical record there was no individualized plan, as part of the resident's plan of care, to promote and manage bladder continence based on the MDS assessment from June 2014, and that the plan was implemented. Staff confirmed the resident used briefs and was changed when necessary for urinary incontinence. The PSWs stated they do not assist the resident in a toileting regimen to become continent. The RN and RPN confirmed that no toileting program was implemented to assist and support the resident to become continent.

E) Resident #001 was identified as potentially having the ability to restore urinary function. The resident was toileted once per day after lunch for bowel continence, however there was no urinary regimen established. Staff confirmed the resident used briefs and was changed when necessary for urinary incontinence. The PSWs confirmed they did not assist the resident with a toileting regimen to become continent. The RN and RPN confirmed that no toileting program was in place to assist and support the resident to become continent. [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 each resident who is incontinent has an individualized plan of care; 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; and if the resident is assessed as being potentially continent or continent some of the time that they receive the assistance and support from staff, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

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

A tour of the home was completed in July 2014 at which time the following maintenance related issues were observed and schedules had not been developed to address their repair.

A) Bathroom doors in resident rooms #33, 29 and 28, were observed to be in a poor state of repair. A plastic beige material had been applied to the lower half of the doors with screws. The material was cracked and split with sharp edges.

B) Bathroom door trim and mill work was badly gouged or missing. i.e room #26, 45, 18.

C) The exterior front door to the home was observed to be warped and not functioning properly. The striker plate and latch were not connecting when tested. The exterior door leading into the courtyard from the dining room could not latch properly.

D) Night tables in rooms #36, 37, 25, 1, 4, 8, 43, 13 were in bad condition, with the top exterior edges eroded away exposing the rough particle board underneath.

E) Electrical outlet covers were rusty in bathrooms #5, 11, 36, 43, 45.

F) The flooring material was bubbled and lifting in the short corridor tub room.

G) The outdoor courtyard was laid with paving stones which were loose and in some areas lying in a depression or hole. The General Manager was aware of the condition of the paving stones but did not have any confirmed dates or schedules in place for repairs.

H) The walls were in poor condition in the short corridor tub room. Two large holes were observed behind the tub and 4 ceramic tiles were broken along one wall (behind baseboard).

I) The resident-staff communication and response system activation stations in resident rooms were not in good condition. The cover plates for the stations were cracked and/or missing over the "cancel" button in rooms 36, 26, 7, 45 and other rooms. [s. 5.]

Additional Required Actions:

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

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (1) This section applies to the use of a PASD if the PASD has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release themself from the PASD. 2007, c. 8, s. 33. (1).

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee did not ensure the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if all of the following are satisfied:

A) The LTC Inspector observed resident #002, #006 and #007 on two specific dates in July 2014 with bed rails in the raised position while in bed. Clinical documentation was reviewed and there was no documentation to identify alternatives to the use of the PASD's was considered, and tried. The Physiotherapist, the Restorative Therapist and the DOC confirmed that alternatives to the use of the PASD were not considered or tried.

B) The LTC Inspector observed resident #002, #006 and #007 using bed rails on two specific dates in July 2014 while in bed. There was no clinical documentation to identify approval for the use of the PASD's was obtained. The Physiotherapist, DOC and Restorative Aide confirmed there was no approval for the use of the PASD.

A review of Resident #002, #006 and #007 clinical records indicated there was no consent for the use of the PASD. The DOC, Physiotherapist and the Restorative Aide confirmed there was no consent for the use of the PASD. [s. 33. (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 s. 33 is developed and implemented in accordance and in compliance with the legislation, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee did not ensure when advised by the Family Council of concerns or recommendations, respond to the Family Council in writing within 10 days of receiving the advice.

The Family Council had advised the home of concerns and suggestions at their meeting in February 2014 and they were not addressed in writing within ten days of receiving. The Family Council had advised the home of concerns at their meetings in April, June, August, and October 2013. There was no documentation of responses in the home's meeting minutes. The General Manager confirmed the concerns had not been addressed in writing within ten days of receiving from the Family Council. [s. 60. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee failed to ensure that procedures were developed and implemented for cleaning of the home, including floors and furnishings.

A) Upholstered pink and orange chair seats located in various resident rooms (i.e. 29, 36) and in the front lounge and the arm rests on various blue sofas were observed to have stains and black discolourations. According to housekeeping staff, the stains could not come out when manually scrubbed and they did not have access to a steam cleaner for the chairs or sofas. The home did not develop any procedures with respect to the frequency of cleaning upholstered furnishings and how they would be cleaned.

B) The floor surfaces within the home, specifically in the dining room, short corridor and resident bathrooms #32, 29, 26, 43 and 13 were observed to be discoloured or “black” in appearance with wear patterns. The home’s "Deep Floor Scrubbing"

procedure F-29 dated 2009 did not identify a frequency for all floors, however housekeeping staff stated the frequency for bedrooms, dining room and corridors was twice per year, in spring and fall. The deep scrubbing process described that the floors were to be stripped and re-waxed. No other floor care program was identified except for the daily mopping of the floors.

According to the General Manager and the Housekeeping Supervisor, a schedule for floor stripping and re-waxing was developed for 2014 and that the floors were scheduled to be completed by the end of July 2014. For the previous year, the floor stripping and re-waxing schedule did not include the rooms identified above (except for #29), the corridors or the dining room. The floors were not all completed twice in 2013 and according to housekeeping staff, the floors appeared discoloured because they were not done this past spring.

The home’s policy and procedure F-10 regarding resident bathroom floors did not specify how to deep clean the floors to prevent the build-up that was observed and how often. The policy only stated that the floors were to be “washed with disinfectant”. The housekeeping staff reported that they did not have a floor machine that could fit into the resident bathrooms for routine buffing to remove built-up soil. The floor care program has not been fully developed or implemented. [s. 87. (2) (a)]

2. The licensee did not ensure that procedures were implemented for the cleaning and disinfection of devices or articles known as personal care articles such as bed pans, wash basins and urinals.

The home’s policy A-21 titled “Cleaning and Disinfection” dated May 2009 required staff to “pre-soak bed pans and wash basins with PerCept and to use mechanical action to remove visible soil after each use”. For commode chairs, the policy required staff to use a cloth soaked in PerCept after each use. The policy was not implemented and was also incomplete and outdated, not describing how the personal care articles were to be stored when cleaned or waiting to be cleaned, which disinfectant product was to be used and how to ensure that each of the articles were returned to the specific residents.

A) Soiled and/or dusty bed pans were observed in shared and private resident washrooms #31/32, 36, 37, 28/29, 1, 5, 7/8, 11, 43, 45 on July 11, 2014 and again on July 14, 2014. All of the articles were unlabeled and stored inappropriately, either on the floor or on wall hooks in contact with clean items such as slings or clothing.

B) A fecal stained commode chair was observed in washroom #31/32 in July 2014.

C) Soiled bed pans and wash basins were observed sitting on open shelves in both soiled utility rooms in July 2014. Some of the articles also appeared clean. No “clean” or “soiled” areas were clearly identified. No instructions were posted in the utility rooms to determine how staff were to manage and clean the articles.

D) Two different disinfectant products were observed in the home, one identified as "Mikroquat" and the other a disinfectant wipe. The product "PerCept" identified in the home's policy could not be located. [s. 87. (2) (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 as part of the organized program of housekeeping that procedures are developed and implemented for cleaning of the home to include the areas in r. 87 (2)(a)(i)(ii); and cleaning and disinfection of the areas in r. 87 (2)(b)(i)(ii)(iii), to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that linen was maintained in a good state of repair.

A) Over 15 meal aprons were observed to be in use in the dining room. The back lining of the meal aprons had cracks throughout. The laundry supervisor reported that the meal aprons were "quite old" and that they were not on a schedule to be replaced.

B) Privacy curtains identified in room 4 and in the long corridor tub room had ripped mesh at the top end, the privacy curtain in room #37 (1st bed right side) was cut down the length of the curtain, and the edge was not finished or sewn. [s. 89. (1) (c)]

WN #20: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not seek the advice of the Family Council, if any, in developing and carrying out the survey, and in acting on its results.

The Family Council representatives stated the home had not asked for their advice, if any, in developing and carrying out the satisfaction survey, and in acting on its results. They did not know they could advise on the development of the survey, and advised they have not been asked to provide feedback on how to act on the survey results. The representatives advised they had not seen an action plan from the home to improve the home, the care, services, programs and goods based on the results of the satisfaction survey. In review of the Family Council minutes and discussion with the General Manager, the home did not seek the advice of the Family Council in developing and carrying out the survey, and in acting on its results. [s. 85. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with

A) The licensee did not ensure the PSWs had accessibility to the point of care (POC) documentation policy called "Point of Care Documentation", number C-61b, revised 2013, and the policy was not complied with. The home's policy stated that all documentation of resident day to day food and fluid intake, ADL care, continence care and mood/behaviour was to be documented by direct care staff on Point of Care (POC). The policy also states that all documentation was to be completed prior to the end of the shift.

The Point of Care (POC) documentation by PSWs was incomplete for resident #001.
- There was no documentation related to the resident receiving a bath on specific dates in July 2014.
- There was no documentation related to an Incontinent Program, specifically toileting before and after meals and at bedtime.
- There was no documentation related to the resident's ability to dress during specific dates in July 2014.

- The staff were expected to walk the resident to the dining room using the walker three times per day at meal times. There was incomplete documentation for eight days in July 2014.

The Point of Care (POC) documentation by PSWs was incomplete for resident #007.
- There was no documentation related to the resident's Nursing Rehab - Dressing and Grooming, and Locomotion on and off the unit for ten days in June, and five days July 2014.
- There was no documentation related to the resident eating on a specific date in June, and there was incomplete documentation for meals, primarily dinner for fifteen days in July 2014.

The Point of Care (POC) documentation by PSWs was incomplete for resident #006.
- There was no mouth care documentation in POC by PSWs for four days in July 2014.
- Mouth care was directed to be done after the resident had eaten as they were prone to thrush. The documentation for ten days in July 2014 was incomplete.
- The documentation in POC for bladder and bowel continence for two days in July 2014 reflects the resident was only changed once, however the resident was observed being changed twice on the day and evening shift. For six days in July 2014 the documentation reflects that the resident was only changed twice in 24 hours.
- The LTC Inspector observed the resident being changed during the day shift on specific dates in July 2014, however it was not documented in POC.
- The plan of care identified the resident was to have their hands washed before and after meals. The LTC Inspector observed stool under the resident's fingernails on a specific date in July 2014. The POA had previously stated to the LTC Inspector that this was an issue. There was no documentation in POC of the care provided to wash the residents hands before and after meals.
- The hourly safety checks were not documented in POC for fourteen days in July 2014.
- There was no documentation that resident was transferred using the mechanical lift and sling on the day and evening shift on three specific dates in July 2014; no documentation for the day shift on specific dates in July 2014; no documentation for the evening shift on two specific dates in July 2014. The resident was observed being transferred with the mechanical lift and sling by two PSWs on five specific dates in July 2014.
- The documentation by PSWs in POC does not reflect that the resident was turned or repositioned every two hours as outlined in the plan of care for fourteen days in July 2014.

The PSWs confirmed they sometimes don't document and they were not able to identify where to find the documentation policy. The DOC confirmed that the policy provided was on a corporate shared drive and PSWs did not have access to the shared drive. The Director of Care (DOC) also confirmed that the documentation by PSWs was a concern and was incomplete for residents.

B) The licensee did not ensure that the policy named "Skin and Wound Care" was complied with. The policy directs staff to reassess the resident and the wound weekly or more often if indicated. Resident #009 and #011 did not receive weekly skin assessments for identified wounds according to the policy and this was confirmed by the DOC.

C) The licensee did not ensure the policy named "Use of Personal Assistance Service Devices (PASDs) was complied with. The policy directs staff to do the following: complete an assessment of the resident and obtain approval by a physician, registered nurse, registered practical nurse, member of the College of Occupational Therapists of Ontario or a member of the College of Physiotherapists of Ontario, complete the assessment collaboratively with an interdisciplinary team, obtain informed consent from the resident or substitute decision maker and develop a plan of care that includes a description of the device that was being authorized and instructions relating to the order, purpose, when it will be used, how it will be used, how long it will be used, and duration and frequency of use. Resident #002, #006 and #007 did not have any of the above items completed, as identified in the home's policy.

D) The licensee failed to ensure the policy "Safety Device-Bed Rails" last revised July 2001 was complied with. The policy directed staff to obtain a consent from the resident or substitute decision maker if the bed rails were requested to be left down. The policy also identifies bed rails were standard equipment on a bed and directs staff to use two bed rails when in bed, unless otherwise indicated on the plan of care to be put down.

E) The licensee failed to implement the procedures and schedules that were required to ensure that their organized program of maintenance services under clause 15 (1) (c) of the Act were in compliance.

The maintenance person was interviewed in July 2014 and reported that they worked part-time, working either 2 or 3 days per week between both the long-term care home

and the retirement home. The majority of his work was remedial in nature with some additional duties related to special projects and preventive checks. They explained that remedial maintenance requests were identified by nursing and management staff and written down in a maintenance log which they reviewed and attempted to repair during their scheduled visits.

The maintenance manual contained a preventive inspection check list for numerous home interior and exterior surfaces and equipment to be inspected on a daily basis. The maintenance policies and procedures for preventive and remedial maintenance were outdated, last revised in October 2003. The procedures were not specific and stated that "the maintenance person is responsible to maintain the above by checking the maintenance request book each day" and that "deterioration should be attended to". No guidance was provided in the procedures as to what exactly needed to be done to ensure that the home, equipment and furnishings were kept in good condition and that manufacturer's recommendations were to be followed. The expectation of the home's policies with respect to maintaining the home was that the maintenance requests be checked "each day". However, no maintenance staff were present each day to check the requests and no other staff assessed the maintenance requests to ensure that they were addressed, especially those that were essential for resident care and services.

Evidence of poorly managed remedial maintenance was identified by reviewing the maintenance request logs. Numerous items were identified by staff for repair and were documented and dated. The maintenance person signed and dated the repairs. A toilet leak was identified in room #43 in April 2014 and was not repaired for eight days. The four residents who used the toilet had to use other toilets within the home for nine days. A toilet was plugged for seven days in May 2014. A grab bar needed to be attached in room #4 in March 2014, but was not attached until six days later. A toilet seat in washroom #18 was loose in May 2014 and was not repaired until eight days later. The above examples were not managed on a "daily" basis as expected by the licensee's own policies.

A tour of the home was completed on specific dates in July 2014, and at which time the following maintenance related issues were observed and schedules had not been developed to address their repair.

i) Bathroom doors in resident rooms #33, 29 and 28, were observed to be in a poor state of repair. A plastic beige material had been applied to the lower half of the doors with screws. The material was cracked and split with sharp edges.

ii) Bathroom door trim and mill work was badly gouged or missing. i.e #26, 45, 18
iii) The exterior front door to the home was observed to be warped and not functioning properly. The striker plate and latch were not connecting when tested. The exterior door leading into the courtyard from the dining room could not latch properly.
iv) Night tables in rooms #36, 37, 25, 1, 4, 8, 43, 13 were in bad condition, with the top exterior edges eroded away exposing the rough particle board underneath.v) Electrical outlet covers were rusty in bathrooms #5, 11, 36, 43, 45
v) The flooring material was bubbled and lifting in the short corridor tub room.
vi) The outdoor courtyard was laid with paving stones which were loose and in some areas lying in a depression or hole. The General Manager was aware of the condition of the paving stones but did not have any confirmed dates or schedules in place for repairs.
vii) The walls were in poor condition in the short corridor tub room. Two large holes were observed behind the tub and 4 ceramic tiles were broken along one wall (behind baseboard).
viii) The resident-staff communication and response system activation stations in resident rooms were not in good condition. The cover plates for the stations were cracked and/or missing over the "cancel" button in rooms 36, 26, 7, 45 and other rooms. (120)

F) The licensee failed to ensure that the policy named "Use of Personal Assistance Service Devices (PASDs) was complied with. The policy directs staff to ensure the residents care plan must indicate how, when and why the device was to be used as a support to promote independence and quality of life. The policy also identifies a bed rail of any size used as an example of a PASD, must be approved by a regulated health professional and was to be completed collaboratively by an interdisciplinary team and includes informed consent for the use of the treatment. The assessment must include alternatives tried and why they were not suitable. The care plan must be developed to include how the PASD was to be used. Documentation must include all of the above and an evaluation of the use of the PASD. Resident #002, #006, #007 were observed in bed using various bed rails and transfer poles and none of the above items were included in their plans of care. This was confirmed by the Restorative Aide, Physiotherapist and Director of Care. (169)

G) The policy named "Thickened Fluids", #NM-5.280, revised in February, 2014, directs staff responsible for thickening fluids to follow manufacturer's preparation guidelines carefully for amount of thickener to add to fluids for desired thickness. The policy further instructs staff delivering snacks to follow manufacturer's recommendations carefully to thicken fluids. The policy also states that ongoing

education was to be provided on proper fluid thickening techniques. (584)

In July 2014 the LTC Inspector observed resident #021 at lunch. The resident's diet order specified pudding-thick fluids. The fluids provided to the resident were of nectar to honey-thick consistencies. Interview with the Health Care Aide (HCA) feeding the resident confirmed that fluids were usually provided at a consistency that was too thin for the resident. The HCA proceeded to thicken the fluids at the table, creating a lumpy fluid mixture that needed to be stirred for fifteen minutes to reduce the lumps and improve appearance and palatability. The HCA did not have access to thickening instructions at point of service and confirmed that thickening was a trial and error process.

Dietary staff confirmed they did not have detailed instructions available in the kitchen and used an estimated recipe for creating thickened fluids. The Food Services Manager (FSM) confirmed that the particular thickener had been used by the home for a year and no manufacturer's instructions were available for the duration of usage of the product. The FSM confirmed that dietary and nursing staff that prepared and served the thickened fluids did not have access to manufacturer's directions to follow for creating appropriate consistencies. Specific manufacturer's instructions were requested by the inspector on a specific date in July 2014; the licensee did not obtain instructions from the manufacturer as requested.

No record of staff training on fluid thickening procedures could be found. The FSM confirmed that staff did not receive training on thickening fluids.

H) The policy named "Food Storage", #B-25, and revised November 2007, directs staff to store loose dry products in labelled containers with tight fitting lids.

On specific date in July 2014, the LTC inspector noted a 22.7 kilogram bag of modified food starch stored in the dietary storage room. The bag's seal was broken, with the top widely exposing the dry contents to air. Dietary staff and the Food Services Manager (FSM) confirmed that this storage method was inappropriate. The FSM further confirmed that the storage method did not follow the home's policy for storage of dry foods.

I) The policy named "Monitoring Residents' Weight and Height", number NM-5.100 and revised February 2014, directs health care staff to complete and enter each resident's weight into Point Click Care (PCC) by the 10th of each month, to compare the weight value to the previous month's weight and re-weigh the resident if a change

of greater than 2.5 kilograms was noted. The policy further directs staff to strike out the previous weight after a re-weigh was obtained.

The home's Monthly Weight Report, for January to July, 2014, was reviewed for all residents with two or more weight values recorded during the time period. Weight changes greater than 2.5 kilograms were documented for 24 out of 69 residents (35%). Recorded re-weigh values and correction of record were not documented for 22 out of the 24 identified residents (92%). Staff confirmed that re-weights were not obtained and recorded as per policy.

J) The policy named "Hydration Management", number 5.130 and revised February 2014, directs staff to reassess residents' needs at a minimum quarterly, provide additional fluids during warmer months, document ongoing failure to meet individual fluid requirements in the care plan and to consider alternative treatments such as hypodermoclysis or intravenous therapy if ongoing failure to meet hydration goals was noted.

Clinical records for resident #023 were reviewed. The resident consumed an average of 48% of their calculated daily fluid requirement for three months, from April 19 to July 18, 2014. Fluid interventions had not been updated since November 25, 2013. Nursing documentation regarding low fluid intake was limited to days when less than 50% of the resident's fluid requirement (550 millilitres per day) was consumed. The interventions did not change from the previous ones of monitoring and encouraging fluids. A Registered Dietitian assessment was reviewed. An ongoing intake of below 50% of calculated daily fluid requirements was noted, without further recommendations to address the potential dehydration. No consideration of alternative hydration treatment was documented.

A review of fluid records for a three week period from June to July 2014 for all residents indicated that meal and snack fluid intake was not consistently recorded. Up to 38% of fluid intake at meals and up to 100% of fluid intake at snacks was not recorded for individual residents. An interview with the home's Registered Dietitian (RD) confirmed that fluid intake records were unreliable due to incomplete fluid records, making it difficult to conduct accurate hydration assessments. (584) [s. 8. (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 any plan, policy, protocol, procedure, strategy or system that is in place in the home is in compliance with, and is implemented in accordance with all applicable requirements under the Act, is complied with, and where the Act or Regulation requires the licensee to keep a record, the licensee shall ensure that the record is kept in a readable and usable format that allows a complete copy of the record to be readily produced, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee did not ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

A) On a specific date in July 2014 the evening PSWs identified they would not have enough Polident tablets to provide denture care to residents at bedtime. The home's process for resident supplies was reviewed with the PSWs, RN and DOC. The stock was reviewed and only a couple of tablets were found in the home's stock. The DOC was contacted and confirmed the shortage of dental supplies.

B) On a specific date in July 2014 the evening PSWs identified they would not have enough incontinent supplies for the evening shift, night shift and part of the following day shift until the new supplies were delivered. The supply process and stock for incontinent supplies were reviewed with the staff. There was less than ten disposable wipes available for incontinent residents. The PSWs, RPNs and RNs confirmed that they were not aware of the contingency supplies, and that these supplies were not readily available at the home to meet the nursing and personal care needs of residents. The DOC confirmed the incontinent supplies were not readily available to staff. [s. 44.]

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 supplies, equipment and devices are readily available in the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

Issued on this 4 day of June 2015 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : KATHLEEN MILLAR (527) - (A1)

Inspection No. / No de l'inspection : 2014_266527_0015 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-000832-14, H-000699-14 (A1)

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

Report Date(s) / Date(s) du Rapport : Jun 04, 2015;(A1)

Licensee / Titulaire de permis : PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
1090 MORAND STREET, WINDSOR, ON, N9G-1J6

LTC Home / Foyer de SLD : SHELBURNE NURSING HOME, DIVISION OF PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
200 ROBERT STREET, SHELBURNE, ON, 000-000

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

Ministère 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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Heidi Vanderhorst

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To PROVINCIAL NURSING HOME LIMITED PARTNERSHIP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 shall:

1. Mitigate immediately any entrapment risks to residents who currently sleep on a therapeutic mattress.
2. Develop a formal tool/form that incorporates the guidelines in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospital, Long Term Care Facilities, and Home Care Settings, April 2003".
3. Assess all residents using the tool/form, beginning with residents who are at most risk for entrapment.
4. Update all resident care plans to include whether bed rails are used, how many, which side of the bed and the reason. Include the use of any interventions such as bed accessories if the bed has not passed all entrapment zones.
5. Educate all staff who provide care to residents on bed safety, bed rail use and entrapment zones.

Grounds / Motifs :

1. The residents were not assessed in accordance with prevailing practices to minimize bed entrapment risk to the resident where bed rails were used. Prevailing practices includes but is not limited to a document endorsed by Health Canada titled “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003”, developed by the Federal Drug and Food Administration.

According to the Resident Care Coordinator, residents were not evaluated for bed rail use other than to determine if they required assistance with bed mobility or whether bed rails would be used as a restraint. The home did not incorporate the risks of bed rail use in their decision making, especially if the bed did not pass entrapment zones 1 to 4.

A) The bed for resident #006 was observed on a specific date in July 2014 to have one bed rail elevated. The resident's plan of care did not have any information regarding their need for a bed rail and when it was to be used.

B) The bed for resident #050 was observed on a specific date in July 2014 to have a therapeutic mattress on the frame and one bed rail elevated. The resident's plan of care identified that the resident was at risk for skin integrity but did not have any information regarding their specialized mattress or their need for a bed rail and why.

C) The bed for resident #051 was observed on a specific date in July 2014 to have a therapeutic mattress on the frame and one bed rail elevated. The resident's plan of care identified that the resident was at risk for skin integrity but did not have any information regarding their specialized mattress or their need for a bed rail and why.

D) Resident #009 was observed sleeping on a therapeutic air mattress on a specific date in July 2014 without any gap fillers or bolsters between the elevated assist rails. The resident's plan of care did not have any information about their therapeutic mattress or that they required bed rails. (120)

2. Where bed rails were in use, steps were not taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident bed systems were assessed for entrapment zone risks in 2011 by a representative from a bed supplier. However, no documentation could be provided to identify which beds were tested for entrapment zones and their status. According to the Restorative Care Coordinator, who was given the task to monitor the beds, many of the beds failed one or more zones of entrapment. In October 2013, another bed safety audit was completed, however the records did not establish who did the audit or the date and the status of all sixty beds. Twenty-four out of the sixty beds passed all four entrapment zones, eight were identified as failing one or more zones of entrapment and the rest of the beds did not have any information as to their status.

According to the Restorative Care Coordinator, many of the beds and mattresses had been replaced between 2011 and October 2013. The most current audit form was not updated and the beds were not re-tested when a change was made to the bed system. The management staff were therefore unable to confirm the safety status of any of the beds.

A) During the inspection, two resident beds identified as “Hill-Rom” beds had elevated bed rails and were ready for use in rooms #33 and #13. Both of these beds also had split rails (zone 5 entrapment risk) attached to the frames. Both sets of bed rails had a large gap within the opening of the rails (zone 1 entrapment risk). No steps had been taken to ensure that the zones would not pose a risk to the residents using the bed rails.

B) Resident #009 was observed sleeping on a therapeutic air mattress with both of their assist rails in the guard or raised position. No bolsters were in place at the time to prevent zone 2, 3 and 4 entrapment risks.

C) The height of the bed rails in rooms #11 and #45 was the same as the height of the therapeutic mattresses on the bed frames. Both sets of rails were in the elevated position. The bed rails were not assessed to determine if residents were at risk of possible injury such as rolling over the top of the bed rail or if the resident or staff were able to grab the rail to reposition themselves. In addition, neither of the air mattresses were equipped with bolsters and no accessories were observed on the resident beds that could reduce entrapment between the bed rail and the soft air mattress.

D) All of the beds in rooms #5, 8 and 45 had at least one bed rail in the elevated position when residents were out of bed. Bed rails were automatically being left in the

raised position throughout the day, regardless of actual assessed need. Residents independently returning to bed that did not pass all four zones of entrapment would be at an increased risk due to the elevated bed rails. (120)

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

Dec 31, 2014

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 shall:

1. Test all bed systems using the appropriate measuring tool and procedures as described in the Health Canada Guidelines titled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and other Hazards, March 17, 2008".

2. Keep a record of the results of the tests including at a minimum the date tested, the name of the tester, the serial number or unique identifying number for the bed and the specific zones that passed or failed.

3. Prepare and submit a plan that includes how the beds that failed one or more entrapment zones will be modified to ensure that they do not pose a risk to the resident using the bed rails. The plan shall be emailed to Bernadette Susnik (Bernadette.susnik@ontario.ca) by December 31, 2014.

Grounds / Motifs :

1. The residents were not assessed in accordance with prevailing practices to minimize bed entrapment risk to the resident where bed rails were used. Prevailing practices includes but is not limited to a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", developed by the Federal Drug and Food Administration.

According to the Resident Care Co-ordinator, residents were not evaluated for bed rail use other than to determine if they required assistance with bed mobility or whether bed rails would be used as a restraint. The home did not incorporate the risks of bed rail use in their decision making, especially if the bed did not pass entrapment zones 1 to 4.

A) The bed for resident #006 was observed on a specific date in July 2014 to have one bed rail elevated. The resident's plan of care did not have any information regarding their need for a bed rail and when it was to be used.

B) The bed for resident #050 was observed on a specific date in July 2014 to have a therapeutic mattress on the frame and one bed rail elevated. The resident's plan of care identified that the resident was at risk for skin integrity but did not have any information regarding their specialized mattress or their need for a bed rail and why.

C) The bed for resident #051 was observed on a specific date in July 2014 to have a therapeutic mattress on the frame and one bed rail elevated. The resident's plan of care identified that the resident was at risk for skin integrity but did not have any information regarding their specialized mattress or their need for a bed rail and why.

D) Resident #009 was observed sleeping on a therapeutic air mattress on a specific date in July 2014 without any gap fillers or bolsters between the elevated assist rails. The resident's plan of care did not have any information about their therapeutic mattress or that they required bed rails. (120)

2. Where bed rails were in use, steps were not taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident bed systems were assessed for entrapment zone risks in 2011 by a representative from a bed supplier. However, no documentation could be provided to identify which beds were tested for entrapment zones and their status. According to the Restorative Care Coordinator, who was given the task to monitor the beds, many of the beds failed one or more zones of entrapment. In October 2013, another bed safety audit was completed, however the records did not establish who did the audit or the date and the status of all sixty beds. Twenty-four out of the sixty beds passed all four entrapment zones, eight were identified as failing one or more zones of entrapment and the rest of the beds did not have any information as to their status.

According to the Restorative Care Coordinator, many of the beds and mattresses had been replaced between 2011 and October 2013. The most current audit form was not updated and the beds were not re-tested when a change was made to the bed system. The management staff were therefore unable to confirm the safety status of any of the beds.

A) During the inspection, two resident beds identified as “Hill-Rom” beds had elevated bed rails and were ready for use in specific resident rooms. Both of these beds also had split rails (zone 5 entrapment risk) attached to the frames. Both sets of bed rails had a large gap within the opening of the rails (zone 1 entrapment risk). No steps had been taken to ensure that the zones would not pose a risk to the residents using the bed rails.

B) Resident #009 was observed sleeping on a therapeutic air mattress with both of their assist rails in the guard or raised position. No bolsters were in place at the time to prevent zone 2, 3 and 4 entrapment risks.

C) The height of the bed rails in two specific resident rooms was the same as the height of the therapeutic mattresses on the bed frames. Both sets of rails were in the elevated position. The bed rails were not assessed to determine if residents were at risk of possible injury such as rolling over the top of the bed rail or if the resident or staff were able to grab the rail to reposition themselves. In addition, neither of the air mattresses were equipped with bolsters and no accessories were observed on the resident beds that could reduce entrapment between the bed rail and the soft air mattress.

D) All of the beds in three resident rooms had at least one bed rail in the elevated position when residents were out of bed. Bed rails were automatically being left in the

raised position throughout the day, regardless of actual assessed need. Residents independently returning to bed that did not pass all four zones of entrapment would be at an increased risk due to the elevated bed rails. (120)

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

Dec 31, 2014

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

1. Prepare and submit a plan that ensures there is a written plan of care for each resident.
2. Ensure the written plan of care includes the planned care for the resident, and the goals the care is intended to achieve.
3. Ensure the written plan of care provides clear directions to staff and others who provide direct care to the resident.
4. Educate direct care providers on the requirements and expectations related to the components and documentation of the residents' written plan of care.
5. Establish and audit to monitor that the residents' written plan of care is up-to-date and reflects the needs and preferences of the resident.
6. Incorporate into the homes quality improvement program a monitoring and evaluation process to determine the effectiveness of the written plan of care in achieving the goals the care is intended to achieve, the residents' outcomes, and the clarity of the plan for staff who are providing the care.

The plan shall be submitted to Kathy Millar, LTC Inspector by January 9, 2015 via email at kathy.millar@ontario.ca.

Grounds / Motifs :

1. The licensee did not ensure that the written plan of care for residents provided clear directions to staff and others who provide direct care.

A) The plan of care stated that resident #001 needed extensive assistance by one person for dressing. The Minimum Data Set (MDS) assessment from May 2014 identified the resident was totally dependent with one person assisting for dressing. In addition, the plan of care identified the resident needed intermittent supervision with repetitive cues and assistance with personal hygiene. The MDS assessment from May 26, 2014 identified the resident required extensive assistance with one person. The Long Term Care (LTC) Inspector observed staff supervising and cuing the resident when providing care on three specific dates in July 2014. The PSWs confirmed that the written plan of care was confusing. (527)

B) Based on the MDS assessment completed on December 2013, February and May 12, 2014 the plan of care for resident #006 identified the resident required a medium

brief for bladder and bowel incontinence. The resident was also noted as gaining weight at all three assessment periods, however the sizing for the brief for the resident had not changed in the plan of care. The RN, RPNs and PSWs confirmed that the resident required a large brief. The LTC Inspector observed the resident wearing a large brief. The home's Continence Management Program 2014 listing of residents' type and size of incontinence products identified that staff was supplied with a large night brief for resident #006 for all shifts. Staff confirmed they were not aware the plan of care was not updated and confirmed it was unclear. (527)

C) Resident #006 was observed with two-half bed rails up while in bed on two specific dates in July 2014. The plan of care and the document the home refers to as a kardex, which was used by the PSWs, did not provide any direction for the use of the bed rails while the resident was in bed. This was confirmed by the Director of Care and Physiotherapist. (169)

D) Resident #007 was observed in bed on two specific dates in July 2014 with two quarter bed rails in the up position by the head of the bed. The plan of care and the kardex did not identify the use of bed rails or provide any direction to staff when to use them. This was confirmed by the Restorative Aide, Director of Care and Physiotherapist. (169)

E) Resident #002 was observed with quarter bed rail in the up position and a transfer pole on the opposite side of the bed. The plan of care did not identify the use of the bed rail or the transfer pole and did not provide any direction to the personal support workers. This was confirmed by the Restorative Aide, Physiotherapist and Director of Care. (169) (527)

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

Feb 06, 2015

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee shall:

1. Prepare and submit a plan that ensures each residents' plan of care is based on an assessment of the resident and needs and preferences as it relates to falls and the need for bed rails.
2. Ensure there is documentation of the assessments and interventions implemented in each residents' clinical record.
3. Update all resident care plans to include the goals and interventions based on the assessments for falls and the need for bed rails.
4. Educate direct care providers on the documentation requirements for assessments of residents.
5. Establish an audit process to monitor the assessments conducted, the documentation, and the implementation of interventions for falls and bed rails.
6. Incorporate into the homes quality improvement program a monitoring and evaluation component to determine the effectiveness of the assessments and outcomes related to falls and the use of bed rails to enhance the quality and safety of resident care.

The plan shall be submitted to Kathy Millar, LTC Inspector by January 9, 2015 at kathy.millar@ontario.ca.

Grounds / Motifs :

1. The licensee failed to ensure that the plan of care was based on an assessment of the resident's needs.

A) Resident #006 was identified as high risk for falls by the nursing staff, however there were no assessments completed to determine the risk for falls for the past six months. Resident #006 was observed with two half bed rails in the up position while in bed on two specific dates in July 2014. The registered nursing staff and the lack of documentation confirmed there was no fall assessments completed. (169)

B) Resident #007 was observed using two quarter bed rails while in bed on two a specific dates in July 2014. The plan of care did not include an assessment of the resident's needs for bed rails. The Restorative Aide, Director of Care and Physiotherapist confirmed an assessment was not completed. (169)

C) Resident #002 was observed with a quarter bed rail in the up position and a transfer pole on the opposite side of the bed on two a specific dates in July 2014, while in bed. The plan of care did not include an assessment of the resident's needs. This was confirmed by lack of documentation in the clinical record and interviews with the Restorative Aide, Physiotherapist and Director of Care. (169)

D) The home has had ongoing non-compliance with a VPC for s. 6 on November 20, 2012 and December 5, 2013. In addition, there was actual harm or risk to residents and the scope was widespread. (527)

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

Feb 06, 2015

Order # / Ordre no : 005 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

1. Ensure that the care set out in the plan of care is provided to each resident as specified in their plan.
2. Monitor through observation and documentation audits the implementation of interventions based on the residents' individualized assessments as outlined in their plan.
3. Educate staff on resident safety and risks that could occur as a result of not providing care to the residents' based on their individualized assessments of their needs and preferences.
4. Monitor and evaluate to ensure that care is being provided as outlined in the residents' plan of care and to determine the effectiveness of the education and practice changes.

The plan shall be submitted to Kathy Millar, LTC Inspector by January 9, 2015 via email at kathy.millar@ontario.ca.

Grounds / Motifs :

1. The licensee did not ensure that the care set out in the plan of care was provided as specified in the plan.

A) The MDS assessments completed December 2013, March and May 2014 identified that resident #001 had the potential ability to restore function related to urinary incontinence. The interventions identified an Incontinent Program for the resident to be toileted before and after meals and at bed time, not to leave the

resident unsupervised, to use verbal reminders for urine control, to use a day pad during the day, evening and a brief to sleep. The PSWs, RN and RPNs confirmed they were not aware the resident was on an Incontinent Program and did not know the specific interventions on the plan of care. The PSWs confirmed the resident wears a medium brief, which they check before or after meals and at bedtime, and change if necessary. They stated they only put the resident on the toilet after lunch for a bowel movement and not for urinary continence. There was no documentation on the clinical record related to establishing a urine elimination routine, urinary patterns or toileting regimen. (527)

B) Resident #011 was required to have a dressing change completed weekly. The treatment sheets were reviewed and indicated resident #011 did not receive dressing changes on specific dates in May, June and July 2014. The wound documentation revealed the wound had a history of severe bleeding, clots and a foul odour. The plan of care directs staff to leave the resident when they resist and to try again at a later time. Based on a review of the clinical record and interviews with staff, they did not attempt to complete the dressing change on the following shift or the following day. This was confirmed by the Director of Care.(169)

C) On a specific date in June 2014 resident #007 was assessed for toileting. The assessment identified the resident needed extensive assistance with the support of one staff; however the plan of care identified the resident needed total assistance by two staff for the entire process of toileting. The PSWs were observed providing total assistance by two staff when toileting the resident. The care provided was contrary to the resident's improvement and potential to restore function to maximum self-sufficiency for toileting as identified in the assessment. The RN, RPNs and PSWs confirmed they where not aware of the improvements noted in the June assessment, and also confirmed the resident was not on a toileting routine. (527)

D) On a specific date in June 2014 resident #007 was assessed as being high risk for falls and was placed on a Falls Prevention Program. The assessment identified the resident needs extensive assistance with two staff physically assisting to transfer. The plan of care identified the resident needed only one staff to assist for transfers. PSWs were observed transferring the resident with one staff member. The staff confirmed that one staff was required to assist the resident when transferring. The PSWs confirmed they knew the resident was at risk for falls and was on the Falls Prevention Program, but were not aware of what the interventions were on the plan of care. (527)

E) Resident #034 stated that they did not receive assistance to go to bed one evening until very late. The resident was unable to remember the date, however stated it was within the past two weeks. The resident states that they were told that the home was short staffed on evenings and they were unable to assist her to bed at her usual time. The resident's choice and preference was to go to bed at a specific time each evening. The staff confirmed that because they were short staffed, resident #034 did not get to go to bed until very late into the evening.

On a specific date in July 2014 resident #034 stated they waited fifteen minutes after ringing the call bell for assistance to the toilet. Before getting the assistance to go to the bathroom, the resident was incontinent in their brief. The resident stated they didn't like it and felt awful. The PSWs confirmed they were not able to assist the resident within a reasonable time as they were short staffed. (527)

F) On a specific date in July 2014 resident #035 stated they did not receive their bath in the evening. Reviewed the staff schedule and compared it to the number of staff that worked, it was identified that the evening shift was short staffed by one PSW. The RPN and PSWs confirmed the resident did not receive their bath because they were short a PSW on the evening shift. (527)

G) On a specific date in July 2014 resident #036 stated that they rang the nursing call bell for assistance to go to the bathroom. The resident stated it took over fifteen minutes for the nurse to respond, which resulted in them being incontinent. The resident stated they felt terrible and felt like a baby, but they were told by staff that the home was short staffed. Confirmed with the PSWs and Registered staff that they were short staffed a PSW on the evening shift, and they were unable to answer the residents' call bell within a reasonable amount of time. (527)

H) The home has had ongoing non-compliance with a VPC for s. 6 on November 20, 2012 and December 5, 2013. In addition, there was actual harm or risk to residents and the scope was widespread. (527)

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

Feb 06, 2015

Order # / Ordre no : 006 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall:

1. Prepare and submit a plan that ensures each resident is reassessed and the plan of care reviewed and revised at any time when (c) care set out in the plan of care has not been effective.
2. Establish a process to assist the interdisciplinary team in identifying when are needs have changed and/or when care set out in the plan of care has not been effective.
3. Educate staff on strategies to identify when care is not effective and the requirements to update the plan of care.
4. Monitor to ensure strategies and processes implemented are effective.

The plan shall be submitted to Kathy Millar, LTC Inspector by January 9, 2015 via email at kathy.millar@ontario.ca.

Grounds / Motifs :

1. The licensee did not ensure that Resident #022 and Resident #023 were reassessed and the plan of care reviewed and revised at any other time when care set out in the plan had not been effective.

A) Clinical records for Resident #023 were reviewed. The resident consumed an average of 532 millilitres of fluid daily, or 48% of their calculated requirement of 1100 millilitres daily, for three months, from April to July 2014. The resident's plan of care directed staff to push and encourage fluids due to resident being at high nutritional and heat related illness risk as well as at risk for constipation. Fluid interventions were last updated in November 2013. The plan of care was not reviewed and revised when care set out in the plan had not been effective. (584)

B) Clinical records for Resident #022 were reviewed. The Registered Dietitian's (RD) quarterly assessments from September 2013 to April 2014 indicated that the resident experienced ongoing poor fluid intake of 50% to 70% of their calculated fluid intake with no change to hydration interventions. The RD specified to continue with current interventions when the hydration plan of care had not been effective in meeting the resident's fluid goals for seven months. (584)

C) The home has had ongoing non-compliance with a VPC for s. 6 on November 20, 2012 and December 5, 2013. In addition, there was actual harm or risk to residents and the scope was widespread. (527)

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

Feb 06, 2015

Order # / Ordre no : 007 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in

accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall:

1. Ensure that Residents' Rights are fully respected and promoted.
2. Ensure that each residents' accommodation is equipped with privacy curtains to provide 100 per cent privacy for each resident of the home.
3. Ensure that each tub room is equipped with privacy curtains to provide 100 per cent privacy when the tub room door is opened.
4. Ensure staff are required to use privacy curtains to maintain privacy for residents at all times.
5. Ensure that each resident is provided with privacy when care is being provided, including bathing, transferring, and treatment.
6. Ensure that residents personal health information is kept confidential at all times.
7. Educate all staff on Residents' Bill of Rights annually.
8. Check all resident care areas to ensure there are privacy curtains, and to ensure they are in good working order to provide 100 per cent privacy for residents.
9. Monitor staff performance to ensure that residents' privacy is provided when providing care and when discussing personal health information.

The plan shall be submitted to Kathy Millar, LTC Inspector by January 9, 2015 via email at kathy.millar@ontario.ca.

Grounds / Motifs :

1. The licensee failed to ensure that every resident had the right to be afforded privacy in treatment and in caring for his or her personal needs. Resident rooms where ceiling lift tracks were installed (i.e. #1, 4, 25, 36) had privacy curtains that could not be closed fully around the bed resulting in a lack of privacy for each resident. The entrance to the tub room in the long corridor did not have a privacy curtain that would provide privacy to residents in the tub when the door was opened. (120)

2. The licensee did not fully respect and promote residents' #013, #014, #031, #032 and #033 right to be afforded privacy in treatment and in caring for their personal needs.

A) On a specific date in July 2014 the LTC Inspector observed resident #013 being

administered insulin into their abdomen by the registered nursing staff, while they were at the main entrance of the home and in full view of all visitors entering the home. The resident's shirt was lifted and the abdomen was exposed. (169)

B) On a specific date in July 2014 the LTC Inspector observed resident #014 being put into bed using a mechanical lift by PSWs. The resident was yelling at the staff and care was being provided to the resident. The curtains were not pulled around the resident while care was provided. The LTC Inspector observed care being provided to the resident from the hallway. (169)

C) On a specific date in July 2014 resident #032 was in the tub room for a bath. The PSW opened the door and did not draw the curtains to ensure the resident had privacy in caring for his personal needs. The LTC Inspector observed the resident up in the chair lift with no clothes on with the door open and no privacy curtains drawn. The PSWs confirmed they forgot to draw the privacy curtains. (527)

D) On a specific date in July 2014 the LTC Inspector observed resident #031 in the sling of a mechanical lift being transferred from the bed into the wheelchair. Three PSWs were in attendance to assist the resident, the resident's room door was open and no privacy curtains were drawn. The resident was not afforded the privacy in caring for his personal needs. (527)

E) On a specific date in July 2014 the LTC Inspector observed resident #033 in the sling of a mechanical lift while being transferred from the bed into the wheelchair. Two PSWs were in attendance to assist the resident, the resident's room door was open and no privacy curtains were drawn. The resident was not afforded the privacy in caring for her personal needs. (527)

3. The licensee failed to ensure that the rights of all residents in the home were promoted including the right to have his or her personal health information kept confidential.

A) On each day of the Resident Quality Inspection (RQI), the inspectors observed and overheard personal health information of various residents being discussed throughout the day. The main nursing station, located at the main entrance does not afford an area for privacy when discussions regarding resident care occur within the interdisciplinary team. During physician rounds, the doctor and health care team would discuss personal health information for various residents and it was overheard

by the inspectors in the Director of Care's office, which was down the hallway. Also, nursing staff would discuss various resident care issues across the nursing station in the hallway, which could also be overheard by the inspectors. Families would also come to the nursing station to discuss care related concerns about residents and this was also overheard by the inspectors throughout the inspection.

The main nursing station, where the residents' clinical records were kept does not afford privacy for the health care team to discuss pertinent health related matters without being overheard by visitors entering the home or anyone in the near vicinity. This was confirmed by visitors and nursing staff.

4. The order was issued as a non-compliance as there was actual harm or risk to residents and it was widespread in the home. (527)

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

Feb 06, 2015

Order # /
Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident’s admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident’s condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall:

1. Prepare and submit a plan that ensures all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff.
2. Review the home's Skin and Wound Care Program policies and procedures to ensure they incorporate clear expectations related to skin and wound assessments by registered nursing staff.
3. Educate registered nursing staff on the Skin and Wound Care Program with a focus on assessments, when assessments are required, communication of assessments, the need to update the plan of care based on the assessments, and the documentation requirements.
4. Monitor and evaluate skin and wound care issues in the home. Incorporate the outcome into the quarterly and annual program plan, and the home's quality improvement program.

The plan shall be submitted to Kathy Millar, LTC Inspector by January 9, 2015 via email at kathy.millar@ontario.ca.

Grounds / Motifs :

1. The licensee did not ensure resident #011 received a weekly wound reassessment by a member of the registered nursing staff for a wound. In May 2014 the wound was assessed by an RPN, but was not subsequently reassessed for six weeks. The wound was a chronic wound and there was no current assessment of the status of the wound. The Director of Care confirmed the lack of weekly assessments. (169)

2. The licensee did not ensure that Resident #009 received reassessment of their wounds.

In May 2014 an assessment was completed of the right heel wound. The wound was noted to be 8.5 cm by 3 cm in size. A reassessment had not been completed to date.

In May 2014 an assessment was completed of the left heel wound. The wound was noted to be 4.5 cm by 3.3 cm in size. A reassessment occurred in June 2014 and the wound was noted to be 8cm by 7cm. The assessment was completed approximately one month later and the wound was noted to be worsening.

The buttock wounds were identified initially in June 2014 and there were no assessments completed to date to determine the status of the wounds.

The Director of Care confirmed there were no weekly assessments for any of the wounds. (169)

3. The order was issued as a non-compliance as there was actual harm or risk to residents and there was a pattern in the home. (527)

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

Feb 06, 2015

(A1)
The following Order has been rescinded:

Order # / Ordre no : 009 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks;
(b) the distribution and service of resident meals;
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 4 day of June 2015 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : KATHLEEN MILLAR - (A1)

Service Area Office / Bureau régional de services : Hamilton