Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 11, 2016	2016_397607_0010	011327-16	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

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

JULIET MANDERSON-GRAY (607), CHANTAL LAFRENIERE (194), KELLY BURNS (554), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 2-6, 2016.

During this Resident Quality Inspection (#011327-16), the following intakes were reviewed and inspected upon concurrently #009419-16, 000625-16 and 005058-16.
Summary of the Intakes:
1) #009419-15- Critical Incident Report, regarding resident to resident alleged abuse.
2) #000625-16- Complaint, regarding the home having outbreak and not following infection control protocols, resident bill of rights and care issues.
3) #005058-16 – Follow Up to a Compliance Order, specific to LTCHA, 2007 S.O. 2007. C.8, s. 6. (7)–Care set out in plan of care is not provided to resident as specified.

During the course of the inspection, the inspector(s) spoke with The Director of Care (DOC), Office Manager, Environmental Services Manager (ESM), Life Enrichment Coordinator (LEC), Nursing Administrator Supervisor, Chief Operations Officer (COO), Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist Assistants (PTA), Personal Support Workers (PSW), Family Council President, Resident Council President, Residents and Families.

During the course of the this inspection, the inspector(s) toured the home, reviewed clinical health records, observed staff to resident interactions, reviewed resident and family council meeting minutes, reviewed the homes investigations notes (specific to an identified Critical Incident Report), reviewed home specific policies related Resident Abuse Prevention, Responsive Behaviours, Continence Care and Bowel Management, Minimizing of restraints, Staff training and Orientation, Complaints Reporting Incidents of Abuse and the Maintenance Requisition Log Book.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **9 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2016_293554_0002	554

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (4) (b), by not ensuring that staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Related to Resident #026:

Resident #026 is dependent on staff for activities of daily living, and was observed in a mobility aide with a safety device fastened during three identified dates and times.

The clinical health records, for resident #026 were reviewed and the following were noted on two identified dates:

1) Physiotherapy Assessment – The Physiotherapist indicated, resident #026's safety device will be removed after the mobility aide adjustments were made. Interview with the Physiotherapist indicated that this was communicated to the Director of Care (DOC).
2) A dump (a mobility aide adjustment, made to prevent a resident from falling) will be added to resident's mobility aide to help prevent falls and improve resident's posture.
3) The Mobility Aide Technician was in yesterday and has made adjustments to resident's mobility aide; resident had been leaning forward while in the device, this causes concern. An Intervention was put in place to decrease falls.
4) The safety device should not be in place at any time.
5) Physician Medication Review, for a three month time period, signed by the attending Physician on an identified date, directed that resident #026 may use safety device while in mobility aide to prevent falls and for safety.
6) Safety device form for a nine identified dates, indicated that a safety device was in place for resident #026 on both the day and evening shifts, as evidenced by the signage for application, release, resident's response signed hourly by PSWs, and the assessed need signed every shift by registered nursing staff.

Interviews with Personal Support Worker (PSW) #109 and Registered Practical Nurse (RPN) #100 both indicated that the resident utilizes a mobility aide for safety, specifically to prevent falls.

The Physiotherapist indicated that concerns regarding resident #026 leaning forward in the resident's mobility aide and the potential risk were discussed with the DOC on an

identified date, and a decision was made to adjust the resident mobility aide; once adjustments were made, the safety device in place was not to be used and this was communicated to the DOC during meetings on three identified dates.

The DOC acknowledged being aware of the above identified concerns brought forward by the Physiotherapist and further indicated that this was communicated verbally to a registered nursing staff member, but could not recall which nurse this was relayed to. She also mentioned that the above information may not have been properly communicated to the attending physician and the direct care staff, hence the reason why the safety device was still being used for this resident .

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care, so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: 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. The licensee has failed to ensure that policy (#HLHS-ECC-1.6), titled, Interventions for

Bowel and Bladder was followed.

Related to resident #028:

Review of the home's Policy (#HLHS-ECC-1.6), titled, Interventions for Bowel and Bladder revealed:

Policy:

1) Each resident shall be assessed for continence care functioning within seven days of admission, quarterly, and with any change in condition that affects continence.
2) Interventions followed to prevent and manage continence will be based on each resident's individual needs.
3) Each resident care plan shall be developed and revised as required to reflect the resident individual needs.

Procedure:

The interdisciplinary team will follow the interventions outlined below based on each and every resident's individual needs.

Responsibility:

1) It is the responsibility of the registered staff to ensure that the continence care program is followed and adhered by.
2) It is the responsibility of the Director of Care to monitor compliance.

Review of the clinical records for resident #028 reveals that specific assessments were not completed on two identified dates.

RPN #100 confirmed that an assessment related to continence care for resident #028 was not completed on three identified dates.

Interview with the DOC confirmed that the home's expectation is that every resident will have continence care assessments completed within seven days of admission, and then quarterly and with any change in condition, and that the RPN's are responsible to complete these assessments based on the Resident Assessment Instrument - Minimum Data set (RAI-MDS) schedule.

Therefore, the home did not follow its policy (#HLHS-ECC-1.6), for resident #028 by not completing these assessments. [s. 8. (1) (a)]

2. The licensee has failed to ensure that plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with related to policy (#CS-5.3), titled, Physical Restraints.

Related to resident #029:

Resident #029 who was observed on five separate days during the Resident Quality Inspection (RQI), seated in a mobility aide in an angled position.

A review of the written and the electronic Plan of care reviewed for the resident revealed the following:

1) Assessment for a safety device intervention completed by a RPN on three different dates.
2) Consent to use a safety device form was signed by the Substitute Decision Maker (SDM) on an identified date.
3) Physician's order received on an identified date, stating "angled mobility aide while seated, instead of safety device for comfort & safety as per family request" signed by Medical Director (MD).
4) "Safety Devices for resident #029 to be angled while using mobility aide for safety."

Review of the Physician Quarterly Medication reviews for continuation of order revealed that for six identified months an order was in place to angle a mobility aide for resident #029, instead of a safety device in place at the family request. Further review of the Physician Quarterly Medication reviews for another ten identified months, could not locate an order identifying that the resident should have an angled mobility aide in place.

Review of the home's policy (#CS-5.3), titled, Physical Restraint- Minimizing of restraints revealed the following:
To be completed by registered staff in accordance with Least Restraint/Last Resort policy and procedures before applying a restraint. Any existing restraints shall be reassessed monthly and with any significant change.

7. Document on the resident's clinical record shall include:

A) Assessment of restraint intervention
B) Type of restraint
C) Physician's order

8. Informed consent for the application of a restraint shall be obtained in accordance with the "Consent of Restraints" policy and policy with an annual signed renewal of consent (In the event the assessment is deemed necessary).

Interview with PSW #108 confirmed that resident #029 sits in an angled mobility aide when up, the device is to be at a specific angle, and is adjusted slightly every hour. The PSW also confirmed that staffs are to document the use of the safety device hourly on the safety device flow sheets, and that observations on the resident are completed every half hour, as well as, the resident is repositioned hourly when up in the angled mobility aide.

RPNs #100 and #111 indicated that a safety device intervention assessment is to be completed quarterly and with any significant change in status. Interview with RPN #100 and the DOC confirmed that resident #029 sits in an angled mobility aide when up and that this is documented as a safety device. They reviewed the plan of care for resident #029 and confirmed that on an identified date, was the last time a "Non-Medicinal Quarterly Review" was signed by the Physician for continuation of non-medical orders and further confirmed that there was no current order for the device for resident #029.

The DOC confirmed that it is the home's expectation that the Physician order would be signed on the “Non-Medicinal Quarterly Review” every three months, consent for the safety device be reviewed and resigned by the SDM annually, and safety device intervention assessments completed quarterly by the registered nurses.

Therefore the licensee has failed to ensure that plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with related to policy (#CS-5.3), titled, Physical Restraints. [s. 8. (1) (b)]

3. The licensee failed to comply with O. Reg. 79/10, s. 8 (1) (b), by not ensuring that where the licensee of a long-term care home is to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, is complied with, specific to the policy to minimize restraining of a resident.

Under O. Reg. 79/10, s. 109 (e), the licensee of a long term care home shall ensure

there is a written policy under section 29 of the Act that deals with, how to consent to the use of physical devices as set out in section 31 of the Act and use of Personal Assistance Devices (PASDs) as set out in section 33 of the Act is to be obtained and documented.

The home's policy, titled, Physical Restraints (Policy #CS-5.3) directed, that informed consents for the application of a safety device shall be obtained in accordance with the Consents for Restraints policy and procedures with an annual signed renewal of consent.

Related to Resident #026:

On a specified date, the health care record indicated that a physician's order was in place for safety and to prevent the resident from falling.

Resident #026 was observed with a safety device fastened on two identified dates.

PSW #109 indicated staffs apply the safety device to resident #026 and that the resident is unable to release device by self.

Review of the clinical health records, for resident #026, failed to provide documented evidence that the consent for the safety device was reviewed annually with resident #026's Substitute Decision Maker (SDM). The DOC indicated that consents specifically for safety devices are to be reviewed and signed annually by SDM`s. [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 that plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with related to policy #HLHS-ECC-1.6, titled, Interventions for Bowel and Bladder Incontinence and policy # CS-5.3, titled, Physical Restraints, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During dates of this inspection, the following was observed:

1) Walls – areas observed chipped, cracked, or gouged in resident rooms #025, #032 and #038; wall damage (holes, dry wall exposed) visible in resident bathroom, behind the toilet in resident room #025; in the spa room, located in the team four hallway; and the corner wall of alcove, which is located in the team three hallway. It was further observed that a panel of unfinished and porous piece of wood was attached to and covering the wall behind the toilet in resident #029's washroom.
2) Flooring – tiled flooring was observed chipped with pieces of the tile missing in resident #025's room; the gera-flooring in the Country Café was observed to be duct taped; there was a hole, approximately six by six, in the gera-flooring near the fire doors of the team three hallway.
3) Spa room – an area of the one piece laminate flooring, approximately two feet by two feet, had been cut into for repairs, the concrete sub-flooring was exposed; this area of the flooring from the laminate floor to the concrete was uneven, posing a trip-fall hazard; no signage was observed posted to alert of this potential hazard. This spa room was located in the team three hall.
4) Wall guard – loose in the spa room, located in the team four hall.
5) Spa room – the acrylic finish, on the bathtub, was observed chipped along the tub edges; this tub was located in the spa room on team one.
6) Counter-top vanity – laminate finish was chipped and or missing in resident #023's and #032's washrooms, and on a cupboard, located in the lounge area adjoining the

main dining room.
7) Baseboard heater – the metal covering for the baseboard was observed loose and hanging, exposing the metal edges of the rad; the heater was not on during the time of this observation. This was observed in resident #021's washroom.
8) Ceiling tiles – observed to have yellowish-brown staining in resident #013's and #029's rooms; throughout the hallway in team three.

PSW #109 and RPN #100 indicated that if staff identify areas within the home as needing repairs, they are to identify the areas in the maintenance request log binder for follow up by the Maintenance Manager.

The maintenance request log binder was reviewed for an identified time period, and failed to provide documented evidence that the above issues were identified as needing repair.

Maintenance Manager indicated the following:

1) The flooring in the spa room on an identified unit had been cut into, to repair a clogged drain; the drain issue was completed on an identified date. - The laminate flooring has not yet been repaired as it is believed that another issue within the flooring exists.
2) The acrylic finish on the tub, on an identified unit was repaired on an identified date, following the 2015 Resident Quality Inspection (RQI). The Maintenance Manager indicated not being told by staff that the acrylic finish was again chipped.
3) Being unable to replace the stained ceiling tiles as the suspended ceiling tiles are tight within the ceiling and impossible to remove; goal is to eventually paint the ceiling tiles.
4) The baseboard heater in resident room #021 is non-functioning, but acknowledged that the metal cover frequently falls off.

The Maintenance Manager indicated that some of the areas identified as needing repair, some examples are, the walls or loose wall guard was not communicated to him as needing repairs, and that staff do not consistently place needed repairs into the maintenance repair log binder.

The Administrator indicated that it is the expectation that staff who identify areas within the home as needing repairs, place such in the maintenance request log binder. [s. 15. (2) (c)].

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 26 (3)19, Safety risks, by not ensuring that the plan of care is based on, at a minimum, interdisciplinary assessment of safety risk with respect to the resident wearing a safety device.

Related to Resident #026 and #017:

Resident #026 and #017 was observed on two separate identified dates with a safety device applied inappropriately.

On a specified date, a review of the clinical records for both residents indicated that a physician's order was in place for safety and to prevent the residents from falling.

The Physiotherapy Assistant (PTA), as well as the Physiotherapist confirmed that safety devices were not applied appropriately and thus poses safety risk to the residents. [s. 26. (3) 19.]

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 by ensuring that the plan of care is based on, at a minimum, interdisciplinary assessment of safety risk with respect to the resident wearing a safety device, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 37 (1) (a), by not ensuring that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items.

The following unlabelled items were observed on identified units during dates of this inspection:

1) Spa rooms – two hair brushes containing long white hair, a disposable razor with a white substance between its blades, as well as a comb containing white hair.

PSWs #123 and #124 indicated that resident care items are to be labelled and stored in resident rooms, not in the spa rooms.

The Administrator indicated it is the expectation that all resident care items be individually labelled for resident's use and stored within resident rooms not spa rooms. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies developed were implemented to respond to resident #041's responsive behaviours.

Related to log #009419-16 for resident #041 and #038:

On an identified date, a crisis care plan was initiated (after several incidents of verbal aggression towards other residents in the dining area) and directed staff to perform fifteen minutes security checks when required.

Review of the Critical Incident Report (CIR) indicated that on an identified date and time resident #041 had an altercation with resident #038 whereby resident #038 sustained an injury.

Review of the progress notes on an identified date and time revealed:

Resident #041 pushed a co-resident's mobility aide down the hall forcefully. No injury was sustained to the resident. Resident #041 was spoken to. Will try to keep Resident #041 away from the dining room table.

In both incidents of aggression on the above identified dates, staff documented that resident #041 was observed and fifteen minute checks were in place for the resident, yet the resident was able to have incidents of aggression towards the two residents during the specified time periods documented.

Therefore licensee has failed to ensure that plan of care strategies were implemented to respond to resident #041's responsive behaviours related to every fifteen minutes check. [s.53. (4) (b)].

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that strategies developed were implemented to respond to resident #041's responsive Behaviours, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, s. 86 (2) (b), by not ensuring there are measures in place to prevent the transmission of infections.

During dates of this inspection, the following unlabelled items were observed:

1) Two urine collection devices were observed in the spa room located off of an identified unit. These devices were observed to contain a dark yellow dried substance within the inside edges. A pair of nail clipper was also observed within a plastic tote within this room; the nail clipper was observed to have a dark brown substance between the nail clipper edges; this is a communal spa room.

2) A urine collection device was observed sitting on the floor, beside the toilet in resident #029's washroom; yellow liquid was observed inside the device, as well as, a bedpan was observed on the floor, beside the toilet in resident #028's washroom; the inside edges of the bedpan contained a brownish substance. These devices were located within a shared washroom.

PSWs #123 and #124 indicated that bedpans are to be used and then cleaned and stored in the hopper room. PSW #123 indicated urine collection devices are used to collect urine specimens and then cleaned. The PSWs further indicated the devices are not labelled for individual usage as well as bedpans and urine collection devices are not to be stored in communal spa rooms or left on the floor of the resident rooms or spa rooms. PSWs #123, #124 and the Administrator indicated bedpans are to be labelled if dedicated for a specific resident.

The Administrator further indicated that urine collection devices are for single use and not to be shared amongst residents, as they cannot be properly cleaned, and also indicated that once bedpans are used, the equipments are to be cleaned and stored in the individual resident bedside drawer or in the utility room. [s. 86. (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 ensuring there are measures in place to prevent the transmission of infections, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. r. 134. Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

The licensee has failed to ensure that there was monitoring and documentation of resident #045's response and the effectiveness of the medication being taken during a specific time period.

Related to Resident #045:

During the Resident Quality Inspection (RQI) it was identified that resident #045 had a change in condition and was being treated with medications for specific diagnoses on two identified dates. On both occasions, the resident was exhibiting symptoms of infections. The physician ordered a specific medication for an identified time period.

A review of the clinical records for a specific time period, identified that there was no monitoring of the resident symptoms or the effectiveness of the medication for all shifts.

An interview with RPN #100 confirmed that the expectation is that the resident be monitored for symptoms on all shifts during the course of receiving treatments.

Interview with the DOC revealed that staff should be documenting symptoms of the resident illness in the progress notes. Therefore there was no evidence that there was monitoring and documentation of resident #045's response and the effectiveness of the medication being taken on ten shifts of receiving treatment. [s. 134. (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,
(a) when a resident is taking any drug or combination of drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

3. Continence Care Management.

Related to resident #028:

Resident #028 was identified as having scheduled interventions related to continence care in place. The plan of care indicated that PSWs are to monitor the resident as he/she will attempt to initiate these interventions by self.

Interview with PSW #118 indicated that resident #028 receives continence care and staff are to perform this care. The PSW indicated not being aware of scheduled interventions being in place related to continence care for resident #028.

The PSW further indicated that she has been working for the home for almost one year, and does not recall receiving training related to Continence Care. Review of PSW #118 orientation training checklist, specifically section XI., Nursing Care & Services - Continence Care, as well as the Surge Learning 2015 summary for on line training, signed on an identified date, fails to identify training related to Continence Care for PSW #118.

Both the DOC and the Office Manager confirmed that PSW #118 was hired on an identified date, and the orientation checklist for the PSW is signed as being reviewed for orientation training on an identified date by the Nursing Administration supervisor. The DOC also confirmed that records for on line training in 2015, for PSW #118 does not identify training received related to Continence Care.

Interview with the Nursing Administration Supervisor confirmed that there is no formal education related to the Continence Care & Bowel Management program for direct care staff upon hire or annually. [s. 221. (1) 3.]

2. The licensee failed to comply with O. Reg. 221 (1) 5, by not ensuring that training has been provided to all staff who apply physical devices or who monitor residents using a safety device, including, application of these devices, the use of these devices, and their potential danger.

PSW #116, who was hired on an identified date, indicated not receiving training specific to the application, use or potential dangers of safety devices. The PSW was observed working with residents on an identified date.

The DOC indicated that PSW #116 has worked ten shifts during a two month period

The Administrator indicated that normally newly hired staffs are provided with training, regarding the use, application and potential dangers of safety devices, prior to working with residents. The Administrator further indicated that there is no rationale for PSW #116 to not have had specific training as identified, and believes there had not been sufficient time to provide the PSW training prior to the staff start working on the resident care units. The Administrator further indicated it is not the home's policy or practice not to train new staff prior to working with residents; the expectation is that new staffs are provided training as per the orientation checklists prior to working directly with residents. [s. 221. (1) 5.]

3. The licensee failed to comply with O. Reg. 79/10, s. 221 (1) 6, by not ensuring that training has been provided for all staff who apply Personal Assistance Services Device (PASD) or who monitor residents with PASDs including, application of these PASDs, use of these PASDs, and potential dangers of these PASDs.

PSW #116, who was hired on an identified date, indicated that she had not received training specific to the application of PASDs and indicated not knowing what a PASD was, or if it is used within the home.

PSW #116 was observed working with residents on an identified date.

The DOC indicated that PSW #116 has worked ten shifts for a two month time period.

The Administrator indicated that normally newly hired staffs are provided with training, regarding the use, application and danger of PASDs, prior to working on the resident care units with residents, and further indicated that there is no rationale for PSW #116 to not have had specific training as identified. The Administrator also indicated that she believes there had not been sufficient time to provide PSW #116 training prior to her start on the resident care units; and indicated that it is not the home's policy or practice not to train new staff prior to working with residents; as it is the expectations that new staff are provided training as per the orientation checklists prior to working directly with residents. [s. 221. (1) 6.]

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 training shall be provided to all staff who provide direct care to residents related to Continence Care and Bowel Management, to all staff who apply physical devices or who monitor residents restrained by a physical device, including, application of these physical devices, use of these physical devices, and the potential dangers of these physical devices, as well as training be provided for all staff who apply Personal Assistance Services Device (PASD) or who monitor residents with PASDs including, application of these PASDs, use of these PASDs, and potential dangers of these PASDs, to be implemented voluntarily.

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,
(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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the individualized plan of care is implemented for the resident who identified as incontinent.

During an interview with resident #028 the inspector observed that the resident needed continence care. A review of the clinical records confirmed that resident #028 receives continence care .The resident plan of care further indicated that there were scheduled interventions in place related to continence care.

On two identified dates the resident was noted nine times in different areas of the home not receiving scheduled interventions during the time these interventions should be performed by staffs related to continence care.

An interview with PSW #118 indicated that resident #028 receives continence care and was not aware that there were interventions in the plan of care related to scheduled continence care for the resident. The PSW further indicated that care plan information is found in the home's electronic plan of care and indicated that she is able to access this for all residents. PSW #118 does not recall specifically looking at the electronic care plan for resident #028 and confirmed not being aware that there was a specific schedule plan in place related continence care for the resident. Therefore the plan of care was not implemented for continence care for resident #028. [s. 51. (2) (b)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 79 (3), by not ensuring that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

During the initial tour of the home, an inspector identified that the copies of inspection reports and associated orders were not posted within the home; this was discussed with the Administrator on an identified date, the Administrator indicated that copies of all inspection reports and orders for the past two years would be posted before the end of the day.

During subsequent dates of this inspection, the required information was not posted within the home or easily accessible:

- Copies of inspection reports from the past two years for the long-term care home, specifically not posted were inspection reports, #2015_293554_0012 and #2016_293554_0002.

- Orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years, specifically not posted was an order for inspection #2016_293554_0002, which contains an outstanding compliance order for LTCHA, 2007, s. 6 (7) Plan of Care.

During a second interview, on an identified date, the Administrator indicated she believed that she had posted all inspection reports and orders from the past two years.

Upon conclusion of this inspection the above identified inspection report and order were not posted as required by the legislation. [s. 79. (3)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that they sought the advice of the Resident's Council in developing and carrying out of the Satisfaction Survey in 2016.

Interview with the president of the Resident Council indicated to inspector, being unsure if the Council had been involved in the development of the 2016 satisfaction survey.

The Life Enrichment Coordinator (LEC) has indicated that the Licensee has adopted an electronic format for the survey this year and that the advice of the Resident Council was not sought in the development of the 2016 Satisfaction Survey. [s. 85. (3)]

2. The licensee has failed to ensure that they sought the advice of the Family Council in developing and carrying out of the Satisfaction Survey in 2016.

Interview with the president of the Family Council indicated being unsure if the Council had been involved in the development of the 2016 Satisfaction Survey.

The LEC has indicated that the Licensee has adopted an electronic format for the Survey this year and that the advice of the Family Council was not sought in the development of the 2016 Satisfaction Survey. [s. 85. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or staff member concerning the care of a resident or operation of the home receives a response to the investigation within 10 business days.

Related to Log # 000625-16 regarding resident #042:

On an identified date a verbal complaint was received by the Administrator at the home from the Substitute Decision Maker (SDM) of resident #042.

The Administrator indicated to the inspector that there was no opportunity to provide a response during the initial verbal complaint and was directed by Chief Operations Officer (COO) to wait to speak to SDM when the SDM returned to the home.

The Administrator indicated that the SDM returned to the home on an identified date. She further informed the inspector that the SDM had also contacted corporate office, and that she had been directed that the complaint would be managed by corporate office.

Telephone interview was conducted on an identified date, with COO for corporate office by the inspector related to the verbal complaint received at the home on an identified date, involving the SDM for resident #042.

The COO explains that the SDM had contacted her after speaking to the home on an identified date. The COO confirmed with inspector that she had contacted the SDM on an identified date, to provide a response to the investigation into the complaint, but indicated that the SDM was not contacted with 10 business days post receipt of the complaint. (194). [s. 101. (1)]

Issued on this 30th day of June, 2016

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

Original report signed by the inspector.