Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 26, 2015	2015_331595_0001	T-000095-14	Resident Quality Inspection

Licensee/Titulaire de permis

STAYNER NURSING HOME LIMITED
244 MAIN STREET EAST 7308 HIGHWAY #26, P.O. BOX 350 STAYNER ON L0M 1S0

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

STAYNER NURSING HOME LIMITED
244 MAIN STREET EAST 7308 HIGHWAY #26, P.O. BOX 350 STAYNER ON L0M 1S0

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

MARINA MOFFATT (595), LINDSAY DYRDA (575), MONIKA GRAY (594)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 05-09 and 12-15, 2015

This inspection includes logs #T-001270-14 and #T-001442-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Staff, Personal Support Workers (PSWs), Laundry staff, Cook, Dietary Aide, Maintenance, Activity Assistant, Resident Assessment Instrument (RAI) Coordinator, Residents and Family Members.

The inspector(s) also reviewed policies, plans of care and other documentation within the home, conducted daily walk through of the resident care areas and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

25 WN(s)
17 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care provides clear direction to staff and others who provide direct care to Residents #006, #008 and #009.

During an interview with Inspector #595, Resident #006 stated that they had oral issues. Inspector #594 reviewed the resident's care plan which identified a focus to maintain good oral health with assistance and staff to provide total care to comb hair, wash/dry face/hands and perineum.

During an interview with Inspector #594, Resident #006 stated that staff and/or the resident’s spouse will assist with denture care. Inspector #594 interviewed Staff #104 who stated staff provide assistance with mouth care.

Inspector #595 reviewed the health care record for Resident #008. Upon review of the care plan and kardex, it did not identify the resident's oral/dental care needs. The only reference to oral/dental care was in a focus which indicated that the resident required assistance with mouth care.

The inspector spoke with Staff #106 who confirmed that there were no dental/oral care interventions listed in Resident #008's care plan. The staff member informed inspector that Personal Support Workers (PSWs) have access to the kardex and the care plan in resident binders.

Inspector #595 reviewed the care plan for Resident #009. Under the focus of 'Personal Hygiene' a goal was for the resident to maintain good oral hygiene without assistance, however there were no interventions listed pertaining to oral or dental care. The inspector reviewed the kardex which mirrored the same information outlined in the care plan.

Inspector #595 interviewed four staff members who all identified that Resident #009 required some assistance with dental/oral care. It was confirmed by Staff #106 that the care plan did not list interventions for oral/dental care for Resident #009. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Residents #006, #008 and #009, and any other resident has their care plan updated and outlines clear directions to those who provide direct care to those residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy 'Continence Care and Bowel Management Program' is complied with.

Inspector #575 reviewed the home's policy 'Continence Care and Bowel Management Program' revised March 1, 2011. The policy indicated that staff are to conduct a bowel and bladder continence assessment using a clinically appropriate instrument on admission, quarterly, and after any change in condition and that the assessment must include identification of casual factors, patterns, type of incontinence, medications, potential to restore function, and type and frequency of assistance needed.

During an interview, the DOC confirmed that the Continence Care Assessment was not used routinely by staff and would only be used if there was a significant change in the resident's status. Inspector #575 reviewed Resident #007 and #010's health care records and noted that the Continence Care Assessment was not completed for either resident. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policy 'Continence Care and Bowel Management' is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when not being supervised by staff.

During a tour of the home, Inspector #594 observed on the main level of the home:

a. A staff coat/storage room on the west wing which contained two large stationary helium units, a television stored on the floor, a large mechanical floor buffer, vacuum, boots and coats. The door was unlocked, did not contain a locking device, and was unsupervised.
b. A linen storage room on the east hall that contained a locking mechanism but was unlocked and unsupervised. Stored within the room were linens, hooks used on bed systems and a step ladder.
c. An electrical room off the north hallway equipped with a child proof door knob but was unlocked, did contain a locking mechanism but was unsupervised. Four stacks of chairs stacked 12 high, a maintenance cart, and three electrical panels were located within the room.
d. A dirty utility room down the east hall that was unlocked and unsupervised, the door was not equipped with a locking mechanism and contained: a utility sink filled with water, clean wash bins and bed pans, a locked padlock cabinet under the sink, a locked grey plastic storage cabinet, four Vision Aire oxygen dispensing units and electronic computer system equipment (modem/hub).
e. A dirty utility room down the north hall that was unlocked and unsupervised and was not equipped with a locking mechanism, and was slightly ajar. The room contained a utility sink filled with water, clean wash bins and bed pans, a locked padlock cabinet under the sink, a locked grey plastic storage cabinet, five individual labeled bed ban brushes and a sharps collection box containing one large and one small sharps container that were filled.

In an interview with Inspector #594, the Administrator stated all the aforementioned areas were non-residential areas and validated that those doors were kept unlocked in the home. [s. 9. (1) 2.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that Residents #005, #006, #007, and #008, and all other residents using side rails, were assessed for the need/use of bedrails, and that the bed system was assessed.

In an interview with the Administrator, Inspector #595 was advised that the home had a company come in January 2013 to assess all of the beds for entrapment zones. At that time, all beds failed due to the use of 3/4 rails. Inspector questioned the Administrator if residents or their bed system had been reassessed since that time, or if any new admissions were assessed. The Administrator stated that residents from the time of the 2013 assessment were not reassessed, those with new side rails were not reassessed, and newly admitted residents were not assessed. The Administrator continued to explain that there was no formal process in the home to assess residents and their bed system.

During an interview with Inspector #594, Resident #005 identified that they had to use bed rails. Inspector #594 reviewed the health care record for Resident #005. An intervention in the resident's care plan identified that side rails were to be up at all times when the resident was in bed for safety. This intervention was later revised which indicated that the side rails were to be up when the resident was in bed during the night for safety. Inspector #594 interviewed Staff #110 who stated that the resident was physically capable of getting out of bed on their own, and when the side rails were raised, prevented the resident from voluntarily getting out of bed. In a progress note staff documented that they found Resident #005 stuck between the foot of the bed and the side rail as the resident was attempting to get out of bed to use the restroom.

On a day in January Inspector #595 observed the bed system for Resident #006 which revealed the use of one side rail. Upon review of the resident's care plan, it was identified that staff were to put up one side rail at all times when the resident was in bed for safety. It was further identified that this resident had difficulty with mobility and transferring, which was also supported by a recent MDS assessment which highlighted the use of bed rails for bed mobility or transfer.

On another day Inspector #575 observed Resident #007 in bed with side rails up. Inspector reviewed the health care record for Resident #007. The resident's care plan identified that staff were to put up side rails at all times when the resident was in bed for safety. The most recent MDS assessment revealed the use of side rails for bed mobility or transfer. Inspector #575 interviewed Resident #007 who stated that they do not use the side rails for bed mobility, rather for safety.

Inspector #595 reviewed the health care record for Resident #008. In the care plan it was indicated that staff were to put one side rail up at all times when in bed as the resident prefers this. Inspector #595 spoke with Staff #106 who informed the inspector that the side rails for Resident #008 are used for repositioning and do not prevent the resident from getting out of bed. Upon further review of the most recent MDS assessment it was indicated that the resident does not use side rails. Inspector #595 observed the side rail up while the resident was in and out of bed.

Inspector #595 interviewed Staff #103 who confirmed that neither Resident #008 nor #007 received an assessment to determine the need for side rails. Staff #103 stated that the side rails for Resident #008 were raised out of habit and that there was no specific reason why the side rails were initially implemented. Staff #103 continued on and

explained that they were not aware of the reason for the use of side rails for Resident #007, although they believe that the resident's family wanted the side rails up.

Inspector #595 toured the home and noted that 44/47 resident beds had side rails in the up position, with both residents in and out of bed. It was noted that two beds did not have any side rails raised, and one resident sleeps in their chair. There was one bed in a room with no assigned resident - this bed was not included in the total count. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During an interview with Inspector #594, Resident #005 identified that they had to use bed rails. Inspector #594 reviewed the health care record for Resident #005. An intervention in the resident's care plan identified that side rails were to be up at all times when the resident was in bed for safety. This intervention was later revised which indicated that the side rails were to be up when the resident was in bed during the night for safety. Inspector #594 interviewed Staff #110 who stated that the resident was physically capable of getting out of bed on their own, and when the side rails were raised, prevented the resident from voluntarily getting out of bed. In a progress note staff documented that they found Resident #005 stuck between the foot of the bed and the side rail as the resident was attempting to get out of bed to use the restroom.

Inspector #595 toured the home and noted that 44/47 resident beds had side rails in the up position, with both residents in and out of bed. It was noted that two beds did not have any side rails raised, and one resident sleeps in their chair. There was one bed in a room with no assigned resident - this bed was not included in the total count.

Inspector #595 spoke with the Administrator who informed the inspector that the home had a company come in January 2013 to assess all of the beds for entrapment zones. At that time, all beds failed due to the use of 3/4 rails. Inspector asked the Administrator if residents or their bed system had been reassessed since that time, or if any new admissions were assessed. The Administrator stated that residents from the time of the 2013 assessment were not reassessed, those with new side rails were not reassessed, and newly admitted residents were not assessed. The Administrator continued to explain that there was no formal process in the home to assess residents and their bed system.

Inspector #595 asked the Administrator to specify what the home was doing to prevent the entrapment of residents. The Administrator stated that the home evaluated resident

condition and risk, and would constantly assess those residents with behaviours or who were restless at night. If staff observed that a resident's limb was caught in the side rail, bumper pads would be instituted to prevent further incidents. The staff member also identified that if a resident was restless during the night, staff would transfer them into a 'cozy chair' (to prevent entrapment) or bring the entire bed out to the nursing station to be observed. [s. 15. (1) (b)]

3. The licensee has failed to ensure that where bed rails are used, other safety issues related to the use of bed rails are addressed, including height and latch reliability.

Inspector #595 asked the Administrator to clarify if the company had assessed for height and latch reliability at the time of the January 2013 assessment. The Administrator reviewed the assessment spreadsheet provided by the company and could not clearly identify whether latch and height reliability were assessed. It was determined that only entrapment zones were assessed at that time. [s. 15. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents using side rails are assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and other safety issues related to the use of bed rails are addressed, including height and latch reliability, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system could be easily accessed, and used by Residents #007 and #010 at all times.

On a day in January Inspector #575 observed Resident #007 sitting in their wheelchair beside their bed, however the call bell was on the opposite side of the bed, not within reach. A few days later Inspector #575 observed Resident #007 sitting in their wheelchair beside the bed with the call bell on the floor, not within reach.

Inspector #575 reviewed the home's policy 'Nursing Standards of care - Quality Management' that indicated that 'call bells are always within easy reach for non-mobile residents in their rooms'. Inspector interviewed the DOC who confirmed that Resident #007 was non-mobile. Inspector reviewed the resident's care plan and noted that staff were to have commonly used articles within easy reach and reinforce the need to call for assistance. Staff #113 stated that the resident does use the call bell for assistance and that staff are to ensure it is within reach at all times. Inspector #575 spoke with Resident #007 who reported that they use the call bell for assistance.

On two days in January Inspector #575 observed Resident #010 sitting in their wheelchair beside their bed however the call bell was on the opposite side of the bed, not within reach.

The inspector reviewed the home's policy 'Nursing Standards of care - Quality Management' that indicated that 'call bells are always within easy reach for non-mobile residents in their rooms'. Inspector interviewed the DOC who confirmed that Resident #010 was non-mobile. Inspector reviewed the resident's most recent care plan and noted that staff were to have commonly used articles within easy reach. During an interview with Resident #010, it was identified that if the resident needed staff's attention they would use 'a call bell'. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the homes resident-staff communication and response system can be easily accessed, and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone in the home.

A Critical Incident (CI) submitted to the Director reported an alleged incident of staff-to-resident abuse.

Resident #003 reported to the Administrator that the evening prior, Staff #109 threw a glass of orange juice at them and the glass struck them and caused juice to spill on their hair and clothing. The Administrator spoke with nursing staff regarding the incident and there were no reports of a resident being struck by a glass, however there was documentation which reported that drinking glasses were allegedly thrown by the resident, at the television set in the lounge. The Administrator explained to resident that an investigation would be initiated.

Staff #109 had documented that evening that they were in the lounge giving out evening (hs) snack when they heard drinking glasses hitting the floor and witnessed glasses hitting the TV screen, however could not confirm whether it was Resident #003 throwing them.

Staff #102, who was working with Staff #109 at the time of the incident, came into the home that same day, and stated that they witnessed Staff #109 throwing the drinking glasses at the TV. According to Staff #102, Staff #109 told them it was the resident who threw the glasses.

Staff #109 was called into the home the same day. Their version of the story was not consistent with the accounts from Staff #102 and Resident #003. Staff #109 was put on paid leave pending the investigation, and informed that if the allegations were true, would constitute abuse and result in dismissal due to the home's Zero Tolerance policy.

Over a week later, Staff #109 was called into the home to meet with the Administrator and the DOC. As a result of a detailed investigation conducted by the home, Staff #109's employment was terminated due to abuse. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone in the home, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents set out the consequences for those who abuse or neglect residents.

Inspector #595 reviewed the home's policy 'Resident Abuse & Neglect - Zero Tolerance'. Inspector could not identify where in the policy it outlined the consequences for those who abuse or neglect residents. Inspector #595 questioned the Administrator about the location of these requirements in the policy. The Administrator could not locate the consequences for staff in this specific policy. [s. 20. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policy 'Resident Abuse & Neglect - Zero Tolerance' complies with the LTCHA and any additional matters as may be provided for in the regulations, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Resident #008 informed Inspector #595 that a staff member had hit them in the shoulder and rustled them. The resident could not remember the staff member's name, however they claimed that they informed other staff of the incident. Resident #008 also alleged that staff members have yelled at them but could not recall specific dates or staff.

The next day, Inspector #595 brought this information forward to the home's Administrator. The Administrator stated that this resident had not come forward previously with any concerns of abuse, however they would "keep an ear out" for any other information surrounding this resident's alleged abuse. That same day, the Administrator initiated an investigation surrounding the alleged abuse. The Administrator talked with staff who confirmed that the resident had not come forward with any concerns. That same day the Administrator approached Resident #008 and asked questions about how staff treat them and to explain further about the comment made to Inspector #595. The resident stated that they did not recall the conversation and that they were satisfied with the care provided by staff.

Days later, Inspector #595 checked the Critical Incident System to determine if the home submitted a Critical Incident Report based upon the alleged abuse reported by Resident #008. There was no evidence that the home reported any type of abuse to the Director.

Resident #011 reported to Inspector #594 that Staff #111 was rushing them during care causing pain. The next day Inspector #594 brought this information forward to the home's Administrator. The Administrator stated that this resident had not come forward with any concerns with this specific staff member. The Administrator spoke with Resident #011 who stated that they aren't given enough time to get up and that when they do get up it hurts. The Administrator spoke with staff #111 and instructed them to be patient while caring for residents and allow residents to participate in their own care. Staff #111 received a written warning.

Days later, Inspector #595 checked the Critical Incident System to determine if the home submitted a Critical Incident Report based upon the alleged abuse reported by Resident

#011. There was no evidence that the home reported any type of abuse to the Director.

Upon review of Resident #001's progress notes, Inspector #594 noted documentation pertaining to an altercation between Resident #001 and Resident #012 in 2014. Resident #001 was observed by staff to be holding Resident #012 by the arms and pushing them into the wall. It was documented that Resident #012 hit their head but no injury was present at the time. Resident #012 was removed from the situation by staff, and Resident #001 continued to be display responsive behaviours as staff were trying to assist them. Resident #001 was not receptive to staff interventions and threw an object and continued to display responsive behaviours. Due to ongoing responsive behaviours, medication was administered by staff to Resident #001 with effect.

Inspector #595 checked the Critical Incident System to determine if the home submitted a Critical Incident Report based upon the documented resident-to-resident abuse. There was no evidence that the home reported any type of abuse to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of Resident #013's communication abilities.

Inspector #595 reviewed the health care record for Resident #013. The most recent care plan identified that the resident has an inability to express emotion and share information. Interventions identified engaging the resident in conversation so they could express fears and worries, staff were to monitor for changes in cognitive status, and to provide reassurance and patience while communicating with Resident #013.

Inspector #595 interviewed Staff #105, #106, and #108 who all identified that Resident #013 does not talk, however will sometimes answer 'yes' or 'no'. Staff #107 identified that they have not heard this resident speak in a long time. Inspector #595 approached Resident #013 and attempted to converse with the resident, however the resident smiled and patted the inspector's hand and would not speak. [s. 26. (3) 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 Resident #013's and any other resident's plan of care is based on an interdisciplinary assessment of their communication abilities, including hearing and language, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment is required.

Inspector #595 reviewed the health care record for Resident #008. It was noted that there was no indication of the home offering the resident an annual dental assessment. Inspector interviewed the DOC who stated that the home will only offer dental assessments to those residents who trigger with dental issues or identify dental issues, will be offered a dental assessment at that time or at their care conference. The staff member also stated that sometimes the residents or their families will arrange appointments on their own. The DOC stated that they do not go around to every resident and ask if they want a dental assessment. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #007, #008 and #010, who are incontinent, received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Inspector #595 reviewed the health care record for Resident #008. Upon review of the assessments in PointClickCare, the inspector was unable to locate any incontinence assessments. However, the resident's care plan, listed goals and interventions for incontinence.

Inspector #595 spoke with Staff #105, #106, #107 and #108 who all identified that Resident #008 was occasionally incontinent, and as a result used incontinent products, was on a toileting routine, and received some assistance with toileting. All staff identified different reasons for the resident's incontinence. Inspector #595 spoke with Staff #103 who confirmed that the resident was not assessed using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

2. Inspector #575 reviewed the health care record for Resident #007 regarding continence care. According to the most recent MDS assessment, the resident is frequently incontinent. Inspector #575 was unable to locate a bowel and bladder

continence assessment. During an interview, the DOC confirmed to the inspector that the assessment was not completed for Resident #007. [s. 51. (2) (a)]

3. Inspector #575 reviewed the health care record for Resident #010 regarding continence care. According to the most recent MDS assessment, the resident was incontinent. Inspector was unable to locate a bowel and bladder continence assessment. During an interview, the DOC confirmed that the assessment was not completed for Resident #010.

Inspector #575 reviewed the home's policy 'Continence Care and Bowel Management Program' revised March 1, 2011. The policy indicated that staff were to conduct a bowel and bladder continence assessment using a clinically appropriate instrument on admission, quarterly, and after any change in condition and that the assessment must include identification of casual factors, patterns, type of incontinence, medications, potential to restore function, and type and frequency of assistance needed. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Residents #007, #008 and #010 and any other resident who is incontinent, receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The home has failed to ensure that the policy titled 'Weight & Height' was implemented.

Inspector #575 reviewed the home's policy 'Weight & Height' dated October 26, 2006. The policy stated that each resident's height is taken on admission and annually thereafter.

During an interview, Staff #103 informed Inspector #575 that heights are only measured on admission and are not completed annually. Inspector reviewed five resident health care records (#014, #015, #016, #017 and #018) who were admitted to the home more than one year ago and noted that heights were only taken on the day of or within days of admission.[s. 68. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a weight monitoring system to measure and record with respect to each resident, height upon admission and annually thereafter, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have receive retraining annually on the home's policy to promote zero tolerance of abuse and neglect of residents. The Administrator informed Inspector #595 that all staff except one employee, Staff #112, had completed the annual re-training for 2014. [s. 76. (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 the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate.

Critical Incident (CI) submitted to the Director reported an alleged incident of staff-to-resident abuse. It was alleged that Staff #109 threw a plastic cup at a resident. Inspector #595 reviewed the home's investigation package as provided by the Administrator. The following interventions were implemented throughout the investigation:

- Staff #109 was called into the home to speak with management;
- Staff #109 was advised that they would be placed on paid suspension pending the result of the investigation;

- Staff #109 was informed that they could not enter the home unless given permission;
- The Administrator and DOC explained to Staff #109 what would happen pending the outcomes of the investigation (confirmed allegations constituted abuse and would result in dismissal); and
- The Ministry of Health and Long-Term Care was notified as per the home's policy.

Inspector #595 reviewed the home's policy 'Resident Abuse & Neglect - Zero Tolerance'. Under 'Section Three: Actions to be Taken by Staff Role and Responsibilities' it outlined the following items for a 'staff member alleged to have caused the abuse or neglect':

- Document details as soon as possible including dates, times, witnesses.
- Cooperate fully with individuals or organizations responsible for the investigation. It is the right of anyone alleged to abuse or neglect to be accompanied by a co-worker during the investigatory meetings.
- Seek supportive counseling if desired.
- Maintain confidentiality regarding the report and names of all those involved in the incident.

Despite the home's actions with Staff #109, the policy 'Resident Abuse & Neglect - Zero Tolerance' failed to identify procedures and interventions to deal with persons who (allegedly) abused or neglected residents, as appropriate. [s. 96. (b)]

2. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies measures and strategies to prevent abuse and neglect.

Inspector #595 reviewed the home's policy 'Resident Abuse & Neglect - Zero Tolerance' and could not identify measures and strategies to prevent abuse and neglect of residents. Inspector #595 interviewed the Administrator who stated that the only measures mentioned in the policy were staff completing educational sessions and management staff keeping track of those who completed specific sessions. Within the policy, these interventions were mentioned under staff education and training, and did not highlight them as preventative measures or strategies of abuse and neglect. [s. 96. (c)]

3. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including training on the relationship between power imbalances

between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations.

Inspector #595 reviewed the home's policy 'Resident Abuse & Neglect - Zero Tolerance'. Under 'Section One: Education and Training about Prevention of Abuse and Neglect Staff Education' the following items were to be reviewed by staff:

- Policy and Procedures for Zero Tolerance of Abuse and Neglect
- Policy and Procedures on Reporting and Whistle-blowing Protection Against Retaliation
- Policy and Procedures for Managing Complaints
- Policy and Procedures Minimizing Restraining and Use of PASDs

The policy does not outline the training and retraining requirements for all staff including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations. [s. 96. (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate; (c) identifies measures and strategies to prevent abuse and neglect; and (e) identifies the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented, is promptly prepared.

The Administrator stated to Inspector #595 that there was an ongoing list in the front of the policy binders that identified what policy/procedure was reviewed and the date it was reviewed. The Administrator could not produce a written record at that time and stated that they do not document who reviews the policies and any changes made to them. The Administrator mentioned that any major or significant changes made to a policy would be brought forward to meetings and reviewed there. [s. 99. (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written record of: at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences; the changes and improvements are promptly implemented and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy addresses the duties and responsibilities of the staff, including who has the authority to apply or release a physical device.

Inspector #575 reviewed the home's policy 'Minimizing Restraining of Residents: Use of Restraints' revised July 1, 2010. Inspector noted that the policy only indicated that staff under the instruction of the physician or RN (extended class) can apply a restraint by physical device and does not indicate who can release the device. The DOC informed Inspector #575 that PSWs are authorized to apply and release restraints and confirmed this was not indicated in the policy.

The licensee has failed to ensure that the home's policy 'Minimizing Restraining of Residents: Use of Restraints' addressed the duties and responsibilities of the staff, including who has the authority to apply or release a physical device. [s. 109. (b) (i)]

2. The licensee has failed to ensure that the home's 'Minimizing Restraining of Residents: Use of Restraints' policy addressed the duties and responsibilities of the staff, including ensuring that all appropriate staff are aware at all times of when a resident is being restrained by a physical device.

Inspector #575 reviewed the home's policy 'Minimizing Restraining of Residents: Use of Restraints' revised July 1, 2010. Inspector noted that the policy did not indicate the duties and responsibilities of the staff, including ensuring that all appropriate staff are aware at all times of when a resident is being restrained by a physical device. The DOC confirmed that the policy did not include this information. [s. 109. (b) (ii)]

3. The licensee has failed to ensure that the home's policy 'Minimizing Restraining of Residents: Use of Restraints' addressed types of physical devices permitted to be used.

Inspector #575 reviewed the home's policy titled 'Minimizing Restraining of Residents: Use of Restraints' revised July 1, 2010. Inspector noted and the DOC confirmed that the policy did not address the use of physical devices permitted to be used. [s. 109. (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 home's policy 'Minimizing Restraining of Residents: Use of Restraints' identifies duties and responsibilities of staff including, who has the authority to apply a physical device to restrain a resident or release a resident from a physical device; how all appropriate staff are aware at all times of when a resident is being restrained by the use of a physical device; and the types of physical devices permitted to be used, to be implemented voluntarily.

WN #17: 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,
(e) that a written record is kept relating to each evaluation under clause (d) 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. 229 (2).

s. 229. (8) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and O. Reg. 79/10, s. 229 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of the annual Infection Prevention and Control Program (IPAC) program evaluation is kept that includes the date of the evaluation, the names of the persons who participated, a summary of the changes made, and the date those changes were implemented.

Inspector #575 interviewed the DOC regarding the home's IPAC program. The DOC stated that the program policies and procedures are located in the home's Environment Manual and that staff also refer to the Provincial Infectious Diseases Advisory Committee (PIDAC) Manual located at the nursing station. The DOC stated that the IPAC program is evaluated and updated annually during the home's Health and Safety team meeting. The DOC provided Inspector #575 with the meeting report dated October 10, 2014. The report indicated the staff who were present and that all policies were reviewed (in the Environment Manual) and minor revisions were made, however the report did not indicate a summary of what changes were made to the IPAC program nor the date those changes were implemented. [s. 229. (2) (e)]

2. The licensee has failed to ensure that the outbreak management system in place for detecting, managing, and controlling infectious disease outbreaks includes defined staff responsibilities.

Inspector #575 interviewed the DOC regarding the IPAC program. The DOC stated that the outbreak management system for detecting, managing and controlling infectious disease outbreaks included the checklist for outbreak procedures located in the Environment Manual and any other procedures are located in the PIDAC Manual both located at the nursing station. Inspector #575 reviewed both manuals and was unable to locate defined staff responsibilities. The DOC confirmed that the outbreak management system did not include defined staff responsibilities. [s. 229. (8) (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 within the infection prevention and control program a written record is kept relating to each evaluation 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; and that there are in place, an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

A Critical Incident Report (CI) was submitted to the Director pertaining to staff-to-resident abuse. The CI outlined the alleged abuse, the investigation conducted, and the measures taken with the resident after the incident. The Administrator confirmed to Inspector #595 that the home did not amend the CI with the outcomes of the investigation as the information was the same, however the new information was that the investigation confirmed that staff #109's actions constituted emotional abuse and as a result, was terminated. [s. 23. (2)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #005 was not restrained by the use of a physical device.

During an interview with Inspector #594, Resident #005 stated they were upset because of the use of side rails while in bed. Inspector interviewed Staff #110 who stated the resident is physically capable of getting out of bed on their own and when the rails are raised, do prevent the resident from voluntarily getting out of bed. Staff #110 stated the side rails are used as a safety device.

Inspector #594 reviewed Resident #005's plan of care and was unable to locate consent by the resident or a doctor's order for use of a restraining device. Review of a progress note stated that staff found the resident stuck between the foot of the bed and the side rail as the resident was attempting to get out of bed to use the restroom. Resident #005's care plan stated interventions with a focus of risk of falls was to put side rails up at all times when in bed for safety. Months later the intervention was revised to state that side rails are to be up when in bed during the night for safety.

During an interview with Inspector #595, the DOC stated no consent or doctor's orders are obtained when full side rails are initiated.

Inspector #594 reviewed the home's Restraint Use policy #NAM 026 which defines an environmental restraint as any device or barrier that limits the movement of an individual secludes, and thereby confines an individual to a specific geographic area or location. Appendix B in the policy identified alternative treatments to restraints for falls including but not limited to putting a mattress on the floor. [s. 30. (1) 3.]

WN #20: 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 ensure that the policy for the required program, Skin and Wound Care, included goals and objectives and relevant policies, procedures and protocols.

Inspector #594 interviewed Staff #105 who stated there was a skin care and wound management policy but no further program documentation. Inspector reviewed the home's Skin Care & Wound Management policy #NAM046-1 which failed to identify goals and objectives. The policy also stated that each resident shall receive a "head-to-toe" skin assessment by a member of the registered nursing staff (and including an assessment of the resident's mouth and feet), upon admission and quarterly. In an interview, the DOC stated the "head-to-toe" skin assessment was a paper based assessment which was no longer completed, and as a result the policy was not up to date, and that the home does not have a written description of the skin and wound program that included goals and objectives. [s. 30. (1) 1.]

2. The licensee has failed to ensure that 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, was kept for the required program Continence Care and Bowel Management.

Inspector #575 reviewed the home's Continence Care and Bowel Management Program. During an interview, the DOC identified that the program was evaluated and updated annually and provided Inspector #575 with the 2012 and 2013 evaluations. It was noted by Inspector that the 2012 and 2013 program evaluations did not include the date of the evaluation or the names of the participants. [s. 30. (1) 4.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the skin and wound care program provides for screening protocols, assessment and reassessment instruments.

Inspector #594 reviewed the home's Skin Care and Wound Management policy #NAM 046-1 which failed to provide for screening protocols and for assessment and reassessment instruments. Inspector interviewed the DOC who verified the program failed to provide for screening protocols, assessment and reassessment instruments. [s. 48. (2)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (1) The skin and wound care program must, at a minimum, provide for the following:
2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents. O. Reg. 79/10, s. 50 (1).

s. 50. (1) The skin and wound care program must, at a minimum, provide for the following:
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids. O. Reg. 79/10, s. 50 (1).

s. 50. (1) The skin and wound care program must, at a minimum, provide for the following:
4. Treatments and interventions, including physiotherapy and nutrition care. O. Reg. 79/10, s. 50 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the skin and wound care program provided strategies to promote resident comfort and mobility.

Inspector #594 reviewed the home's Skin Care and Wound Management policy #NAM

046-1 which failed to provide for strategies to promote resident comfort and mobility. Inspector interviewed the DOC who verified the policy failed to provide strategies to promote resident comfort and mobility. [s. 50. (1) 2.]

2. The licensee has failed to ensure that the skin and wound care program provided strategies for transferring and positioning residents to reduce pressure and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

Inspector #594 reviewed the home's Skin Care and Wound Management policy #NAM 046-1 which stated positioning aids used to relieve pressure and to promote each resident's comfort and healing, as required, shall be available within the home and accessible to staff. The policy failed to identify strategies for transferring and positioning residents. Inspector #594 interviewed the DOC who verified that the policy failed to provide strategies for transferring and positioning residents to reduce pressure and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids. [s. 50. (1) 3.]

3. The licensee has failed to ensure that the skin and wound care program provided for treatments and interventions including nutritional care.

Inspector #594 reviewed the home's Skin Care and Wound Management policy #NAM 046-1 which failed to provide for treatments and interventions including nutritional care. Inspector interviewed the DOC who verified the policy failed to provide for treatments and interventions including nutritional care. [s. 50. (1) 4.]

4. The licensee has failed to ensure resident's exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

Inspector #594 reviewed Resident #019's health care record which identified a pressure wound and Resident #020 who also had a pressure wound. In an interview, Staff #105 stated that registered staff document an assessment of the wound on a Wound Care Note in the progress notes. Inspector identified progress notes defined as Wound Care Note.

Inspector #594 interviewed the DOC who stated that the home does not have a clinically

appropriate assessment instrument specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

5. The licensee has failed to ensure Resident #019 and #020 had been assessed by a Registered Dietitian (RD) at the time of exhibiting altered skin integrity.

Inspector #594 reviewed Resident #019's health care records. Resident #019 was identified in a Wound Care progress note with altered skin integrity. A wound care progress note was completed in August 2014. Assessment by the dietitian did not occur until September 2014 as indicated in a Dietary Progress note. The Dietary Progress note stated the dietitian was flagged by a registered staff member.

Inspector #594 reviewed Resident #020's health care records. The resident was identified in a Wound Care progress note, with altered skin integrity in December 2013. Assessment by the dietitian did not occur until June 26, 2014 as indicated in a Dietary Progress note.

Inspector #594 reviewed the home's Skin Care & Wound Management policy #NAM046-1 which failed to state a referral to the RD. Inspector #594 interviewed staff #105 who stated when a resident is exhibiting a stage two ulcer, a referral to the RD is completed. The inspector interviewed staff #103 who stated a referral to the dietitian is completed when a wound hasn't been healing for a while. The process for a referral is to leave a note on the communication board or through a dietitian referral note in PointClickCare.

Review of the home's Nutrition & Skin Integrity policy #DM 091 states a referral to the RD, as a member of the interdisciplinary team responsible for residents' skin integrity, is made by either Nursing staff or the Physician whenever a resident has stage II, III or IV decubitus ulcers or slow healing wounds. Inspector #594 interviewed the DOC who stated if a resident is identified with a stage two wound, a referral is sent to the dietitian by way of a Dietary referral note in PCC. The DOC verified that no referral was received by the Registered Dietitian for Residents #019 and #020 when altered skin integrity was identified or when their wound's were established as Stage 2. [s. 50. (2) (b) (iii)]

6. The licensee has failed to ensure Resident #019 and #020 had been reassessed weekly by a member of the registered staff.

Inspector #594 reviewed Resident #019's progress notes which stated that the resident had a pressure wound. According to the progress notes, the reassessment of the

resident's wound did not occur until 10 days later.

Inspector #594 reviewed Resident #020's health care record and identified progress notes which stated that the resident had a pressure wound. According to the progress notes, from January 01, 2014 until January 15, 2015 Resident #020 did not receive a weekly wound assessment on eleven occasions:

March 19-30, 2014 [11 days];
April 30 – May 11, 2014 [11 days];
May 11 – 25, 2014 [14 days];
May 26-June 08, 2014 [13 days];
June 11-21, 2014 [10 days];
July 06-16, 2014 [10 days];
August 17-31, 2014 [14 days];
August 31-September 14, 2014 [14 days];
September 17 – 28, 2014 [11 days];
November 12-23, 2014 [11 days] and,
November 26-December 07, 2014 [11 days]. During this time the progress notes identified a pattern of skin breakdown and an open wound area.

According to the home's Skin Care & Wound Management policy #NAM 046-1, each resident who exhibits skin breakdown and/or wounds shall be assessed, each week, or more frequently, if needed, by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director, the report included the date and time of the incident.

A Critical Incident Report (CI) was submitted to the Director. The Administrator informed Inspector #595 that Resident #003 came to them with concerns of abuse which occurred the evening prior. The Administrator confirmed that the date and time of the incident were wrong on the CI. [s. 104. (1) 1.]

2. The licensee has failed to ensure that in making a report to the Director, the report included names of all residents involved in the incident, the names of any staff members or other persons who were present at or discovered the incident, and the names of staff members who responded to the incident.

A Critical Incident Report (CI) was submitted to the Director. The Administrator informed Inspector #595 that Resident #003 came to them regarding concerns of abuse which occurred the evening prior by Staff #109. Inspector #595 reviewed the CI submitted by the home. All staff members names were identified except for the staff member #109, whose initials were only given within the report. [s. 104. (1) 2.]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis.

Inspector #575 interviewed the DOC regarding the use of restraints. The DOC stated that currently the home does not consider any restraints being used and therefore there are no analysis of the restraining of residents by use of a physical device undertaken on a monthly basis. The DOC stated that when restraints are used, the home does not conduct an analysis of the restraining of residents on a monthly basis and rather the home conducts an analysis during the annual resident care conferences. [s. 113. (a)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who apply a physical device or who monitor residents restrained by physical devices received training in the application, use and potential dangers of these physical devices.

Inspector #594 reviewed the homes Restraint Use Policy #NAM 026 which stated for Staff Orientation and Training that direct care staff must receive annual retraining on restraint policies and procedures and the correct use of equipment as it relates to their jobs. According to the document restraint training includes hands on instruction and practice on correct use of physical restraints and other as deemed necessary by the home.

During an interview, the Administrator stated that the home uses an online learning module, Restraints and PASDs by Surge Learning to complete staff training on restraints and PASDs. According to the Administrator, the home's Restraint Use Policy #NAM 026 was embedded in the online learning module. Inspector #594 reviewed the course outline for Restraints and PASDs learning presentation by Surge Learning which focused on, but not limited to, protection from certain restraints, restraining by physical devices and requirements relating to restraints and PASD. The Administrator and Inspector #594 reviewed the Restraints and PASDs training by Surge Learning via video presentation. Inspector was unable to identify the training in the application, use and potential dangers of physical restraints in the presentation. The Administrator verified the presentation does

not provide the training required and told Inspector that no residents were being restrained by a physical device.

During an interview with Inspector #575, the DOC indicated that currently the home does not consider any restraints being used. [s. 221. (1) 5.]

2. The licensee has failed to ensure that all staff who apply PASDs or who monitor residents with PASDs received training in the application, use and potential dangers of these PASDs.

Inspector #594 interviewed the Administrator who stated that the home used an online learning module, Restraints and PASDs, by Surge Learning to meet staff training requirements on PASDs. According to the Administrator, the home's Restraint Use Policy #NAM 026 is embedded in the online learning module. Inspector #594 reviewed the course outline for Restraints and PASDs learning presentation by Surge Learning which focused on, but not limited to, requirements relating to PASDs. The Administrator and Inspector reviewed the Restraints and PASDs by Surge Learning video presentation. Inspector was unable to identify the training in the application, use and potential dangers of PASDs. The Administrator verified that the presentation did not provide the training required. [s. 221. (1) 6.]

Issued on this 27th day of February, 2015

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

Original report signed by the inspector.