Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 27, 2015;	2015_384161_0010 (A1)	O-001966-15	Resident Quality Inspection

Licensee/Titulaire de permis

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr. OTTAWA ON K1V 8N5

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

ST PATRICK'S HOME
2865 RIVERSIDE DRIVE OTTAWA ON K1V 8N5

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

JESSICA LAPENSEE (133) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

As a result of the Resident Quality Inspection, #2015_384161_0010, three Compliance Orders (COs) were issued. CO #002 was issued pursuant to the LTCHA, 2007, S.O. 2007, c.8, s. 86 (3), related to the home's infection prevention and control program. CO #002 was initially given a compliance date of August 31, 2015. The compliance date has now been extended to September 30th, 2015. No other changes have been made.

Issued on this 27 day of August 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

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

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 27, 2015;	2015_384161_0010 (A1)	O-001966-15	Resident Quality Inspection

Licensee/Titulaire de permis

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr. OTTAWA ON K1V 8N5

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

ST PATRICK'S HOME
2865 RIVERSIDE DRIVE OTTAWA ON K1V 8N5

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

JESSICA LAPENSEE (133) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): May 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 2015.

During the course of the inspection, the inspector(s) conducted a tour of the Resident care areas, reviewed Residents' health care records, home policies and procedures, staff work routines, posted menus, observed Resident rooms, observed Resident common areas, reviewed the Admission process and Quality Improvement system, reviewed Residents' Council and Family Council minutes, observed a medication pass, observed several meal services, and observed the delivery of Resident care and services.

During the course of the inspection, the inspector(s) also conducted 2 Complaint inspections and 7 Critical Incident Inspections.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, Volunteers, Chair of Residents' Council, Member of Family Council, Personal Support Workers (PSW), Nutritional Service Aides, Housekeeping Aides, Rehabilitation/Restorative Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Admissions Coordinator, Dietary Supervisors, Human Resource Manager, Support Service Manager, Registered Dietitian, Coordinator Clinical Practice and Performance, Vice President Building Operations, Vice President Nursing Programs, Vice President Clinical Care and the President/Chief Executive Officer

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Admission and Discharge

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Reporting and Complaints

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

- **12 WN(s)**
- **7 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators
Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

The licensee failed to ensure that the elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

On May 6, 7 and 8 2015, Inspectors # 573 and #599, observed the following in regards to the home's elevators.

The home has two elevator cars that have front and rear access doors for each of the home's five (5) floors. The rear elevator doors have a swipe card security access system. To open the rear elevator doors, the system has to be activated and open the rear doors. The system was noted to be in place and functional for the 2nd, 3rd, 4th and 5th floor rear door access. The 1st floor rear doors were noted to open without having to swipe the rear door security system. By pressing the 1R button in the elevator panel, the rear elevator doors automatically open to a service hallway leading to staff lounge, offices, the home's kitchen and receiving areas.

On May 12 and 13 2015, Inspectors #117 and #161 were able to open the rear access elevator doors in both elevator cars without swiping the elevator security system. Doors to the staff lounge and an office were open, with no staff present. The door to the home's kitchen was open with one staff noted to be present. Next to the kitchen there was a small storage room with an open door (# 1038) with an identified sign on the door frame "Dietary Only Housekeeping". In this storage room was cart that appeared to be a kitchen cart, several boxes with ECOLAB cleaning products, tubing and connectors linked to ECOLAB cleaning products. The following signage was posted on the open door: "Chemical closet door must remain closed and locked when not in use". Below this was an ECOLAB WHMIS poster chart referencing the different products in the closet. No staff were noted to be present in hallway or by the door. It was also noted that the hallway continued to an unlocked door that opened into the home's receiving bay area. The receiving bay has a garage/receiving bay door noted to be closed but there are 2 buttons - one green and one red - if the green button is pressed, the garage door opens to the exterior of the home.

On May 13 2015, Inspector #117 spoke with the home's Vice President (VP) for Building Operations regarding unlocked 1st floor elevator rear access to non-residential areas. The VP confirmed that the home does have an elevator rear door swipe card security system in place and that it functions for all floors except the 1st floor. He confirmed that any person who can press the 1st floor elevator rear access button, can access non-residential areas of the home. He confirmed that this area is not always supervised nor are the door to various areas always locked although they do all have locking mechanisms. The VP stated that the elevator company, Schindler, had informed the home that the elevator rear doors could not be locked due to fire codes and the need to not limit access to egress. The VP stated that he would that he would be contacting the home's architect to get further information on the possibility of activating the swipe card security system for the 1st floor rear elevator doors.

On May 14 2015, the VP of Building Operation confirmed to Inspector #117 that the rear elevator doors can be locked with swipe card or key pad code access for 1st floor access. The VP stated the he would be contacting the home's security company to lock and set up swipe card security system access for the 1st floor rear elevator doors as soon as possible. [s. 10. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (3) The licensee shall ensure that the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations. 2007, c. 8, s. 86. (3).

Findings/Faits saillants :

The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.86(3) in that the licensee failed to ensure that the infection prevention and control program and what is provided for under the programs, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations.

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

The home has implemented, as part of their Infection Prevention and Control Program, the Just Clean Your Hands Program which indicates that hand hygiene is to

be performed before and after resident contact.

On May 8, 2015, the VP Nursing indicated that the home's implementation of the program has included the review of the accessibility of hand washing stations and hand sanitizer dispensers on each of the units for all moments of care and that the staff had just received training in January 2015. The VP Nursing indicated that her expectation was that all nursing staff wash or disinfect their hands prior to contact with residents and that hand hygiene be implemented at all moments of care.

On May 8, 2015 Inspector #592 observed PSW #110 accompany a resident to their room. PSW #110 assisted the resident to lie down in their bed. Isolation cart containing personal protective equipment was noted beside the resident's room and a signage at the side of the door indicating "please report to the nursing station for further instructions prior to entering this room. PSW #110 came out of the room to join inspector #592 who was waiting beside the isolation cart. PSW was not observed to perform hand hygiene after providing care to the resident in their room. Inspector #592 noted that a hand sanitizer dispenser was located in the home's hallway and in residents the resident's room. During an interview with PSW S #110, she told inspector #592 that the isolation cart was in use for the resident who was diagnosed with an Antibiotic Resistant Organism (ARO). She indicated that Personal Protective Equipment was to be wear only when they are providing personal care to residents and that she did not previously wear it as she was only assisting resident to go in to bed. After the interview, PSW S#110 went directly to the clean linen cart to grab clean towels and entered the resident's room. PSW proceeded to assist the resident with her morning care.

PSW S#110 was not observed to perform any hand hygiene in between the two residents. Later that day, inspector #592 spoke with PSW S#110 who confirmed that she did not performed any hand hygiene between the two residents even though it was the home's expectations but that she should of have, especially when providing care to residents diagnosed with an ARO.

2, It was noted on a tour of the home that infection control carts containing personal protective equipment (PPE) were located outside the door of 11 resident rooms. There was no posted signage indicating what precautions were to be taken when providing care to the residents residing in these specified rooms.

During an interview on a specified unit with PSW S#107, she told inspector #592 that

the home's expectation is to have signage posted outside the resident door indicating the personal protection equipment staff has to wear. She further added that an infection control cart containing the appropriate Personal Protective Equipment is also available outside the room. PSW S#107 further indicated that resident in a specified room # was not requiring any contact precautions, and that the isolation cart was left by mistake, therefore no signage was posted. During an interview on this unit with RPN S#108, she told inspector #592 that there is supposed to be a sign posted outside the rooms with an infection control cart to make staff aware of what type of precautions to take when providing care to the resident. Indicated that one particular resident does wander on the unit at times and would sometimes remove the signage posted. She further confirmed that all rooms mentioned and identified with no signage were residents who needed contact precautions to be used including a specified resident who was diagnosed with an ARO. During an interview on this unit with RPN S#106, she told inspector #592 the rooms are to be identified with a postage indicating what kind of equipment to use with an infection cart outside of the resident's rooms. She confirmed that 2 resident rooms did not have postage because both resident were not infected anymore, therefore both cart were left at the resident's doors by mistake.

During an interview with the VP Nursing, she told inspector #592 that it is expected that when a resident is diagnosed with an ARO, a sign with the type of precautions is supposed to be posted on the door outside the resident's room to advise the staff what type of precautions are to be used and what PPE is required. She further added that the RPN/RN is responsible for posting the signage outside the resident's room and to ensure that everything is in place.

3. On a specified date in May 2015, it was noted on a tour of the home that a total of 35 isolation carts containing personal protective equipment (PPE) were located throughout the home.

Four days later a list was provided by the Coordinator of the Clinical Practice and Performance to inspector #592 identifying a total of 29 residents diagnosed with an ARO. The home had identified the resident in a specified room as being positive with an ARO. Inspector #592 observed an isolation cart beside an identified room containing movies, cd's, wishing carts and facial tissues. During an interview with PSW S#149, she told inspector #592 that resident in the room was not under isolation precautions as the resident only keeps the isolation cart for her personal belongings at her request. She further added that this Resident was not diagnosed with an ARO,

therefore no need for any protective personal equipment for that resident.

The resident in another specified room was also identified on the home list as being ARO positive. Inspector #592 did not observe any isolation cart nor posted signage beside this resident room indicating the use of any protective personal equipment. During an interview with RPN S#148, she told inspector #592 that residents who are identified with an ARO should have an isolation cart with a signage indicating what kind of precautions to take. RPN S# 148 confirmed that this resident was diagnosed with an ARO and should have the isolation cart and the posted signage beside the door .

In another specified room, a resident was also identified on the home list as having an ARO. Inspector #592 did not observe any isolation cart and posted signage indicating the use of any protective personal equipment beside this resident's room. During an interview with RPN S#103, she confirmed after the revision of the resident's health care record , that this resident in was not requiring any personal protective equipment, as the resident was not diagnosed with any ARO.

Later that day, during an interview with the VP Nursing Program, she told inspector #592 that she was expecting that all residents who were identified on the current list as ARO positive were provided with a PPE cart and a posted signage of the precautions to take while caring for these residents. She further indicated that the nursing staff is responsible to ensure that all the required isolation carts are being set up with the appropriate posted signage. On a specified date in May 2015 discussion held with the VP Nursing Programs regarding the discrepancy between (1) the list of 29 residents diagnosed with an ARO provided by the Coordinator of the Clinical Practice and Performance to inspector #592 on a specified date in May 2015 and (2) the additional 11 isolation carts observed by inspector #592 throughout the home. The VP Nursing Programs told the inspector that these carts could be left over from the previous outbreak due to a lack of storage. The VP Nursing Programs indicated to inspector #592 that the home has just started to do swabs in order for the home to do a closer follow-up. She indicated that Registered staff are responsible for knowing the type of ARO as well as the location of the ARO and to set up the isolation carts and conduct the follow-ups. The VP Nursing Programs Indicated that this information would be documented in the affected resident's progress notes once the resident was confirmed positive. She indicated that when they moved from the old home to the new home, they had lost track of the residents who had been identified as ARO positive and that there was a lack of documentation in this regard. The VP Nursing Programs further indicated that the home is unsure of the mode of transmission of the ARO's

and that many of the residents had been identified as ARO positive a long time ago and hence, the home needs to swab the residents for ARO again.

On the same specified date in May 2015 the VP Nursing Programs also told inspector #592 that the home is currently working on a tracking tool and, as well, are re-swabbing residents who had been diagnosed being ARO positive to ensure that the data and the location of the ARO is accurate.

4. On May 7, 2015, inspector #592 observed the following unlabeled personal care items:

In the Dublin house spa room there was 1 jar of used Pond's cream, one hairbrush with hair in the bristles, 1 nail clipper and 1 roll-on antiperspirant deodorant. In the Donegal house spa room there was 1 used bar of soap. In the Carlow house spa room there was 1 hair brush with hair on the bristles, 1 used comb and 2 roll-on deodorants. In the Cavan house spa room there were 2 hairbrushes with hair on their bristles, 8 roll-on deodorants, one razor with hair and yellow matter in the blade, 1 container of Aveeno-skin relief moisturizing cream and 1 container of used petroleum jelly. In the Galway house spa room there were 7 roll-on deodorants, two bars of soap used in a lever 2000 box, 1 comb, 1 razor. On May 8, 2015, during an interview with PSW S#107, told inspector #592 that personal items, such as brushes, combs, toothbrushes are being kept in the resident's room. PSW are to ensure that all resident have their personal items and no labeling is required as the personal items stay in the resident's room.

On May 8, 2015, during an interview with RPN S#108 she indicated that if resident's personal items are being found unlabeled in the spa rooms, personal items should discarded due to possible infection control issues. [s. 86. (3)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident.

On a specified date in May 2015, it was noted during a tour of the home that an infection control cart containing personal protective equipment (PPE) was located outside four resident rooms although there was no signage indicating what type of precautions were required when providing care to the resident.

During an interview on a specified date in May 2015 with PSW S#118, she told inspector #592 that resident in a specified room was diagnosed with an ARO and staff were to wear PPE. She further told inspector #592 that the planned care for resident diagnosed with an infection would be in the POC software in the kardex or care plan section. PSW S#118 was unable to find any planned care for this resident in the POC. PSW S# 118 asked her co-worker PSW S#119 where would be located the information for the planned care for resident diagnose with an infection. Co-worker PSW S# 119 was not able to find any information and confirmed that another resident in a differed room was also diagnosed with an ARO and was not able to find any planned care and directions for this resident either.

During an interview on a specified date in May 2015, with PSW S# 129, she told inspector #592 that Resident in a specified room was diagnosed with an ARO in a specified area of their body, therefore staff were to wear PPE's. She further told inspector #592 that no information of the planned care for this resident was provided to them other than the verbal morning report communicated by the registered staff.

During an interview on a specified date in May 2015, with RPN S#130, she told inspector #592 that resident in a specified room was diagnosed with an ARO and a bacterial infection. She further told inspector #592 that nursing staff refers on the check list located in the nursing desk for the current status of resident diagnosed with

an infection. In addition she told inspector #592 that the information should be in the PSW's POC for the planned care of the affected residents. She confirmed that this was also diagnosed with an ARO and was unable to find any documentation in the electronic Point click care software and in the Resident Health Care Records for both of the residents. She confirmed that the plan of care for both residents did not include the bacterial infection nor ARO, nor provide any direction to staff as to what care or precautions were required for the resident related to a bacterial infection nor ARO.

On a specified date in May 2015, during an interview with the VP Nursing, she told inspector #592 that residents who are being identified with infections should have a planned care documented in the POC/care plan. She further indicated that any documentation in the plan of care should reflect in the POC and would include the precautions required when providing care to the residents. [s. 6. (1) (a)] (592)

- Resident #39 is identified as having some cognitive impairment and is at high risk of falls. The resident was observed to be seated in a tilt wheelchair with a lap belt and a tab alarm attached to the wheelchair

Interviewed staff members RPN S#126 and PSW S#122 stated to Inspector #117 that Resident #39 is at risk of falls. The wheelchair lap belt is a safety measure and a fall prevention intervention. They stated that the resident was able to undo the lap belt. Resident #39 was observed to undo the lap belt when asked by the unit RPN S#126.

A review of the resident's current plan of care, dated in the winter of 2015, identifies that the resident has a tilt wheelchair for mobility. Fall mats, a wheelchair tab alarm and a BAM monitor for their bed as fall prevention interventions and a PASD (positioning aide safety device). Further review of the POC system, which documents the provision of resident care, shows the same fall and mobility interventions in place. There is no information on the application and use of the wheelchair lap belt. The plan of care and POC were reviewed with PSW S#122, RPN S#126 and unit RN #116. All three stated that the use and application of the wheelchair lap belt as a fall prevention intervention and as a PASD should be identified in the resident's plan of care and POC. The Unit RN S#116 reviewed the home's monthly restraint and PASD audit form which is completed by the home's Restorative Care Lead on a monthly basis. This form identifies the use of the tilt wheelchair and lap belt as a PASD for Resident #39. Unit RN S#116 immediately accessed the home's Point Click Care system and changed the resident's electronic plan of care and POC system to reflect the use and application of the lap belt as a fall prevention intervention.

Resident #39's written plan of care did not identify the resident's planned care in regards to the use and application of a wheelchair lap belt as a fall prevention intervention and a PASD. [s. 6. (1) (a)] (117)

2. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and other that provide direct care to residents.

On a specified date in March 2015 the home submitted a Critical Incident Report to the Director reporting that Resident #067 had been sent to hospital after exhibiting responsive behaviours during a shower including kicking the shower chair which resulted in bruising to the Resident's right foot. A review Resident #067's health care record indicates that the Resident has a history of progressive cognitive impairment. A review of the Resident's progress notes from a specified date in March 2015 to a specified date in May 2015 indicate that Resident #067 has displayed responsive behaviours including resistive to care, refusing medications, physical altercations with co-residents and staff, as well as rummaging in other resident rooms. A review of the Resident's plan of care does not identify the behavioural triggers, strategies to respond to these behaviours nor interventions.

On May 20, 2015 this was validated by the Coordinator of Clinical Practice and Performance. [s. 6. (1) (c)] (161)

3. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

Upon review of the health care record for Resident #056, the resident was diagnosed with a chronic disease and as per resident plan of care resident is being identified with frequent urinary tract infections.

On a specified date in January 2015, Resident #056 was identified with a urinary tract infection and was treated for a total of 7 days with success.

On a specified date in March 2015, Resident #056 was identified by an RPN member, with the symptoms of a urinary tract infection. RPN member placed a note in the Physician's book requesting an assessment of Resident #056 on that date. However the physician schedule was adjusted and he was not present in the home until several

days later.

On a specified date in March 2015, the physician visited Resident #056 and informed Nursing staff to continue attempts in obtaining urine sample and to continue the current treatment plan.

Over an 11 day period in May 2015, it was indicated in the progress notes that resident #056's health status had declined as resident was observed being restless with an increase of behaviours and no more weight bearing requiring nursing rehab to be involved. Resident was also observed in a decrease in their appetite and food intake.

Notes were left to physician indicating resident #056 to be restless over past number of days and the symptoms of a potential urinary tract infection, however, the SDM was not made aware of the medical concerns and the declining status of Resident #056. The SDM was not provided the opportunity to participate fully in the development and implementation of the plan of care for this Resident until 12 days after when she visited the home on a specified date in March 2015.

On a specified date in May 2015, during an interview with the VP Nursing Program, she told inspector #592, that a response letter was send to the SDM following written concerns of not being contacted regarding the declining status of Resident #056. The VP Nursing indicated that following the investigation, the home did recognize that Nursing Staff did not contact the SDM and that the home's expectation is that any change in status of the resident should be communicated immediately to the SDM in order to participate fully in the development and implementation of the plan of care for residents. [s. 6. (5)] (592)] (Log #O-002045-15)

4. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Inspector #138 observed the morning fluid pass on Donegal on May 13, 2015. It was noted by the inspector that the beverage cart had written directions that outlined several residents to receive fortified juice (15ml corn syrup with 125ml juice), specifically for Resident #062, Resident # 063, and Resident #064. The inspector observed the fluid pass and did not observe that any fortified juices were distributed. It was specifically observed that Resident #062 was provided juice that was poured by a PSW from the container of juice on the beverage cart and that it was prepared with thickener but not with corn syrup. The inspector also noted that corn syrup was not on

the beverage cart nor were there any beverages specifically labelled for residents that could have been fortified juice. The inspector again observed the morning fluid pass the following day on Donegal and noted that the beverage cart did not have any corn syrup or any prepared beverages for specific residents on the beverage cart. The inspector observed PSW, Staff #136, pour beverages from the cart for Resident #062, Resident #063, and Resident #064 and noted that no corn syrup was added to the beverages. These residents drank the beverage that was poured for them.

The inspector also observed the morning fluid pass on Dublin on May 15, 2015 and noted that the beverage cart on this unit also had written directions that outlined several residents were to receive fortified juice including Resident #065 and Resident #038. The inspector observed the fluid pass and noted that juice was poured for both these residents from the beverage cart and were not prepared with corn syrup. The inspector spoke with the PSW, Staff #146, distributing the fluids and she stated that she does not provide fortified juice and directed the inspector to the RPN. The RPN, Staff #133, stated that fortified juices are only provided on an as needed basis.

The inspector reviewed the nutritional plan of care for the above residents which, according to the home's dietitian, is considered to be the hard copy of the care plan found on the resident's chart as well as information in the dietary binder on the unit servery. It was noted that the nutritional plan of care for the residents mentioned above (Resident #062, #063, #064, #065, and #038) all stated that fortified juice was to be provided at snacks. The dietitian stated to the inspector that fortified juice is a current intervention used in the home for specific residents. [s. 6. (7)] (138)

5. The licensee has failed to ensure that the interventions set out in the Resident #04's written plan of care related to his/her Resistive behaviours to Activities of Daily Living were not provided to the resident as specified.

On three specified dates in May 2015 Inspector #573 observed that Resident #04's fingernails in both hands were long, untrimmed and unclean with black colour dirt underneath the nails. It was also noted Resident #04 to have a few long facial hairs under their chin that was poorly shaven and groomed.

Inspector reviewed Resident #04's Plan of care in effect which identifies that Resident #04 requires one staff limited assistance for personal hygiene and one staff extensive assistance for bathing. The plan of care indicates that Resident #04 is resistive to Activity of Daily Living (ADL) care and the interventions in place indicated

- "If possible, negotiate a time for ADLs so that the resident participates in the decision making process. Return at the agreed time".
- "If resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again".
- "ROH – Behavioural Support Outreach program to assist with behaviours".

Inspector #573 reviewed the bath list which indicates that Resident #04's shower days were scheduled twice weekly. Upon reviewing Resident #04's "Activities of Daily Living – Bathing" report, from the POC documented from a specified date in April 2015 to a month later indicated that Resident #04 had refused showers for 7 days. There is no indication in the progress notes that Resident #04 was provided with any alternate bathing care for the refused shower days.

On May 11, 2015, PSW S#121 and RPN S#111 both stated to Inspector that Resident #04 has poor personnel hygiene and constantly resists or refuses assistance for the personnel hygiene and bathing. RPN S#111 indicated that on Resident #04 shower days, if resident resists their shower PSW staffs would approach again before noon and if resident still refuses or resists for personal hygiene and bathing, the resident would not get their shower on that day. Further both the PSW S#121 and RPN S#111 were not aware of any alternative interventions that would be provided to the resident to ensure that Resident #04 receives their personnel hygiene and bathing on regular basics.

On May 14, 2015 during an interview with RN S#116 indicated that resident was seen by Behavioural Support Outreach (BSO) in 2013 for resistive behaviours to care and since then the resident was not referred back to the BSO outreach to manage their resistive behaviours to care.

All the interventions set out in the Resident #04's written plan of care related to their Resistive behaviours to Activities of Daily living was not provided to the resident as specified. [s. 6. (7)] (573)

6. The licensee has failed to ensure that the provision of the care set out in the plan of care for Resident #02 is documented.

On three days in May 2015, Inspector #573 observed that Resident #02 fingernails were long, untrimmed and unclean with brown matter under the long finger nails. Resident #02's Plan of care in effect indicated that resident requires extensive assistance for personal hygiene and bathing due to their physical condition, further the

plan of care indicated that resident to get bath twice a week.

Inspector #573 reviewed the bath list which indicated that Resident #02's had 2 scheduled bath days per week. Upon reviewing The "Activities of Daily Living – Bathing" report from the POC documentation, there is no indication that Resident #02 received their bath and nail care on two scheduled dates in May 2015.

On a specified date in May 2015, Inspector spoke with the PSW S#121 who indicated that Resident fingernails were to be cleaned and trimmed by staffs on the bath days and further indicated that the bath was provided to the Resident #02 on the scheduled days in May 2015 but it was not documented in the in POC. PSW S#121 concurred with the Inspector that Resident #02's nails were dirty and needed to be cleaned.

On a specified date in May 2015, Inspector #573 spoke to the In-charge floor RN S#116 indicated that when bathing and nail care is provided to residents by the PSW staff members, the expectation of the PSW staff members is to document in the POC that set out care was provided to the residents.

The provision of the Bathing and Nail Care as set out in the plan of care is not documented for Resident #02. [s. 6. (9)(1)] (573) [s. 6.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with 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:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every resident has the right not to be restrained.

On Thursday, May 6, 2015 Inspectors #599 noted a posted memo on the exit door of a specified unit stating "NO RESIDENTS ARE TO LEAVE THE UNIT DUE TO ENTERIC OUTBREAK (STOMACH FLU) PLEASE DO NOT LEAVE THE UNIT."

On May 7, 2015, on this specified unit, during an interview with Resident #044 who was standing beside the exit door, she told inspector #592 that she was quite upset and did not understand why she was not allowed to leave the unit. She further added that she was not sick and was wandering why she was getting punished. She told inspector #592 that since a week, she was told every day to not leave the unit and told inspector #592 that she just want to be able to get some fresh air as she is use to go daily from the unit by herself.

On May 8, 2015, during an interview, Resident #047 told inspector #592 that he does not like "being locked". He indicated that he use to go daily outside and sit under the sun but since a week, he is been confined in the unit. Resident #047 further indicated that it is the second time this year that residents are being confined on the unit and that he feels like a prisoner.

On May 8, 2015, while interviewing RPN S#109, a resident inquired if she could visit her husband and was told by the RPN, that she was not permitted to leave the unit due to the outbreak. Resident #048 told inspector #592 that she was not being allowed to visit her husband who was residing on another unit in the home. She further added that she was missing him and she was quite sad and worry as her husband health was declining. She further stated that she normally spends time with him but since the outbreak, she was not permitted.

On May 8, 2015, during an interview with RN S#105, she told inspector #592 that last

week two residents were diagnosed with a virus and the instructions were to keep all the residents on the unit.

Upon a revision of the home Policy for control of enteric disease outbreaks titled: Infection Prevention and Control Program, Number PM0103-41 dated on 2013.07 it was indicated under Procedure tab.3 "Take steps to control the spread of infection by enteric isolation of the residents who are showing symptoms and quarantine the resident's on if symptoms are confined to a specific unit."

On May 8, 2015, during an interview with the VP Nursing, she told inspector #592 that the person in charge of the infection control was on holidays and that she was the person covering for her. She told inspector #592 that the home was declared in enteric outbreak by Public Health on the specified unit since April 29th affecting a total of four residents and 2 staff members. She told inspector #592 that the residents were not permitted to go out from this unit by exception of residents who have cardiac follow-up. She further stated that she realized that it was against the resident's right and that she will remove the posted memo and reinforce with the staff that resident are no more to be restrained on the unit.

While doing the interview an Agency staff, RN S#124 came in the VP Nursing office and told the VP Nursing that she was concern about the residents on this specified unit. She mentioned that residents on this unit were quite independent and were getting agitated and staff were not able to restrain them anymore on the unit and asked the VP Nursing for further instructions. VP Nursing told RN S#124 to let the residents go out of the unit if they wish too as it was against their rights to keep them in.

On May 11, 2015, Inspector #161 and #592 noted a memo posted on another unit exit door indicating "unit close".

On May 11, 2015, during an interview with RN S#103, she told inspector #592 that 3 residents were in isolation and 1 in observation. She further indicated that a respiratory outbreak was declared on Sunday May 10, 2015 by Public Health. She told inspector #592 that Residents were not allowed to go out of the unit and has been working for 20 years and that it was the home's practice. She further added that only one resident was permitted to leave the unit this morning for an appointment, but the other resident or to be restrained on the unit. RN S#103 further added that one

resident was still trying to leave the unit this morning but was brought back on the unit. She told inspector #592 that the resident was just standing beside the door earlier but could not find the resident anymore. RN S#103 interrupted the interview to go to locate resident and brought the resident back on the unit. RN S#103 told resident that they were not allowed to leave the unit went outside the unit and brought back the resident who was waiting to go in the elevator on the unit. RN S#103 told Resident to remain on the unit.

Inspector #592 interviewed Resident #041 who was just brought back on the unit and told inspector #592 that they were not sick. The resident told inspector #592 in a sad tone that the nurses do not let her/him go to church downstairs and that she/he wants to go out and that she/he missed the church this morning. Resident #041 was repeating again and again to nurse inspector "not sick, want to go out".

On May 12, 2015, during an interview with the VP Nursing, she told inspector #592 that she thought that her instructions to the staff members were clear and they were not to restrain the residents on the unit. She further added that she will handle the situation right away as it was against Resident's Rights. [s. 3. (1) 13.]

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 the home is in outbreak every resident's right not to be restrained on their unit is respected, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The home failed to ensure that all doors, leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

On May 07 2015, Inspector #138 noted the following:
- at 09:00am , the storage door # 2045, on Carlow unit, had a key in the lock and was opened by the Inspector. The storage area contained a cart with linens.
- at 11:08, on Dublin unit, the storage room # 3045 had a key in the lock of the door. The Inspector was able to open the door. Inside was a walker and no call bell system.

On May 08 2015, Inspector #138 noted at 9:25 am, on Cavan unit, that the# 2023 "Clean Utility" room door was propped open with a yellow wedge door stopper. Inside the room was oxygen storage and cupboards with various supplies. No staff were noted in the area. There was no call bell inside the room. This door was noted to be propped open until 10:30am. At the time there was a staff member in the spa room. The staff member was not supervising the clean utility room.

On May 12, 2015, at 15:12 Inspector #117 noted on Kerry unit, that the tub room / spa door was propped open. No staff were noted to be present in the spa area of in the immediate unit hallways. In the tub room, there was a 3 litre container of ARJO Huntleigh Disinfectant Cleaser IV on the shelf behind the tub that is easily accessible. In the shower room, a spray bottle with a non-identified pinkish clear liquid approximately 200 ml. The spray bottle does have the printed words of ECOLAB on it but does not have any other type of identification. Inspector #117 went to unit nursing station, where staff are getting their shift report.

Discussion was held with PSW S#153 who stated that she had opened the spa door to bring evening care carts out in hallway and did not close the spa room door as another staff were present in the spa room at that time. The PSW S#153 confirms that the spa room door should be left closed when no staff are present or the spa room not

in use. The staff member got up and closed the spa room door.

On May 12 2015, at 15:23, Inspector #117 noted on Kilkenny unit that the spa/tub room door was open. No staff were noted to be around the door or in hallway. Inside the tub spa room, in the shower section, a spray bottle with 12 oz of MIKRO QUAT detergent germicide deodorizer was noted to be present. Inspector reported open door to the unit RPN S#152. The RPN confirmed that the door should always be closed unless staff are present. The RPN S#152 then closed the spa room door and indicated to the Inspector that she would be following up with PSW staff to ensure that all non-residential area doors are kept closed and locked when not in use.

On May 13 2015, Inspector #117 noted at 11:04, on Carlow unit, that the tub room door was fully open, with no staff in attendance. No residents were noted to around that part of the hallway. Inspector #117 spoke with PSW S#119, who was in hallway. The staff member S#119 stated that she had just finished giving a resident his bath and just brought him to his room. The PSW stated that they usually keep the door of the spa room closed and locked when not in use but they left it open to "air out" the room as there is much humidity.

On May 13 2015, at 10:25 am , Inspector #117 observed that on Cavan unit the tub room/spa door (# 2049A) was not fully closed. It was open by 6 inches. No staff were noted to be in the room or in hallway and no residents were noted to be in hallway. It was
observed that an unidentified cleaning product in a spray bottles was on the shower grab bar.

On May 13 2015, Inspector #117 had a discussion with the home's VP Building Operations regarding the closing and locking of doors leading to non-residential areas. The VP confirmed that all doors leading to non-residential areas in the home do have a locking mechanisms, electronic swipe card or keys, and that these doors are to be closed when not in use. He confirmed that all of the home's staff are aware of this policy. He will follow up with all departments to ensure that doors are kept closed and locked when not in use. [s. 9. (1) 2.]

Additional Required Actions:

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

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).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 r.30 (1) 3 in that the licensee did not ensure that each of the interdisciplinary programs required under section 48 of this Regulation are evaluated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On May 19, 2015 discussion held with the Vice President of Nursing Programs. She indicated that the following interdisciplinary programs that are required under section 48 of this Regulation, had not been evaluated in 2014 in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

1. Falls prevention and management program.

2. Skin and wound care program.

3. Continence care and bowel management program.

4. Pain management program.

On May 19, 2015 discussion held with the President/Chief Executive Officer of the home who indicated that the above programs had not been evaluated in 2014. [s. 30. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following interdisciplinary programs that are required under section 48 of this Regulation, are evaluated on an annual basis in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

1. Falls prevention and management program.

2. Skin and wound care program.

3. Continence care and bowel management program.

4. Pain management program., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to comply with section 71.(4) of the regulation in that the licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

Inspector #138 observed the lunch meal service on May 6, 2015 on Cavan, May 13, 2015 on Dublin, May 14, 2014 on Carlow, and May 15, 2015 on Wexford and noted that the posted menu on the units as well as the menu therapeutic spreadsheets outlined that a slice of bread/roll and pureed bread is to be offered to residents during the lunch meal which would be in addition to the main entree. The inspector did not observe any bread/roll or pureed bread offered to residents that was in addition to the main entree. It was confirmed by the nutritional service aides on the units that sliced bread/roll and pureed bread was not offered to the residents.

The inspector also noted during the lunch meal service on May 13, 2015 on Dublin, May 14, 2015 on Carlow, and May 15, 2015 on Wexford that minced salad was not available according to the menu therapeutic spreadsheets despite residents on that unit requiring a minced texture modification. The nutritional service aides on all units stated to the inspector that the pureed salad was to be used for those residents requiring a minced texture. It was also noted at the lunch service on Carlow that minced strawberries were not available as indicated by the menu therapeutic spreadsheets. The nutritional service aide stated to the inspector that the minced strawberries were not available and that whole strawberries would be given to those residents requiring a minced texture. [s. 71. (4)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The license failed to comply with section 73.(1)8. of the regulation in that the licensee failed to ensure course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

Inspector #138 observed the lunch meal service on Cavan on May 6, 2015 and noted that residents were provided the entrée portion of the meal before having time to finish the soup course. Resident #073 who received the entrée portion before finishing the soup portion of the meal sent the entrée portion back as it was too cold by the time the resident was ready to eat it.

Inspector #138 observed the lunch meal service at Dublin on May 8, 2015 and noted that the soup was delivered to the residents' tables starting at 11:50am and was even delivered to the place setting of four residents not yet in the dining room. The entrée portion of the meal was immediately delivered afterward so that several residents had

soup and entrée courses at their table including Resident #069, Resident #070, Resident #038, and Resident #068 who were provided their entrée before they had the opportunity to finish the soup. The desserts were then provided to residents at 12:13pm regardless of if the resident was ready for the dessert. Most residents were eating the entrée portion of the meal when the desserts were distributed but there were several residents including Resident #038 and Resident #068 not yet finished the soup portion of the meal and had all three courses on the table including the soup, entrée and dessert.

The inspector once again observed the lunch meal service on Dublin on May 13, 2015 and noted that the lunch meal service commenced at noon. It was observed that the entrees were delivered to multiple residents before residents had finished the soup portion of the meal. It was also observed that the desserts were distributed at 12:13pm before the residents finished their entrees and before some residents, including Resident #068 and #069, finished both their soup and their entrée.

The inspector reviewed the dietary binder in the servery that contains the nutritional information for the residents and is a component of the nutritional plan of care and noted there were no directions to provide any of the residents with all courses of the meal at one time. [s. 73. (1) 8.]

2. The licensee failed to comply with section 73.(1)9. of the regulation in that the licensee failed to provide residents with any eating aids, assistive devices, personal assistance and encouragement required to safety eat and drink as comfortably and independently as possible.

Inspector #138 observed several meal and snack services and noted feeding techniques that were not in line with safe feeding practices. Specifically, the inspector observed the lunch meal service on Dublin on May 8, 2015 and again on May 13, 2015 and observed a PSW, Staff #122, circulate the dining room both times providing physical assistance with food and drink while the PSW was standing and the residents were sitting. On May 13, 2015 on Donegal at breakfast the inspector observed another PSW, Staff #136, circulate the dining room and provide physical assistance to residents with food and drink while the staff member was standing and the residents were seated. Also that day on Donegal during the am fluid pass the inspector observed a PSW, Staff #135, spoon feed thickened fluids to Resident #071 and Resident #062 while standing and both residents seated in a wheelchair. The inspector reviewed the care plan for these residents and both Resident #071 and #062 were identified at nutritional risk with documented difficulties in

chewing/swallowing.

The inspector also observed incidences where physical assistance during the meal was inadequate. During the meal service on May 8, 2014 on Dublin it was observed that Resident #065 was provided a dessert at the time the resident was eating the entrée portion of the meal. The resident began to eat the dessert however the dessert was pushed out of reach of the resident by staff and the resident was encouraged verbally and physically to eat the entrée. The dessert was not put within reach of the resident once the entrée was cleared from the table. The dessert was never eaten by Resident #065.

The inspector observed the lunch meal service on Wexford on May 15, 2015 and noted that Resident #066 was seated at a table and was reclined in a tilt wheelchair. The resident was provided a bowl of soup at the start of the meal service however it was placed on the table out of reach of the resident and the resident remained reclined in the tilt wheelchair. The inspector continued to observe the resident and no assistance or set up was provided to the resident for the next fifteen minutes. The inspector approached the RPN, Staff #147, and inquired as to why the resident was not set up properly to eat the soup. The RPN stated the she was unsure but was aware that the resident's condition has recently changed and that the resident may require assistance with eating. The RPN proceed to the resident, set up the resident properly at the table, and provided assistance to the resident. The inspector spoke with the RN, Staff #150, who stated that the resident has had a recent change in condition including significant weight loss.

Inspector #138 also observed an incident were a resident was not provided with assistive devices to eat as independently as possible. During the lunch meal service on Dublin on May 13, 2015 it was observed that Resident #069 was having difficulty feeding self in that the resident was unable to get food on to the fork. The inspector reviewed the resident's nutritional information in the dietary binder, considered to be a part of the plan of care, and noted that the resident was to be provided a plate guard with meals. The inspector noted that no plate guard or any other adaptive feeding aides were provided to the resident. The resident eventually required assistance by a staff member to finish the meal. [s. 73. (1) 9.]

3. The license failed to comply with section 73.(2)(b) of the regulation in that the licensee failed to ensure that no person who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Inspector #138 observed the lunch meal service on Dublin on May 8, 2015 and observed that the soup was distributed to residents at 11:50am while staff did not arrive in the dining room to assist residents until 11:57am. Specifically, Resident #068, Resident #069, and Resident #070 were seated at the same table with soup in front of them. A PSW, Staff #151, sat at the table at 11:57am and stated to the inspector that the three residents required total feeding assistance and began to provide assistance to Resident #068 and #069. Resident #070 was not provided assistance with the soup until fifteen minutes later when a second staff member sat at the table to provide assistance to the resident at 12:12pm.

At another table, a different PSW began to assist Resident #074 and #075 at 11:59am with the soup that had been previously distributed. It was noted in the plan of care that both residents required complete feeding. Resident #038 also sat at the table with soup and was later provided with the entrée and dessert so that all three meal courses were sitting at the table at once for the resident The plan of care for this resident outlined that the resident required complete assistance with feeding. This resident was not provided any attempt at feeding assistance until over twenty minutes later at 12:20pm in which the resident refused the meal. It was noted by the inspector that the health care record for Resident #038 documents that the resident is at a high nutritional risk and has a pattern of undesirable weight loss. [s. 73. (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 1)to ensure residents on Cavan and Dublin, especially those requiring assistance, are served their meals in a course by course manner with adequate time to finish the course before the next course is offered, 2) to ensure residents on all units are provided with personal assistance and encouragement, including the use of proper feeding techniques, to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 r. 131. (4)(a) in that the license did not ensure that a member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if, the staff member has been trained by a member of the registered nursing staff in the administration of topicals.

On May 11, 2015 Registered staff member #S111 indicated to Inspector #161 that PSW's administer Triad cream to Resident #001's pressure ulcer. She indicated that she does not need to train the PSWs to administer topicals as they already know how to administer them with the exception of antibiotic topicals which they are not permitted to administer.

On May 11, 2015 PSW #S112 indicated to Inspector #161 that she learned how to apply topicals at school but was not trained by a registered nursing staff member at the home.

On May 12, 2015 Registered staff member #S125 indicated to Inspector #161 that she does not train the PSW's to administer topicals as she assumes that they know unless a PSW asks questions regarding the application of a topical.

On May 12, 2015 the Vice-President of Clinical Care and the Coordinator, Clinical Practice and Performance indicated to Inspector #161 that not all of the PSWs have been trained at the home regarding the administration of topicals. They further indicated that they would immediately put a plan in place to resolve this issue. [s. 131. (4) (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 member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if, the staff member has been trained by a member of the registered nursing staff in the administration of topicals, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the infection prevention and control program required under subsection 86(1) of the Act is evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices.

On May 8, 2015 in an interview the VP Nursing, she stated that there is an infection prevention and control program (IPC) in the home with an interdisciplinary committee that meets quarterly, however the annual review of the IPC program for 2014 was not completed and she was unable to provide any relative documents of when was the last annual review for the home. [s. 229. (2) (d)]

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 Infection Prevention and Control Program (IPC)is evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #11: 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,
(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. The licensee has failed to comply with O. Reg. 79/10 s.87(2)b in that there were several Residents whose resident care equipment, specifically assistive aids were heavily soiled/unclean.

On May 6, 2015 Inspector #573 observed the following:

Resident #002's wheelchair was observed with food stains and dried debris on hand rests, frames and black seat foam cushion.

Resident #004's four wheeled walker was observed with white dry smears on black seat foam cushion, dried debris on the frame.

On May 13, 2015 Inspector #161 observed the following:

Resident #002's wheelchair was observed with food stains and dried debris on hand rests, frames and black seat foam cushion.

Resident #004's four wheeled walker was observed with white dry smears on black seat foam cushion, dried debris on the frame.

On May 13, 2015 Inspector #161 spoke with the Rehabilitation/Restorative Services Lead #S131 who indicated that she is in charge of the Resident assistive device cleaning process program. She discussed the home's process for the cleaning of resident's assistive devices. Inspector #161 asked Rehabilitation/Restorative Services Lead #S131 to accompany Inspector #161 to observe Resident #002's and Resident #004's assistive aids. Upon observation of these assistive aids, staff member #S131 agreed with Inspector #161 that these Resident's assistive aids were heavily soiled/unclean and that she would address this issue immediately. [s. 87. (2) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 162. Approval by licensee

Specifically failed to comply with the following:

s. 162. (3) Subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following:
1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act. O. Reg. 79/10, s. 162 (3).
2. If the licensee is withholding approval for the applicant's admission, give the written notice required under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act. O. Reg. 79/10, s. 162 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that O.Reg. 79/10 s. 162 (3) long-term care home applications for resident admissions are reviewed within five (5) business days of having received the applications from the placement coordinator.

As per O.Reg. 162. (1) Subject to sections 163 and 164, when an applicant who has been determined by a placement co-ordinator to be eligible for long-term care home admission applies for authorization of his or her admission to a particular long-term care home, the appropriate placement co-ordinator shall, (a) give the licensee of the home, in addition to the material required under subsection 44 (7) of the Act, any other information possessed by the placement co-ordinator that in the placement co-ordinator's opinion is relevant to the licensee's determination of whether to give or withhold approval for the applicant's admission to the home; and (b) request the licensee to determine whether to give or withhold approval for the applicant's admission to the home. O. Reg. 79/10, s. 162 (1).

On May 13 2015, the home's Vice President of Clinical Care (VP) spoke with Inspector #117 regarding the resident long-term care applications. The Vice President stated that the home currently has over 240 resident long-term care home applications that have yet to be reviewed, accepted or rejected by the home. She states that since October 2013, the home has had a waitlist of over 200 resident long-term care applications. She has been the only person within the home who reviews the resident applications for acceptance or rejection for placement on their admission waitlist. The VP states that she and the home's administrator have been in contact with the local Community Care Access Centre (CCAC) regarding their delays in reviewing, accepting and or rejecting resident admission applications for the past year. She is

aware that the CCAC is concerned with the home's delay in processing the admission applications. The VP states that on April 10 2015, she, the VP of Nursing Program and the home's Admission Coordinator had a one day period to review the outstanding resident long-term care applications. She states that they were able to review approximately 20 applications. The VP states that a plan has been put in place starting the week of May 18 2015, she and the home's Admission Coordinator will have 2 dedicated days per week to review the long-term care applications, with the goal to have the 250 (approximately) outstanding applications reviewed, accepted and or rejected and that this information be communicated to the local CCAC.

The VP states that when the review is completed, the home will have implement a new process for the reviewing of resident long-term care application, whereby the home's Admission Coordinator will be the primary reviewer with having the VP review more complex applications. The goal with this new process is to have all applications reviewed within the legislated timeline of five business days.

The above information was confirmed with the home's Admission Coordinator and Administrator on May 13 2015. [s. 162. (3)]

Issued on this 27 day of August 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

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

Amended Public Copy/Copie modifiée du public de permis

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

Inspection No. / No de l'inspection : 2015_384161_0010 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-001966-15 (A1)

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

Report Date(s) / Date(s) du Rapport : Aug 27, 2015;(A1)

Licensee / Titulaire de permis : ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr., OTTAWA, ON, K1V-8N5

LTC Home / Foyer de SLD : ST PATRICK'S HOME
2865 RIVERSIDE DRIVE, OTTAWA, ON, K1V-8N5

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Janet Morris

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

To ST. PATRICK'S HOME OF OTTAWA INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Order / Ordre :

The licensee is required to ensure that the home's two elevators are equipped with a system to restrict resident access to the 1st floor rear elevator service corridor. While the licensee is addressing rear elevator access, the licensee must immediately mitigate any risks relating to the accessibility of residents unsupervised on the 1st floor service corridor and kitchen.

Grounds / Motifs :

1. The licensee failed to ensure that the elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

On May 6, 7 and 8 2015, Inspectors # 573 and #599, observed the following in regards to the home's elevators.

The home has two elevator cars that have front and rear access doors for each of the home's five (5) floors. The rear elevator doors have a swipe card security access system. To open the rear elevator doors, the system has to be activated and open the rear doors. The system was noted to be in place and functional for the 2nd, 3rd, 4th and 5th floor rear door access. The 1st floor rear doors were noted to open without having to swipe the rear door security system. By pressing the 1R button in the elevator panel, the rear elevator doors automatically open to a service hallway

leading to staff lounge, offices, the home's kitchen and receiving areas.

On May 12 and 13 2015, Inspectors #117 and #161 were able to open the rear access elevator doors in both elevator cars without swiping the elevator security system. Doors to the staff lounge and an office were open, with no staff present. The door to the home's kitchen was open with one staff noted to be present. Next to the kitchen there was a small storage room with an open door (# 1038) with an identified sign on the door frame "Dietary Only Housekeeping". In this storage room was cart that appeared to be a kitchen cart, several boxes with ECOLAB cleaning products, tubing and connectors linked to ECOLAB cleaning products. The following signage was posted on the open door: "Chemical closet door must remain closed and locked when not in use". Below this was an ECOLAB WHMIS poster chart referencing the different products in the closet. No staff were noted to be present in hallway or by the door. It was also noted that the hallway continued to an unlocked door that opened into the home's receiving bay area. The receiving bay has a garage/receiving bay door noted to be closed but there are 2 buttons - one green and one red - if the green button is pressed, the garage door opens to the exterior of the home.

On May 13 2015, Inspector #117 spoke with the home's Vice President (VP) for Building Operations regarding unlocked 1st floor elevator rear access to non-residential areas. The VP confirmed that the home does have an elevator rear door swipe card security system in place and that it functions for all floors except the 1st floor. He confirmed that any person who can press the 1st floor elevator rear access button, can access non-residential areas of the home. He confirmed that this area is not always supervised nor are the door to various areas always locked although they do all have locking mechanisms. The VP stated that the elevator company, Schindler, had informed the home that the elevator rear doors could not be locked due to fire codes and the need to not limit access to egress. The VP stated that he would that he would be contacting the home's architect to get further information on the possibility of activating the swipe card security system for the 1st floor rear elevator doors.

On May 14 2015, the VP of Building Operation confirmed to Inspector #117 that the rear elevator doors can be locked with swipe card or key pad code access for 1st floor access.
The VP stated the he would be contacting the home's security company to lock and set up swipe card security system access for the 1st floor rear elevator doors as soon as possible. (117)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Jun 30, 2015

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 86. (3) The licensee shall ensure that the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations. 2007, c. 8, s. 86. (3).

Order / Ordre :

(A1)
In order to ensure that infection prevention and control program complies with standards and requirements provided for in the regulations including:

a) ensure that all staff participate in the homes hand hygiene program.

b) ensure that measures are taken to prevent the transmission of infections.

c) ensure that information gathered related to signs symptoms indicating the presence of infection in residents are monitored in accordance with evidence based practices, that the signs symptoms are recorded and that immediate action is taken as required. This information that is gathered must be analyzed at least once a month to detect trends for the purposes of reducing the incidence of infection and outbreaks.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.86(3) in that the licensee failed to ensure that the infection prevention and control program and what is provided for under the programs, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations.

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

The home has implemented, as part of their Infection Prevention and Control Program, the Just Clean Your Hands Program which indicates that hand hygiene is to be performed before and after resident contact.

On May 8, 2015, the VP Nursing indicated that the home's implementation of the program has included the review of the accessibility of hand washing stations and hand sanitizer dispensers on each of the units for all moments of care and that the staff had just received training in January 2015. The VP Nursing indicated that her expectation was that all nursing staff wash or disinfect their hands prior to contact with residents and that hand hygiene be implemented at all moments of care.

On May 8, 2015 Inspector #592 observed PSW #110 accompany a resident to their

room. PSW #110 assisted the resident to lie down in their bed. Isolation cart containing personal protective equipment was noted beside the resident's room and a signage at the side of the door indicating "please report to the nursing station for further instructions prior to entering this room. PSW #110 came out of the room to join inspector #592 who was waiting beside the isolation cart. PSW was not observed to perform hand hygiene after providing care to the resident in their room. Inspector #592 noted that a hand sanitizer dispenser was located in the home's hallway and in residents the resident's room. During an interview with PSW S #110, she told inspector #592 that the isolation cart was in use for the resident who was diagnosed with an Antibiotic Resistant Organism (ARO). She indicated that Personal Protective Equipment was to be wear only when they are providing personal care to residents and that she did not previously wear it as she was only assisting resident to go in to bed. After the interview, PSW S#110 went directly to the clean linen cart to grab clean towels and entered the resident's room. PSW proceeded to assist the resident with her morning care.

PSW S#110 was not observed to perform any hand hygiene in between the two residents. Later that day, inspector #592 spoke with PSW S#110 who confirmed that she did not performed any hand hygiene between the two residents even though it was the home's expectations but that she should of have, especially when providing care to residents diagnosed with an ARO.

2, It was noted on a tour of the home that infection control carts containing personal protective equipment (PPE) were located outside the door of 11 resident rooms. There was no posted signage indicating what precautions were to be taken when providing care to the residents residing in these specified rooms.

During an interview on a specified unit with PSW S#107, she told inspector #592 that the home's expectation is to have signage posted outside the resident door indicating the personal protection equipment staff has to wear. She further added that an infection control cart containing the appropriate Personal Protective Equipment is also available outside the room. PSW S#107 further indicated that resident in a specified room # was not requiring any contact precautions, and that the isolation cart was left by mistake, therefore no signage was posted. During an interview on this unit with RPN S#108, she told inspector #592 that there is supposed to be a sign posted outside the rooms with an infection control cart to make staff aware of what type of precautions to take when providing care to the resident. Indicated that one

particular resident does wander on the unit at times and would sometimes remove the signage posted. She further confirmed that all rooms mentioned and identified with no signage were residents who needed contact precautions to be used including a specified resident who was diagnosed with an ARO. During an interview on this unit with RPN S#106, she told inspector #592 the rooms are to be identified with a postage indicating what kind of equipment to use with an infection cart outside of the resident's rooms. She confirmed that 2 resident rooms did not have postage because both resident were not infected anymore, therefore both cart were left at the resident's doors by mistake.

During an interview with the VP Nursing, she told inspector #592 that it is expected that when a resident is diagnosed with an ARO, a sign with the type of precautions is supposed to be posted on the door outside the resident's room to advise the staff what type of precautions are to be used and what PPE is required. She further added that the RPN/RN is responsible for posting the signage outside the resident's room and to ensure that everything is in place.

3. On a specified date in May 2015, it was noted on a tour of the home that a total of 35 isolation carts containing personal protective equipment (PPE) were located throughout the home.

Four days later a list was provided by the Coordinator of the Clinical Practice and Performance to inspector #592 identifying a total of 29 residents diagnosed with an ARO. The home had identified the resident in a specified room as being positive with an ARO. Inspector #592 observed an isolation cart beside an identified room containing movies, cd's, wishing carts and facial tissues. During an interview with PSW S#149, she told inspector #592 that resident in the room was not under isolation precautions as the resident only keeps the isolation cart for her personal belongings at her request. She further added that this Resident was not diagnosed with an ARO, therefore no need for any protective personal equipment for that resident.

The resident in another specified room was also identified on the home list as being ARO positive. Inspector #592 did not observe any isolation cart nor posted signage beside this resident room indicating the use of any protective personal equipment. During an interview with RPN S#148, she told inspector #592 that residents who are identified with an ARO should have an isolation cart with a signage indicating what

kind of precautions to take. RPN S# 148 confirmed that this resident was diagnosed with an ARO and should have the isolation cart and the posted signage beside the door .

In another specified room, a resident was also identified on the home list as having an ARO. Inspector #592 did not observe any isolation cart and posted signage indicating the use of any protective personal equipment beside this resident's room. During an interview with RPN S#103, she confirmed after the revision of the resident's health care record , that this resident in was not requiring any personal protective equipment, as the resident was not diagnosed with any ARO.

Later that day, during an interview with the VP Nursing Program, she told inspector #592 that she was expecting that all residents who were identified on the current list as ARO positive were provided with a PPE cart and a posted signage of the precautions to take while caring for these residents. She further indicated that the nursing staff is responsible to ensure that all the required isolation carts are being set up with the appropriate posted signage. On a specified date in May 2015 discussion held with the VP Nursing Programs regarding the discrepancy between (1) the list of 29 residents diagnosed with an ARO provided by the Coordinator of the Clinical Practice and Performance to inspector #592 on a specified date in May 2015 and (2) the additional 11 isolation carts observed by inspector #592 throughout the home. The VP Nursing Programs told the inspector that these carts could be left over from the previous outbreak due to a lack of storage. The VP Nursing Programs indicated to inspector #592 that the home has just started to do swabs in order for the home to do a closer follow-up. She indicated that Registered staff are responsible for knowing the type of ARO as well as the location of the ARO and to set up the isolation carts and conduct the follow-ups. The VP Nursing Programs Indicated that this information would be documented in the affected resident's progress notes once the resident was confirmed positive. She indicated that when they moved from the old home to the new home, they had lost track of the residents who had been identified as ARO positive and that there was a lack of documentation in this regard. The VP Nursing Programs further indicated that the home is unsure of the mode of transmission of the ARO's and that many of the residents had been identified as ARO positive a long time ago and hence, the home needs to swab the residents for ARO again.

On the same specified date in May 2015 the VP Nursing Programs also told inspector #592 that the home is currently working on a tracking tool and, as well, are re-swabbing residents who had been diagnosed being ARO positive to ensure that

the data and the location of the ARO is accurate.

4. On May 7, 2015, inspector #592 observed the following unlabeled personal care items:

In the Dublin house spa room there was 1 jar of used Pond's cream, one hairbrush with hair in the bristles, 1 nail clipper and 1 roll-on antiperspirant deodorant. In the Donegal house spa room there was 1 used bar of soap. In the Carlow house spa room there was 1 hair brush with hair on the bristles, 1 used comb and 2 roll-on deodorants. In the Cavan house spa room there were 2 hairbrushes with hair on their bristles, 8 roll-on deodorants, one razor with hair and yellow matter in the blade, 1 container of Aveeno-skin relief moisturizing cream and 1 container of used petroleum jelly. In the Galway house spa room there were 7 roll-on deodorants, two bars of soap used in a lever 2000 box, 1 comb, 1 razor. On May 8, 2015, during an interview with PSW S#107, told inspector #592 that personal items, such as brushes, combs, toothbrushes are being kept in the resident's room. PSW are to ensure that all resident have their personal items and no labeling is required as the personal items stay in the resident's room.

On May 8, 2015, during an interview with RPN S#108 she indicated that if resident's personal items are being found unlabeled in the spa rooms, personal items should discarded due to possible infection control issues. [s. 86. (3)]

Given the widespread non-compliance described above, the extensive compliance history of the home coupled with the potential risk to Residents, an Order is being issued. (161)

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

Sep 30, 2015(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. Plan of care

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that there is a written plan of care for each resident that meets all of the legislated provisions and requirements of the LTCHA, 2007 S.O. 2007, c.8, s.6. Plan of Care.

The plan shall include the following:
1. Registered Nurse and Registered Practical Nurse support required to develop a written plan of care for Residents with care needs related to infections, falls, use of restraints/PASD, responsive behaviours, snacks and fluid intake between meals and personal hygiene and to implement the individualized plan of care for each Resident;

2. Ongoing supervision of the personal care staff to ensure that the Resident's plan of care provides clear direction and ensure that the care set out in the plan of care is provided to each Resident;

3. Communication strategies to ensure that all staff who provide direct care to a resident are kept aware of the contents of the plan of care;

4. Ongoing monitoring to ensure the documentation of the provision of care, outcomes of care and effectiveness of each Resident's plan of care is completed.

This plan must be submitted in writing to Kathleen Smid and Lyne Duchesne, LTCH Inspectors at 347 Preston St, 4th floor, Ottawa, Ontario, K1S 3J4 or by fax (613) 569-9670 on or before June 12, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident.

On a specified date in May 2015, it was noted during a tour of the home that an infection control cart containing personal protective equipment (PPE) was located outside four resident rooms although there was no signage indicating what type of precautions were required when providing care to the resident.

During an interview on a specified date in May 2015 with PSW S#118, she told inspector #592 that resident in a specified room was diagnosed with an ARO and staff were to wear PPE. She further told inspector #592 that the planned care for resident diagnosed with an infection would be in the POC software in the kardex or care plan section. PSW S#118 was unable to find any planned care for this resident in the POC. PSW S# 118 asked her co-worker PSW S#119 where would be located the information for the planned care for resident diagnose with an infection. Co-worker PSW S# 119 was not able to find any information and confirmed that another resident in a differed room was also diagnosed with an ARO and was not able to find any planned care and directions for this resident either.

During an interview on a specified date in May 2015, with PSW S# 129, she told inspector #592 that Resident in a specified room was diagnosed with an ARO in a specified area of their body, therefore staff were to wear PPE's. She further told inspector #592 that no information of the planned care for this resident was provided to them other than the verbal morning report communicated by the registered staff.

During an interview on a specified date in May 2015, with RPN S#130, she told inspector #592 that resident in a specified room was diagnosed with an ARO and a bacterial infection. She further told inspector #592 that nursing staff refers on the check list located in the nursing desk for the current status of resident diagnosed with an infection. In addition she told inspector #592 that the information should be in the PSW's POC for the planned care of the affected residents. She confirmed that this was also diagnosed with an ARO and was unable to find any documentation in the electronic Point click care software and in the Resident Health Care Records for both of the residents. She confirmed that the plan of care for both residents did not include the bacterial infection nor ARO, nor provide any direction to staff as to what care or

precautions were required for the resident related to a bacterial infection nor ARO.

On a specified date in May 2015, during an interview with the VP Nursing, she told inspector #592 that residents who are being identified with infections should have a planned care documented in the POC/care plan. She further indicated that any documentation in the plan of care should reflect in the POC and would include the precautions required when providing care to the residents. [s. 6. (1) (a)] (592)

- Resident #39 is identified as having some cognitive impairment and is at high risk of falls. The resident was observed to be seated in a tilt wheelchair with a lap belt and a tab alarm attached to the wheelchair

Interviewed staff members RPN S#126 and PSW S#122 stated to Inspector #117 that Resident #39 is at risk of falls. The wheelchair lap belt is a safety measure and a fall prevention intervention. They stated that the resident was able to undo the lap belt. Resident #39 was observed to undo the lap belt when asked by the unit RPN S#126.

A review of the resident's current plan of care, dated in the winter of 2015, identifies that the resident has a tilt wheelchair for mobility. Fall mats, a wheelchair tab alarm and a BAM monitor for their bed as fall prevention interventions and a PASD (positioning aide safety device). Further review of the POC system, which documents the provision of resident care, shows the same fall and mobility interventions in place. There is no information on the application and use of the wheelchair lap belt. The plan of care and POC were reviewed with PSW S#122, RPN S#126 and unit RN #116. All three stated that the use and application of the wheelchair lap belt as a fall prevention intervention and as a PASD should be identified in the resident's plan of care and POC. The Unit RN S#116 reviewed the home's monthly restraint and PASD audit form which is completed by the home's Restorative Care Lead on a monthly basis. This form identifies the use of the tilt wheelchair and lap belt as a PASD for Resident #39. Unit RN S#116 immediately accessed the home's Point Click Care system and changed the resident's electronic plan of care and POC system to reflect the use and application of the lap belt as a fall prevention intervention.

Resident #39's written plan of care did not identify the resident's planned care in regards to the use and application of a wheelchair lap belt as a fall prevention intervention and a PASD. [s. 6. (1) (a)] (117)

2. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and other that provide direct care to residents.

On a specified date in March 2015 the home submitted a Critical Incident Report to the Director reporting that Resident #067 had been sent to hospital after exhibiting responsive behaviours during a shower including kicking the shower chair which resulted in bruising to the Resident's right foot. A review Resident #067's health care record indicates that the Resident has a history of progressive cognitive impairment. A review of the Resident's progress notes from a specified date in March 2015 to a specified date in May 2015 indicate that Resident #067 has displayed responsive behaviours including resistive to care, refusing medications, physical altercations with co-residents and staff, as well as rummaging in other resident rooms. A review of the Resident's plan of care does not identify the behavioural triggers, strategies to respond to these behaviours nor interventions.

On May 20, 2015 this was validated by the Coordinator of Clinical Practice and Performance. [s. 6. (1) (c)] (161)

3. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

Upon review of the health care record for Resident #056, the resident was diagnosed with a chronic disease and as per resident plan of care resident is being identified with frequent urinary tract infections.

On a specified date in January 2015, Resident #056 was identified with a urinary tract infection and was treated for a total of 7 days with success.

On a specified date in March 2015, Resident #056 was identified by an RPN member, with the symptoms of a urinary tract infection. RPN member placed a note in the Physician's book requesting an assessment of Resident #056 on that date. However the physician schedule was adjusted and he was not present in the home until several days later.

On a specified date in March 2015, the physician visited Resident #056 and informed

Nursing staff to continue attempts in obtaining urine sample and to continue the current treatment plan.

Over an 11 day period in May 2015, it was indicated in the progress notes that resident #056's health status had declined as resident was observed being restless with an increase of behaviours and no more weight bearing requiring nursing rehab to be involved. Resident was also observed in a decrease in their appetite and food intake.

Notes were left to physician indicating resident #056 to be restless over past number of days and the symptoms of a potential urinary tract infection, however, the SDM was not made aware of the medical concerns and the declining status of Resident #056. The SDM was not provided the opportunity to participate fully in the development and implementation of the plan of care for this Resident until 12 days after when she visited the home on a specified date in March 2015.

On a specified date in May 2015, during an interview with the VP Nursing Program, she told inspector #592, that a response letter was send to the SDM following written concerns of not being contacted regarding the declining status of Resident #056. The VP Nursing indicated that following the investigation, the home did recognize that Nursing Staff did not contact the SDM and that the home's expectation is that any change in status of the resident should be communicated immediately to the SDM in order to participate fully in the development and implementation of the plan of care for residents. [s. 6. (5)] (592)] (Log #O-002045-15)

4. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Inspector #138 observed the morning fluid pass on Donegal on May 13, 2015. It was noted by the inspector that the beverage cart had written directions that outlined several residents to receive fortified juice (15ml corn syrup with 125ml juice), specifically for Resident #062, Resident # 063, and Resident #064. The inspector observed the fluid pass and did not observe that any fortified juices were distributed. It was specifically observed that Resident #062 was provided juice that was poured by a PSW from the container of juice on the beverage cart and that it was prepared with thickener but not with corn syrup. The inspector also noted that corn syrup was not on the beverage cart nor were there any beverages specifically labelled for residents that could have been fortified juice. The inspector again observed the

morning fluid pass the following day on Donegal and noted that the beverage cart did not have any corn syrup or any prepared beverages for specific residents on the beverage cart. The inspector observed PSW, Staff #136, pour beverages from the cart for Resident #062, Resident #063, and Resident #064 and noted that no corn syrup was added to the beverages. These residents drank the beverage that was poured for them.

The inspector also observed the morning fluid pass on Dublin on May 15, 2015 and noted that the beverage cart on this unit also had written directions that outlined several residents were to receive fortified juice including Resident #065 and Resident #038. The inspector observed the fluid pass and noted that juice was poured for both these residents from the beverage cart and were not prepared with corn syrup. The inspector spoke with the PSW, Staff #146, distributing the fluids and she stated that she does not provide fortified juice and directed the inspector to the RPN. The RPN, Staff #133, stated that fortified juices are only provided on an as needed basis.

The inspector reviewed the nutritional plan of care for the above residents which, according to the home's dietitian, is considered to be the hard copy of the care plan found on the resident's chart as well as information in the dietary binder on the unit servery. It was noted that the nutritional plan of care for the residents mentioned above (Resident #062, #063, #064, #065, and #038) all stated that fortified juice was to be provided at snacks. The dietitian stated to the inspector that fortified juice is a current intervention used in the home for specific residents. [s. 6. (7)] (138)

5. The licensee has failed to ensure that the interventions set out in the Resident #04's written plan of care related to his/her Resistive behaviours to Activities of Daily Living were not provided to the resident as specified.

On three specified dates in May 2015 Inspector #573 observed that Resident #04's fingernails in both hands were long, untrimmed and unclean with black colour dirt underneath the nails. It was also noted Resident #04 to have a few long facial hairs under their chin that was poorly shaven and groomed.

Inspector reviewed Resident #04's Plan of care in effect which identifies that Resident #04 requires one staff limited assistance for personal hygiene and one staff extensive assistance for bathing. The plan of care indicates that Resident #04 is resistive to Activity of Daily Living (ADL) care and the interventions in place indicated

- "If possible, negotiate a time for ADLs so that the resident participates in the decision making process. Return at the agreed time".
- "If resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again".
- "ROH – Behavioural Support Outreach program to assist with behaviours".

Inspector #573 reviewed the bath list which indicates that Resident #04's shower days were scheduled twice weekly. Upon reviewing Resident #04's "Activities of Daily Living – Bathing" report, from the POC documented from a specified date in April 2015 to a month later indicated that Resident #04 had refused showers for 7 days. There is no indication in the progress notes that Resident #04 was provided with any alternate bathing care for the refused shower days.

On May 11, 2015, PSW S#121 and RPN S#111 both stated to Inspector that Resident #04 has poor personnel hygiene and constantly resists or refuses assistance for the personnel hygiene and bathing. RPN S#111 indicated that on Resident #04 shower days, if resident resists their shower PSW staffs would approach again before noon and if resident still refuses or resists for personal hygiene and bathing, the resident would not get their shower on that day. Further both the PSW S#121 and RPN S#111 were not aware of any alternative interventions that would be provided to the resident to ensure that Resident #04 receives their personnel hygiene and bathing on regular basics.

On May 14, 2015 during an interview with RN S#116 indicated that resident was seen by Behavioural Support Outreach (BSO) in 2013 for resistive behaviours to care and since then the resident was not referred back to the BSO outreach to manage their resistive behaviours to care.

All the interventions set out in the Resident #04's written plan of care related to their Resistive behaviours to Activities of Daily living was not provided to the resident as specified. [s. 6. (7)] (573)

6. The licensee has failed to ensure that the provision of the care set out in the plan of care for Resident #02 is documented.

On three days in May 2015, Inspector #573 observed that Resident #02 fingernails were long, untrimmed and unclean with brown matter under the long finger nails.

Resident #02's Plan of care in effect indicated that resident requires extensive assistance for personal hygiene and bathing due to their physical condition, further the plan of care indicated that resident to get bath twice a week.

Inspector #573 reviewed the bath list which indicated that Resident #02's had 2 scheduled bath days per week. Upon reviewing The "Activities of Daily Living – Bathing" report from the POC documentation, there is no indication that Resident #02 received their bath and nail care on two scheduled dates in May 2015.

On a specified date in May 2015, Inspector spoke with the PSW S#121 who indicated that Resident fingernails were to be cleaned and trimmed by staffs on the bath days and further indicated that the bath was provided to the Resident #02 on the scheduled days in May 2015 but it was not documented in the in POC. PSW S#121 concurred with the Inspector that Resident #02's nails were dirty and needed to be cleaned.

On a specified date in May 2015, Inspector #573 spoke to the In-charge floor RN S#116 indicated that when bathing and nail care is provided to residents by the PSW staff members, the expectation of the PSW staff members is to document in the POC that set out care was provided to the residents.

The provision of the Bathing and Nail Care as set out in the plan of care is not documented for Resident #02. [s. 6. (9)(1)] (573) [s. 6.]

Given the widespread non-compliance described above, the extensive compliance history of the home coupled with the potential risk to Residents, an Order is being issued.
(161)

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

Sep 30, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 27 day of August 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

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

Service Area Office /
Bureau régional de services : Ottawa