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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Mar 10, 2015	2015_396103_0014	O-001597-15	Resident Quality Inspection

Licensee/Titulaire de permis

TRENT VALLEY LODGE LIMITED
195 Bay Street TRENTON ON K8V 1H6

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

TRENT VALLEY LODGE LIMITED
195 BAY STREET TRENTON ON K8V 1H9

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

DARLENE MURPHY (103), JESSICA PATTISON (197), KARYN WOOD (601), SUSAN DONNAN (531)

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): February 17-20, 23-27, 2015

The following were concurrently completed during this Resident Quality Inspection: Logs #O-001161-14, O-001061-14, O-001152-14, O-001182-14, O-001430-14, O-001564-15.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Resident and Family Council presidents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Food service supervisor (FSS), Dietary aides, Laundry aide, Housekeeping staff, Restorative care worker, Physiotherapy aide, Manager of support services, Life Enrichment Coordinator, RAI coordinator, Unit clerk, Administrative assistant, Director of Care and the Administrator.

During the course of the inspection, the inspectors: conducted a walking tour of the home, observed resident dining, medication administration practices and resident care, reviewed resident and family council meeting minutes, resident health care records and applicable policies including abuse and infection control.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (2)	CO #003	2014_280541_0030	103

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. 228. Continuous quality improvement

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

2. The system must be ongoing and interdisciplinary.

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 s. 228 whereby the licensee did not ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following:

1. There must be a written description of the system that includes goals, objectives, policies, procedures and protocols, and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Resident's Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii.the communications under paragraph 3. O. Reg 79/10, s. 228.

This finding is in regards to log# O-001161-14:

The home had previously been issued a Compliance order #002 (Quality Improvement) during the previous Resident Quality Inspection in October 2014. The order had a compliance date of January 19, 2015.

On February 24, 2015 during an interview with the Director of Care, she confirmed that the quality improvement and utilization review system planning meeting was held on January 26, 2015 and development was in the planning stage.

On February 27, 2015 the Administrator confirmed that the quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents in long term care continues to be developed.

In addition, the following non-compliances were noted during this inspection:

-the skin and wound care program does not have a written description that includes goals and objectives and the program is not evaluated annually,
-The medication management system is not evaluated annually,
-The Zero tolerance of Abuse policy is not evaluated annually. [s. 228. 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.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

s. 8. (4) During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. 2007, c. 8, s. 8 (4).

Findings/Faits saillants :

1. The following finding is related to logs O-001182-14, O-001152-14, O-001430-14 and O-001103-14.

The licensee has failed to comply with LTCHA 2007, s. 8(3) whereby there was not at least one Registered Nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times in the long-term care home. [s. 8. (3)]

The home's registered nursing staff schedule was provided to Inspector #197 and was reviewed from October 9, 2014 to February 25, 2015.

It was noted that during this time period there were 17 shifts where the home used a Registered Practical Nurse to fill the scheduled Registered Nurse position.

The dates/shifts are as follows:
October 17, 2014 - RN day shift was unfilled and indicated RPN S#108 filled the shift
November 5, 2014 - two day shift RN's were unfilled and RPN S#109 covered the RN

shift
November 8, 2014 - RPN S#108 filled the day RN shift
November 14, 2014 - RPN S#109 filled the day RN shift
November 19, 2014 - RPN S#109 filled the day RN shift
November 24, 2014 - RPN S#129 filled the evening RN shift
December 11, 2014 - RPN S#124 filled the night RN shift
December 17 and December 18, 2014 - RPN S#129 filled the evening RN shift
December 19, 2014 - RPN S#109 filled 2 hours of the RN day shift
December 29 and December 30, 2014 - RPN S#108 filled the day RN shift
January 9, 2015 - RPN S#108 filled the day RN shift
January 14, 2015 - RPN S#108 filled the day RN shift
January 15 and January 16, 2015 - RPN S#129 filled the evening RN shift
January 28, 2015 - RPN S#109 filled the day RN shift

On February 23, 2015, RPN S#108 was interviewed and stated she has been asked to cover RN shifts and has worked in the building without an RN on site. S#108 further stated there has always been an RN available by phone if needed.

On February 24, 2015, RPN S#109 was interviewed and stated that she has been asked to work in the home when there has been no RN on site.

On February 24, 2015, an interview was conducted with RN S#100 and the Director of Care. RN S#100 stated that the home, at times, has been unable to have a RN on site for all shifts and have utilized RPN's to cover these shifts. They will often use agency staff to fill this shift, but will use RPN's when they need to. The Director of Care stated that the home is in the process of hiring two new RN's. [s. 8. (3)]

2. The licensee has failed to comply with LTCHA 2007, s. 8(4) whereby the acting Director of Nursing and Personal Care was also considered to be the Registered Nurse on duty and present in the long-term care home on identified dates. [s. 8. (4)]

During an interview with the Director of Care and RN S#100 on February 24, 2015, the Director of Care indicated that she started working in the home on January 12, 2015. RN S#100 indicated that the previous DOC's last day in the home was October 10, 2014 and that she was the acting Director of Care from October 13, 2014 to January 9, 2015.

The schedule was reviewed for this time period. On 44 day shifts, RN S#100 was considered to be both the RN on duty, as well as the acting Director of Care. [s. 8. (4)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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 comply with LTCHA 2007, s. 19 (1) (a) whereby residents were not protected from sexual abuse.

Under O. Reg. 79/10 s. 2 (1) (a), sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

On an identified date, Resident #20 reported to Inspector #197 that Resident #45 comes into the room at night and exposes themself while making inappropriate comments and that this has been reported to staff.

Resident #45's health care record was reviewed and indicated the resident ambulates independently. The following information was documented in the resident progress notes:

- on a designated date, S#128 noted that Resident #45 was seen wandering out of Resident #20's room.

- on a designated date, S#108 noted that Resident #45 was in Resident #12's room while the maintenance man was painting. When Resident #45 went to leave the room they looked behind Resident #12's curtains. Will need to monitor for going into other resident's rooms.

- on a designated date, S#107 noted "inappropriate behaviour" ....PSW found Resident #45 in Resident #20's room with their clothing opened.

- on a designated date, S#108 noted "inappropriate behaviour"... PSW found Resident #45 in Resident #12's room with their clothing opened.

- on a designated date, S#128 noted Resident #45 was involved in an incident with Resident #20. Statements were taken and will be forwarded to day manager for consideration.

- on a designated date, S#128 noted Resident #45 exposed themself to Resident #20.

- on a designated date, S#107 documented "seen by Dr. M. this afternoon. Dr. M. is aware of increased sexual behaviour", monitor.

- on a designated date, S#128 documented Resident #45 up wandering and Resident #20 making accusatory statements that Resident #45 was exposing themself.

- on a designated date, S#107 documented Dr. R. spoke with Resident #45. Aware of concerns of showing self in public.

On a designated date, S#108 was interviewed and confirmed Resident #45 had an increased behaviour of exposing themself and the Substitute Decision Maker and physician are aware.

On a designated date, S#107 was interviewed and confirmed there have been concerns with Resident #45 exposing themself in public and that both physicians are aware of the concerns and there have been no medication adjustments.

On a designated date, S#109 confirmed aware of the behaviour and that the RPN in charge is responsible for reporting the incidents to the RN on duty who completes an internal incident statement and forwards to management who conduct an investigation and complete a critical incident.

On February 25, 2015, S#100, the Acting Director of Care at the time was interviewed and confirmed being notified of the incident that occurred on a designated date. S#100 stated she thought the incident had been taken care of and did not investigate. S#100

confirmed the investigation would be documented but was unable to provide the report of the investigation by the duty RN. S#100 confirmed that a critical incident report was not completed or submitted to the Director. S#100 stated only one incident involving Resident #45 had been reported to management.

The licensee failed to protect residents from sexual abuse as evidenced by the following:
- all incidents of alleged. suspected or witnessed abuse were not reported or investigated.
-The Director was not immediately notified of alleged, suspected or witnessed incidents of sexual abuse of Resident #12 and #20 and an unidentified resident that resulted in harm or risk of harm to residents.
-The licensee policy "Zero Tolerance Abuse/ Neglect was not complied with.
-The licensee policy "Zero Tolerance of Abuse/Neglect" was not evaluated annually
-The licensee policy "Zero Tolerance of Abuse/Neglect" did not include training and retraining requirements for all staff that include power imbalances between residents and staff, and situations that may lead to abuse and how to avoid such situations. [s. 19. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 31(3) in that the staffing plan for the home does not include all required components. [s. 31. (3)]

On February 23, 2015, the home was asked to provide a copy of their written staffing plan.

The staffing plan provided was one page and set out the number of staff working in the home for each department on days, evenings and nights. No other information was included to indicate how the home provides for a staffing mix that is consistent with residents' assessed care and safety needs, how they promote continuity of care, or what the back-up plan is for nursing and personal care staffing.

During an interview with the Director of Care and RN S#100 on February 24, 2015, they indicated that as of right now there are no other components to the staffing plan and that this is something they are working on.

During an interview with the Administrator on February 27, 2015, he indicated to Inspector #103 that the staffing plan had not been evaluated on an annual basis.

Non compliance related to O. Reg. 79/10, s. 31 was previously issued in the following inspections:
- September 2, 2014, Inspection # 2014_280541_0030 (WN, VPC)
- January 30, 2015, Inspection # 2015_347197_0005 (WN, VPC) [s. 31. (3)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 50 (2)(b)(iv) whereby a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was not reassessed at least weekly by a member of the registered nursing staff.

Resident #14 had identified skin impairments that required dressing changes three times weekly. The resident's health care record was reviewed.

Documented wound care assessments were completed on two identified dates in a one month time frame and a partial assessment was documented on one identified date in the following one month time frame.

RN S#100 was interviewed and stated the home is currently not completing weekly wound assessments. The DOC was also interviewed and stated she has developed a tool to facilitate the completion of these assessments by the registered staff and anticipates introducing this tool over the next few weeks.

This non-compliance was identified during a previous inspection at the home in August 2014 and a voluntary plan of correction was issued at that time. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 134 (a) whereby a resident taking any drug or combination of drugs, including psychotropic drugs, was not monitored and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs was not recorded.

Resident #12 had identified diagnoses. On an identified date, Resident # 12 was interviewed by Inspector #601, and the resident reported ongoing pain for about two years. The resident stated the pain medication was only sometimes effective.

Resident #12's health care record was reviewed including the medication record. It indicated an identified analgesic was being administered at the residents request (prn), for identified areas of pain.

During an identified month, the medication record indicated the as needed (prn) analgesic was administered sixty times. There were twenty-eight times during this identified month where the effectiveness of the pain medication was not clear or the

effectiveness response was delayed for more than an hour.

RPN S#109 was interviewed and stated when a nurse administers a prn medication; an alert will automatically generate a response time in the e-mar for the nurse to document the effectiveness of the medication. The nurse is able to postpone the evaluation of the prn medication by clicking the OK button. The effectiveness needs to be documented and sometimes the nurse will respond on a later shift to eliminate the alert from continuing throughout the shift.

DOC is aware the documentation of pain medication effectiveness is not always being completed and the explanation to the effectiveness is not describing the resident's response to the medication. It is the home's expectation for the nurses to provide a detailed, timely response of the effectiveness of prn medication being administered.

The monitoring and documentation of Resident #12's response to the pain medication is not clear and documentation of the effectiveness of the pain medication was not always completed in a timely manner. [s. 134. (a)]

2. Resident #14 had identified diagnoses. The resident was interviewed and stated identified areas are painful at varying times throughout the day. The resident acknowledged taking regular doses of pain medications each day and stated they can ask the nurse for additional pain medications between these times if they require it for pain control. The resident described the pain as nagging, sometimes constant and feels there are only short periods of time when they have no pain. The resident also stated the pain is worse at night and told this inspector they previously used a hot pack which always felt good. The resident stated they are not currently receiving hot packs.

The resident's medication record was reviewed for an identified one month time frame. Resident #14 had an order for an identified analgesic to be used as needed for pain control (prn). During that one month period of time, the resident received the prn pain medication sixty-eight times. The resident health care record was reviewed and on twenty eight out of the sixty eight doses taken, the effectiveness of the medication was described as no effect, minimal effect or some effect. Twenty three out of the sixty-eight doses had no documented effect.

The physician orders were reviewed and there had been no medication changes over a three month time frame.

The DOC was interviewed and stated she expects that pain medications should be evaluated after each dosage is given to properly assess the resident's pain control. Additionally, the DOC stated she believed the physician should have been notified of the poor pain control to ensure the resident's regular doses of pain medications were reassessed. The DOC stated she believes the large number of prn pain medications was probably an indication of inadequate pain control. [s. 134. (a)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home; 2007, c. 8, s. 15 (1).
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and 2007, c. 8, s. 15 (1).
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTHCA 2007, s.15 (1)(b) in that the organized program of laundry services for the home does not meet the personal clothing needs of the residents.

During stage 1 resident interviews on February 18 and 19, 2015 the following comments were made by residents:

Resident #7 stated the laundry goes downstairs for a very long time, 2-3 weeks sometimes. The resident feels the need to wear clothes for several days to avoid running out of clean clothes.

Resident #19 stated a housecoat is missing, but it could be in laundry as it takes a long

time to get clean laundry back. It's been about a week since the resident has seen it.

Resident #16 stated they are looking for a shirt that was sent to the laundry on February 2, 2015. The resident stated the shirt was returned on February 18, 2015, 16 days after it was sent to be washed.

Resident #20 stated they do not have a lot of clothing and will often run out of clean clothes since it takes so long for the laundry department to return clean personal items.

Resident #32 stated they are missing three sets of sheets and a pair of pants. The resident said they could be missing or it could just be that they haven't returned from laundry, as it does take awhile for personal items to be returned.

The Resident's Council minutes dated December 2, 2014 stated the following: "Residents expressed a concern that laundry was not being delivered and they did not have clean clothes. This will be passed along to our Maintenance Manager."

The written laundry policies and procedures (XII-A-10.30 and XII-A-10.50) for the home, last revised April 2011, state the following:

The principal functions of the laundry department are to ensure that a daily supply of clean linen is always available and that all residents' personal clothing is washed, dried and returned to the resident within 48 hours of receiving personal items.

The laundry department staff will maintain the highest standards of customer service by:
1. Ensuring all linen and clothing are laundered on a daily basis and returned to the home areas;
3. Ensuring that the resident's personal clothing is laundered and distributed to the correct room and resident within 48 hours of receiving;

On February 25, 2015, the full-time laundry aide, staff member #S116 was interviewed related to laundry services in the home. She stated that there are no current written policies and procedures related to laundry services in the home. She indicated that she has been told they are under revision. Staff member #S116 further stated that the expectation is that resident's personal laundry is to be cleaned and returned to the floor within 72 hours, however, this goal is not currently being met. The inspector was shown a room that was full of large bins of resident's dirty laundry and the staff member stated some clothing has been there for at least two weeks. The staff member also stated this

morning four staff members came down looking for clothing for residents who had no clean clothing in their rooms.

Staff member #S116 stated that she works 20, eight hour shifts per month and feels it is not enough time to meet the laundry needs in the home. She further stated that clothing deliveries do not occur on weekends or statutory holidays.

On February 25, 2015, the Support Services Manager was interviewed. He confirmed that the expectation was that personal laundry should be returned to residents within 72 hours. However, he did recognize that this is currently not happening and he stated he is working on revising the departmental policies and procedures. He also stated that he is going to be working on a plan to improve laundry services within the home. [s. 15. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the laundry services in the home meet the personal clothing needs of the residents, to be implemented voluntarily.

WN #8: 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. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

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 written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The licensee's Zero Tolerance Abuse/Neglect policy states the following:

Page 4. Reporting and Investigations of Incidents
1. Any and all incidents shall be immediately reported to the charge nurse, the Administrator/Manager of Resident care or delegate. An incident report shall be completed.
2. The Administrator or Manager of Resident care shall immediately investigate the incident and shall notify the Director and initiate a critical incident report.

5. The resident and the resident's substitute decision maker if any are notified of the results of the investigation required under subsection 23(1) of the Act immediately upon completion of the investigation.

On an identified date, Resident #20 was interviewed and stated a resident exposed themself and made sexually inappropriate comments. Resident #20 told the inspector that the incident happened more than once, it was reported to staff, but nothing has been done about it.

Review of Resident #45 progress notes indicated the following:
-on an identified date, witnessed by PSW coming out of Resident #20's room
-on an identified date, Resident #20 reported the incident and statements taken for manager consideration
-on an identified date, resident in the hall in front of Resident #20 observed by PSW opening clothing
-on an identified date, Resident #20 making accusations that Resident #45 was exposing themself.

On February 25, 2015, S#100, the Acting Director of Care at the time of the incident, was interviewed and the homes Zero Tolerance Abuse/Neglect policy was reviewed. S#100 stated she was only made aware of one incident on an identified date. S#100 confirmed the policy was not complied with whereby additional incidents that may have constituted resident abuse were not reported by staff to management.

On February 27, 2015 the Administrator was interviewed and confirmed that the policy was not complied with. [s. 20. (1)]

2. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 of the Act to make mandatory reports.

On February 25, 2015 during an interview with the Director of Care and review of the home's Zero Tolerance/Abuse Policy confirmed that the policy does not contain an explanation of the duty under section 24 of the Act to make mandatory reports. [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 the zero tolerance of abuse policy meets the minimum requirements outlined in the legislation and the policy is complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 33(1) in that not all residents were bathed, at a minimum, twice a week by the method of his or her choice.

On February 18, 2015, a family member indicated to Inspector #197 there is not always enough staff in the home, especially on weekends and holidays. The family member further indicated that baths have been missed on weekends.

On February 24, 2015, PSW #S118 expressed frustration related to the staffing in the home. She stated two weeks ago baths on the evening shift did not get done due to short-staffing in the home.

The health care record of resident's who are bathed on Sunday, specifically the evening shift, were reviewed and the following was found:

Resident #47 is bathed on Thursdays and Sundays. On Sunday, February 15, 2015 there was no bath documented and a progress note was written on February 16, 2015 by the RN on duty stating "Resident missed bath on Sunday". The resident was not available for interview.

Resident #45 is bathed on Sundays and Wednesdays. On Sunday, February 15, 2015 there was no bath documented and a progress note was written on February 16, 2015 by the RN on duty that "Bath missed Sunday". Resident #45 was interviewed but stated they did not recall missing a bath.

Resident #46 is bathed on Sundays and Wednesdays. On Sunday, February 15, 2015 there was no bath documented and no progress notes related to bathing. On February 26, 2015, Resident #46 was interviewed and stated they missed a bath recently on a Sunday afternoon because they did not have enough staff.

There was no evidence that residents #45, #46 or #47 were offered another bath before their next scheduled bath day.

On February 26, 2015 during an interview with the Director of Care, she indicated that she has heard that baths are sometimes not being done and her expectation is that they are offered later in the day/shift. She is supposed to be notified when baths are missed but was unaware of the three baths that were missed on Sunday, February 15, 2015. The Director of Care further indicated that this issue was also brought forward by Resident's Council.

On February 26, 2015, Unit Clerk #S125 was interviewed and stated on February 15, 2015 one staff member called in sick and another staff member did not show up. Both of these staff were supposed to be working on the Maple/Oak unit where the baths were missed. She stated there are usually three PSW's scheduled on that unit but there were only 2 that day and one was agency staff. Unit Clerk #S125 further indicated that they do have a high volume of sick calls, but they are usually able to cover these shifts by using agency staff. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents receive a minimum of two baths a week by the method of their choice, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 51 (2)(b) whereby a resident who is incontinent does not have an individualized plan to promote and manage bowel and bladder continence.

Resident #6 was interviewed by this inspector and expressed upset that staff will not toilet them using a commode chair or a toilet. The resident stated when they ask to be toileted the staff say they can only use a bedpan or "go in the brief" because they are no longer able to weight bear. The resident stated at times they feel the urge to void or have a bowel movement. The resident stated they were previously toileted but was suddenly told by "one female" that staff could no longer do it. The resident stated since that time there have been no efforts to address this issue.

Physiotherapy assistant S#123 was interviewed and stated the resident is unable to weight bear and has poor range of motion. The staff member stated the resident is no longer being seen by physiotherapy/restorative care for range of motion and was discharged several months ago.

Restorative care aide S#120 was interviewed and stated Resident #6 was previously seen by restorative care, but is currently discharged from the program. The staff member stated she believes the resident used to be toileted but is no longer able to weight bear.

S#122 and S#121 were interviewed and stated that residents requiring a hoyer lift are not toileted. The staff member stated unless a resident is able to weight bear or use a sit/stand lift, the home does not have the means to toilet residents. S#122 further stated the home has never had slings that would accommodate the toileting of non weight-bearing residents. The staff stated a bed pan is the only option.

Resident #6's care plan in effect at the time of this inspection related to continence care was reviewed.

Under "toileting" the following was documented:

Expected outcome-to be toileted routinely by staff
Interventions-uses mechanical lift; transferred into bed to use bedpan to void and have a BM. Resident states in too much pain when hoyer lift is used to transfer onto the toilet.

Under "Bladder Continence":

Expected outcome-will be dry and comfortable with routine toileting by staff
Interventions-tended to be incontinent but some control present (on day shift)

Under "Bowel Incontinence"-

Expected outcome-to maintain continence
Interventions-toileted at same time each day to prevent incontinence; frequently incontinent of bowel 2-3 times a week.

Resident #6's continence assessments dated October 15, 2014 and January 8, 2015 were both reviewed. The resident was identified as having functional incontinence related to mobility issues.

The DOC was interviewed in regards to the toileting of residents that require a hoyer lift. The DOC agreed this does not support the resident's ability to maintain some level of continence or promote resident dignity. The DOC believes that staff are not putting the resident first and that this resident does not have an individualized care plan in place to address the toileting issues. [s. 51. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all residents who are incontinent have an individualized plan to promote and manage bowel and bladder continence, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 129 (1) (b) whereby controlled substances were not stored in a separate, double locked stationary cupboard in the locked area or stored in a separate locked area within the medication cart.

On September 5, 2015, a critical incident was submitted to the Director.

The Critical Incident described the incident as follows:

The RPN was cleaning out a cabinet drawer and found three unaccounted for Fentanyl 12mcg/hr patches underneath miscellaneous items in the drawer.

On February 23, 2015, the RPN on duty was interviewed and confirmed that three narcotic patches were found in a cabinet drawer in the medication room. The RPN confirmed that the drawer was not locked and the narcotics were not double locked.

On February 24, 2015 during an interview with the Director of Care, she confirmed the narcotics were not double locked. [s. 129. (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 all controlled substances are stored in a separate, double locked stationary cupboard or in a separate locked area within the medication cart, to be implemented voluntarily.

WN #12: 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. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 229 (3) whereby the designated staff member to co-ordinate the infection control program does not have the legislated education and experience requirements in infection prevention and control practices.

The following finding is related to log# O-001182-14:

RN S#100 was interviewed and stated she is the designated lead for the home's infection control program. The staff member stated she has never received education or training related to cleaning and disinfection, infectious diseases, outbreak management, data collection and trend analysis or reporting protocols as outlined in the legislation. [s. 229. (3)]

2. The licensee has failed to comply with O. Reg 79/10, s. 229 (10) 1 whereby each resident admitted to the home was not screened for tuberculosis within fourteen days of admission, unless screened at some time in the ninety days prior to admission.

S#100 was interviewed and stated the home is screening residents for tuberculosis (TB) in accordance with the recommendations made by the Leeds, Grenville and Lanark District Public Health Unit. A copy of the recommendations was given to this inspector and indicated the following:

-all new residents must undergo a history and physical examination by a physician/nurse practitioner within 90 days prior to admission or within 14 days after admission. The assessment is recommended to include:

-a symptom review for active pulmonary TB disease,
-a chest x-ray,
-for residents ,65 years of age who are previously skin test negative or unknown, a 2 step tuberculin skin test is completed.

Resident #44 was admitted to the home on an identified date. The resident's health care record was reviewed and the results of a chest x-ray, completed on an identified date was available; there was no indication a symptom review for active pulmonary TB disease was completed.

Resident #43 was admitted to the home on an identified date. The resident's health care record was reviewed and the results of a chest x-ray completed on an identified date was available; there was no indication a symptom review for active pulmonary TB disease was completed.

Resident #42 was admitted to the home on an identified date. There was no indication a chest x-ray had been completed within ninety days prior to admission to the home or fourteen days after admission; there was no indication a symptom review for active pulmonary TB disease was completed.

S#100 was able to confirm Resident #42 did not have a chest x-ray completed within the recommended time-lines and also indicated the home has not yet adopted the use of the TB screening checklist. [s. 229. (10) 1.]

3. The licensee has failed to comply with O. Reg 79/10, s. 229 (10) 3 whereby residents are not offered immunizations against pneumoccocus, tetanus and diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Resident's #43 and #44 were admitted to the home on identified dates. Both resident health care records were reviewed and both had signed consents for tetanus, diptheria and pneumococcal immunizations. To date of this inspection, the immunizations had not been given by the home and there was no documentation to indicate if/when the immunizations had been previously given.

RPN's S#110 and S#108 were interviewed and stated they could not recall ever giving these vaccines to any resident. S#109 was interviewed and stated the consents are obtained at the time of the resident's admission to the home, but stated she doesn't recall the home ever giving any of the immunizations and did not believe the home had the vaccines on site.

The vaccine fridge located in the scheduling office on the second floor was observed by this inspector and did not contain these vaccines.

S#100 was interviewed and stated the DOC has been responsible for ordering the vaccines and that in the interim when the home was without a DOC, she would have been the person to perform that duty. S#100 stated she could not recall the last time the vaccine was available in the home and the home has not been offering these immunizations for an undetermined period of time. [s. 229. (10) 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 the designated lead for infection control receives the legislated educational requirements, that residents are screened for tuberculosis in accordance with the recommendations outlined by the Public Health Unit and to ensure all residents are offered immunizations for tetanus, diptheria and pneumoccocus, to be implemented voluntarily.

WN #13: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 6 (5) whereby a resident was not given the opportunity to participate in the development and implementation of the resident's plan of care.

Resident #6 was interviewed by this inspector and expressed upset that staff will not toilet them using the toilet or a commode chair. The resident stated when they ask to be toileted the staff say they can only use a bedpan or "go in the brief" because they are no longer able to weight bear. Resident #6 further stated that they cannot properly go to the bathroom on a bedpan because it is very uncomfortable and they can not properly go laying down.

The resident health care record was reviewed and the resident did have a scheduled care conference during an identified month. The resident did not attend but the resident's power of attorney did attend. There was no indication toileting was discussed during the care conference. Resident #6 stated they have never been invited to attend these care conferences and that no one ever asks how they think things should be done. [s. 6. (5)]

WN #14: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of resident abuse that the licensee knows of, or that is reported is immediately investigated.

On February 25, 2015, Resident #20 was interviewed and the resident health care record was reviewed. Both confirmed that on an identified date, Resident #20 reported to staff that Resident #45 entered their room at night and exposed themself while making inappropriate comments.

On February 25, 2015, S#107, S#108, and S#109 confirmed that any incidents of abuse are reported to the Registered Practical Nurse who reports to the Registered nurse supervisor who then completes an internal incident report for the Administrator or Manager of Resident Care to investigate.

On February 25, 2015, S#100 was interviewed and confirmed she was the acting Manager of Resident Care and that she was made aware of the incident and understood it to be resolved. S#100 stated the incident was not investigated. [s. 23. (1) (a)]

WN #15: 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 alleged abuse was immediately reported to the Director.

On February 25, 2015, Resident #20 was interviewed and the resident health care record was reviewed. Both confirmed that on an identified date, Resident #20 reported to staff that Resident #45 entered their room and exposed themself while making inappropriate comments.

On February 25, 2015, S#100 was interviewed and confirmed she was the acting Manager of Resident Care and that she did not notify the Director. To date of this inspection, a critical incident was not submitted to the Director outlining the alleged incident of resident abuse. [s. 24. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

On February 18, 2015, Resident #12 informed Inspector #197 that their pain medication is not effective. Record review of the most recent RAI MDS dated January 2, 2015 identified that Resident #12 has daily, moderate pain located in identified areas.

On February 23, 2015, Resident #12 was interviewed by Inspector #601, and the resident reported ongoing pain for about two years. The pain medication was only sometimes effective.

Record review of the home's Pain and Symptom - Assessment and Management Protocol Policy #: V11-G-70.00 Resident Care Manual Original Issue November 2010.

Procedure:
Conduct and document a pain assessment:
- quarterly with an MDS pain score of 2 or more or with significant change of status
- on initiation of a pain medication or PRN analgesic
- when there is a change in condition with pain onset
- with diagnosis of a painful disease
-when resident reports pain or symptoms of greater than 4/10 for 24 for 48 hours
- with history of unexpressed pain-what has helped before-information from family/SDM
- when receiving pain medication for greater than 72 hours
- when report from resident, family, staff/volunteers that pain is present

Initiate a 24 hour Pain and Symptom Monitoring Tool when:
- a schedule pain medication does not relieve the pain
- pain remains regardless of the interventions

- pain medication is changed
- An empiric trial of analgesics is started.

Interview with S#108, RPN confirmed that Resident #12 has unresolved pain and a 24hr Pain and Symptom Monitoring tool was not completed.

Interview with S#103, RAI Coordinator indicated a pain assessment is completed every three months at the same time as the RAI MDS. The RPN is responsible to initiate the pain monitoring tool, if unmanaged pain has been identified. S#103, RAI Coordinator was not able to locate a pain monitoring tool in Resident #12 clinical records. [s. 52. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 53 (1) whereby the licensee did not ensure that a resident with responsive behaviours had actions taken to respond to the needs of the resident including assessments, reassessments, interventions and referral to specialized resources.

Resident #45's health care record was reviewed and indicated an increase in inappropriate, sexual behaviour. S#107 documented on identified dates, the physicians were aware of the increased behaviours but no medication changes were made.

On February 27/15, S#112 was interviewed and was unaware of any interventions in place to manage the behaviour. S#100 was interviewed and confirmed there were no written assessments, reassessments to address the sexual comments/actions with corresponding interventions or referrals made to specialized resources. (531) [s. 53. (1)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the development and implementation of a schedule of recreation and social activities are offered during days, evenings and weekends.

During stage one interviews with Resident #12, #20, #23, and #35, they indicated that they were not aware of activities being provided in the evening.

The activity calendars for the months of November 2014, December 2014, January 2015, and February 2015 were reviewed. The activity calendars for the month of November 2014, January 2015, and February 2015 did not include social activities during the evening hours.

The Life Enrichment Coordinator, S#104 was interviewed and indicated the home has not been offering the residents social activities during the evening hours. [s. 65. (2) (b)]

WN #19: 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 home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff include 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.

Both the Director of Care and the Administrator reviewed the home's "Zero Tolerance Abuse and Neglect Policy" and confirmed that the written policy did not contain or make any reference to training and retraining requirements for all staff that include:
i. 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 situations that may lead to abuse and neglect. [s. 96. (e)]

WN #20: 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 once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are further required to prevent further occurrences.

Both the Director of Care and the Administrator confirmed that the home's "Zero Tolerance Abuse/Neglect" Policy dated December 2007 with one review dated December 2011 is the policy that is currently used and that no evaluation of this policy has been done since 2011. [s. 99. (b)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the Director was informed immediately, in as much detail as is possible in the circumstances of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

The following findings relate to logs# O-001182-14 and O-001564-15:

On three separate dates the home declared an outbreak of a reportable disease.

1. A Critical Incident Report (CIR) was submitted and indicated the Public Health declared the home in Respiratory Outbreak on September 29, 2014. The CIR was submitted to the Director for the first time, twelve days later. On February 25, 2015 the Director of Care and S#100, confirmed that the Director was notified of the Respiratory Outbreak for the first time on October 10, 2014.

2. A Critical Incident Report was submitted to the Director on January 16, 2015. The CIR indicated Public Health declared the home in Respiratory Outbreak on January 9, 2015. The CIR was submitted to the Director seven days later. On February 25, 2015 the Director of Care and S#100 confirmed that the Director was notified of the Respiratory Outbreak for the first time on January 16, 2015.

3. On February 25, 2015 the Inspector was made aware by the Director of Care (DOC) the Public Health declared the home in Enteric Outbreak on January 19, 2015. Interview with the DOC and S#100, confirmed that the home did not notify the Director of the reportable disease.

The home failed to immediately notify the Director of the circumstances of an outbreak of a communicable disease on three separate dates. [s.107. (1) (5)] (601) [s. 107. (1)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

On February 27, 2015 during an interview with the Administrator and the Director of Care both confirmed that there was no annual evaluation of the medication management system completed. [s. 116. (1)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 131 (2) whereby drugs were not administered to a resident in accordance with the directions for use by the prescriber.

Resident #14 has identified skin impairments that require three times weekly dressing changes. The resident was interviewed and stated the dressing changes are uncomfortable and at times painful and reported they did not like having the dressings changed. The resident was asked if they receive pain medication prior to dressing changes and stated sometimes they do and sometimes they don't. The resident stated they don't like to be a bother and just "grins and bears it".

The resident's medication record was reviewed and an order was in place for an identified analgesic to be given subcutaneously ten minutes prior to dressing changes.

The medication records for December, 2014, January 2015 and February 2015 were reviewed.

In December 2014, the resident received the injection once prior to the dressing changes. In January 2015, the resident received the injection three times prior to the dressing changes.
In February 2015, the resident received the injection twice prior to the dressing changes.

RPN S#124 was interviewed and stated she is familiar with Resident #14 and has completed the dressing changes for this resident on occasion. The staff member stated the RN most often completes the dressing changes. This staff member stated she does give the resident the pain injection before the dressing changes because the resident appears uncomfortable without the injection. S#124 stated she wasn't sure if other staff members do the same. [s. 131. (2)]

Issued on this 18th day of March, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103), JESSICA PATTISON (197), KARYN WOOD (601), SUSAN DONNAN (531)
Inspection No. / No de l'inspection :	2015_396103_0014
Log No. / Registre no:	O-001597-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 10, 2015
Licensee / Titulaire de permis :	TRENT VALLEY LODGE LIMITED 195 Bay Street, TRENTON, ON, K8V-1H6
LTC Home / Foyer de SLD :	TRENT VALLEY LODGE LIMITED 195 BAY STREET, TRENTON, ON, K8V-1H9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BILL WEAVER JR

To TRENT VALLEY LODGE LIMITED, 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) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_280541_0030, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 228. Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

2. The system must be ongoing and interdisciplinary.

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the quality improvement and utilization review system complies with the following requirements:

1. There must be a written description of the system that includes goals, objectives, policies, procedures and protocols, and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Resident's Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii.the communications under paragraph 3. O. Reg 79/10, s. 228.

This plan must be submitted in writing to Inspector, Darlene Murphy at 347 Preston Street, 4th Floor, Ottawa ON K1S 3J4 or by fax at 1-613-569-9670 on or before March 20, 2015.

Between the time this order is served and the compliance date, the Administrator will send written monthly summaries to capture the home's progress in working toward compliance. The summaries should be sent by fax on the last Thursday of each month to Inspector, Darlene Murphy by fax at 1-613-569-9670.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10 s. 228 whereby the licensee did not ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following:

1. There must be a written description of the system that includes goals, objectives, policies, procedures and protocols, and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the

Resident's Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii.the communications under paragraph 3. O. Reg 79/10, s. 228.

In regards to log# O-001161-14:

The home had previously been issued a Compliance order #002 (Quality Improvement) during the previous Resident Quality Inspection in October 2014. The order had a compliance date of January 19, 2015.

On February 24, 2015 during an interview with the Director of Care, she confirmed that the quality improvement and utilization review system planning meeting was held on January 26, 2015 and development was in the planning stage.

On February 27, 2015 the Administrator confirmed that the quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents in long term care continues to be developed.

In addition, the following non-compliances were noted during this inspection:

-the skin and wound care program does not have a written description that includes goals and objectives and the program is not evaluated annually,
-The medication management system is not evaluated annually,
-The Zero tolerance of Abuse policy is not evaluated annually.

(531)

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.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall ensure that at least one registered nurse is on duty and present in the home at all times.

The home shall ensure the staffing plan is reviewed to ensure additional back up is available in accordance with the exceptions provided for in O. Reg 79/10 s. 45 (2) when RN coverage is not available.

Grounds / Motifs :

1. The following finding is related to logs O-001182-14, O-001152-14, O-001430 -14 and O-001103-14.

The licensee has failed to comply with LTCHA 2007, s. 8(3) whereby there was not at least one Registered Nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times in the long-term care home.

The home's registered nursing staff schedule was provided to Inspector #197 and was reviewed from October 9, 2014 to February 25, 2015.

It was noted that during this time period there were 17 shifts where the home used a Registered Practical Nurse to fill the scheduled Registered Nurse position.

The dates/shifts are as follows:
October 17, 2014 - RN day shift was unfilled and indicated RPN S#108 filled the

shift
November 5, 2014 - two day shift RN's were unfilled and RPN S#109 covered the RN shift
November 8, 2014 - RPN S#108 filled the day RN shift
November 14, 2014 - RPN S#109 filled the day RN shift
November 19, 2014 - RPN S#109 filled the day RN shift
November 24, 2014 - RPN S#129 filled the evening RN shift
December 11, 2014 - RPN S#124 filled the night RN shift
December 17 and December 18, 2014 - RPN S#129 filled the evening RN shift
December 19, 2014 - RPN S#109 filled 2 hours of the RN day shift
December 29 and December 30, 2014 - RPN S#108 filled the day RN shift
January 9, 2015 - RPN S#108 filled the day RN shift
January 14, 2015 - RPN S#108 filled the day RN shift
January 15 and January 16, 2015 - RPN S#129 filled the evening RN shift
January 28, 2015 - RPN S#109 filled the day RN shift

On February 23, 2015, RPN S#108 was interviewed and stated she has been asked to cover RN shifts and has worked in the building without an RN on site. S#108 further stated there has always been an RN available by phone if needed.

On February 24, 2015, RPN S#109 was interviewed and stated that she has been asked to work in the home when there has been no RN on site.

On February 24, 2015, an interview was conducted with RN S#100 and the Director of Care. RN S#100 stated that the home, at times, has been unable to have a RN on site for all shifts and have utilized RPN's to cover these shifts. They will often use agency staff to fill this shift, but will use RPN's when they need to. The Director of Care stated that the home is in the process of hiring two new RN's.

The licensee has failed to comply with LTCHA 2007, s. 8(4) whereby the acting Director of Nursing and Personal Care was also considered to be the Registered Nurse on duty and present in the long-term care home on identified dates.

During an interview with the Director of Care and RN S#100 on February 24, 2015, the Director of Care indicated that she started working in the home on January 12, 2015. RN S#100 indicated that the previous DOC's last day in the home was October 10, 2014 and that she was the acting Director of Care from

October 13, 2014 to January 9, 2015.

The schedule was reviewed for this time period. On 44 day shifts, RN S#100 was considered to be both the RN on duty, as well as the acting Director of Care. (197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee is hereby ordered to prepare, submit and implement a plan to include the following:
-all direct care staff and managers to complete a mandatory, comprehensive and interactive education session offered in various formats to meet the learning needs of adult learners on all forms of resident abuse. The education should include but not be limited to:
-how to identify all forms of resident abuse as defined by the O. Regs 79/10 s. 2,
-the difference between consensual and non-consensual sexual touching with a focus on residents that have a cognitive impairment,
-the mandatory reporting obligations as outlined in the LTCHA, 2007 s. 24 to immediately report all alleged, suspected or witnessed incidents of resident abuse to the Director,
-the use of the Abuse Decision Trees to assist in the decision to report and investigate allegations of resident abuse,
-the immediate investigation obligations as outlined in the LTCHA, 2007 s. 23
-review of the home's Zero tolerance of abuse policy.

The plan shall also include how the home will measure the effectiveness of the education and re-educate staff and managers as required.

The plan shall be submitted in writing by fax to Inspector, Darlene Murphy at 613 -569-9670 on or before March 20, 2015.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA 2007, s. 19 (1) (a) whereby residents were not protected from sexual abuse.

Under O. Reg. 79/10 s. 2 (1) (a), sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

On an identified date, Resident #20 reported to Inspector #197 that Resident #45 comes into the room at night and exposes themself while making inappropriate comments and that this has been reported to staff.

Resident #45's health care record was reviewed and indicated the resident ambulates independently. The following information was documented in the resident progress notes:

- on a designated date, S#128 noted that Resident #45 was seen wandering out of Resident #20's room.

- on a designated date, S#108 noted that Resident #45 was in Resident #12's room while the maintenance man was painting. When Resident #45 went to leave the room they looked behind Resident #12's curtains. Will need to monitor for going into other resident's rooms.

- on a designated date, S#107 noted "inappropriate behaviour" ....PSW found Resident #45 in Resident #20's room with their clothing opened.

- on a designated date, S#108 noted "inappropriate behaviour"... PSW found Resident #45 in Resident #12's room with their clothing opened.

- on a designated date, S#128 noted Resident #45 was involved in an incident with Resident #20. Statements were taken and will be forwarded to day manager for consideration.

- on a designated date, S#128 noted Resident #45 exposed themself to Resident #20.

- on a designated date, S#107 documented "seen by Dr. M. this afternoon. Dr. M. is aware of increased sexual behaviour", monitor.

- on a designated date, S#128 documented Resident #45 up wandering and Resident #20 making accusatory statements that Resident #45 was exposing

themself.

- on a designated date, S#107 documented Dr. R. spoke with Resident #45. Aware of concerns of showing self in public.

On a designated date, S#108 was interviewed and confirmed Resident #45 had an increased behaviour of exposing themself and the Substitute Decision Maker and physician are aware.

On a designated date, S#107 was interviewed and confirmed there have been concerns with Resident #45 exposing themself in public and that both physicians are aware of the concerns and there have been no medication adjustments.

On a designated date, S#109 confirmed aware of the behaviour and that the RPN in charge is responsible for reporting the incidents to the RN on duty who completes an internal incident statement and forwards to management who conduct an investigation and complete a critical incident.

On February 25, 2015, S#100, the Acting Director of Care at the time was interviewed and confirmed being notified of the incident that occurred on a designated date. S#100 stated she thought the incident had been taken care of and did not investigate. S#100 confirmed the investigation would be documented but was unable to provide the report of the investigation by the duty RN. S#100 confirmed that a critical incident report was not completed or submitted to the Director. S#100 stated only one incident involving Resident #45 had been reported to management.

The licensee failed to protect residents from sexual abuse as evidenced by the following:
- all incidents of alleged. suspected or witnessed abuse were not reported or investigated.
-The Director was not immediately notified of alleged, suspected or witnessed incidents of sexual abuse of Resident #12 and #20 and an unidentified resident that resulted in harm or risk of harm to residents.
-The licensee policy "Zero Tolerance Abuse/ Neglect was not complied with.
-The licensee policy "Zero Tolerance of Abuse/Neglect" was not evaluated annually
-The licensee policy "Zero Tolerance of Abuse/Neglect" did not include training and retraining requirements for all staff that include power imbalances between

residents and staff, and situations that may lead to abuse and how to avoid such situations. [s. 19. (1)]

(531)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) 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. 31 (3).

Order / Ordre :

The licensee is hereby ordered to develop a staffing plan that includes the following:

-provides for a staffing mix that is consistent with resident's assessed care and safety needs and that meets the requirements set out in the Act and Regulation,
-set out the organization and scheduling of staff shifts,
-promotes continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident,
-includes a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work, and
-be evaluated and updated at least annually.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 31(3) in that the staffing plan for the home does not include all required components.

On February 23, 2015, the home was asked to provide a copy of their written staffing plan.

The staffing plan provided was one page and set out the number of staff working in the home for each department on days, evenings and nights. No other information was included to indicate how the home provides for a staffing mix that is consistent with residents' assessed care and safety needs, how they promote continuity of care, or what the back-up plan is for nursing and personal care staffing.

During an interview with the Director of Care and RN S#100 on February 24, 2015, they indicated that as of right now there are no other components to the staffing plan and that this is something they are working on.

During an interview with the Administrator on February 27, 2015, he indicated to Inspector #103 that the staffing plan had not been evaluated on an annual basis.

Non compliance related to O. Reg. 79/10, s. 31 was previously issued in the following inspections:
- September 2, 2014, Inspection # 2014_280541_0030 (WN, VPC)
- January 30, 2015, Inspection # 2015_347197_0005 (WN, VPC)
(197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is hereby ordered to develop a monitoring process to ensure resident's exhibiting altered skin integrity are reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg 79/10 s. 50 (2)(b)(iv) whereby a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was not reassessed at least weekly by a member of the registered nursing staff.

Resident #14 had identified skin impairments that required dressing changes three times weekly. The resident's health care record was reviewed.

Documented wound care assessments were completed on two identified dates in a one month time frame and a partial assessment was documented on one identified date in the following one month time frame.

RN S#100 was interviewed and stated the home is currently not completing weekly wound assessments. The DOC was also interviewed and stated she has developed a tool to facilitate the completion of these assessments by the registered staff and anticipates introducing this tool over the next few weeks.

This non-compliance was identified during a previous inspection at the home in August 2014 and a voluntary plan of correction was issued at that time. [s. 50. (2) (b) (iv)]

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is hereby ordered to develop a monitoring process to ensure there is monitoring and documentation of the resident's response and the effectiveness of the drugs to maximize the resident's comfort.

Provide education to registered nursing staff in the area of pain assessment with a focus on the importance of monitoring/documenting resident response and include the role of non-pharmacological comfort measures to support resident comfort.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg 79/10, s. 134 (a) whereby a resident taking any drug or combination of drugs, including psychotropic drugs, was not monitored and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs was not recorded.

Resident #14 had identified diagnoses. The resident was interviewed and stated identified areas are painful at varying times throughout the day. The resident acknowledged taking regular doses of pain medications each day and stated

they can ask the nurse for additional pain medications between these times if they require it for pain control. The resident described the pain as nagging, sometimes constant and feels there are only short periods of time when they have no pain. The resident also stated the pain is worse at night and told this inspector they previously used a hot pack which always felt good. The resident stated they are not currently receiving hot packs.

The resident's medication record was reviewed for an identified one month time frame. Resident #14 had an order for an identified analgesic to be used as needed for pain control (prn). During that one month period of time, the resident received the prn pain medication sixty-eight times. The resident health care record was reviewed and on twenty eight out of the sixty eight doses taken, the effectiveness of the medication was described as no effect, minimal effect or some effect. Twenty three out of the sixty-eight doses had no documented effect.

The physician orders were reviewed and there had been no medication changes over a three month time frame.

The DOC was interviewed and stated she expects that pain medications should be evaluated after each dosage is given to properly assess the resident's pain control. Additionally, the DOC stated she believed the physician should have been notified of the poor pain control to ensure the resident's regular doses of pain medications were reassessed. The DOC stated she believes the large number of prn pain medications was probably an indication of inadequate pain control. [s. 134. (a)]

(103)

2. Resident #12 had identified diagnoses. On an identified date, Resident # 12 was interviewed by Inspector #601, and the resident reported ongoing pain for about two years. The resident stated the pain medication was only sometimes

effective.

Resident #12's health care record was reviewed including the medication record. It indicated an identified analgesic was being administered at the residents request (prn), for identified areas of pain.

During an identified month, the medication record indicated the as needed (prn) analgesic was administered sixty times. There were twenty-eight times during this identified month where the effectiveness of the pain medication was not clear or the effectiveness response was delayed for more than an hour.

RPN S#109 was interviewed and stated when a nurse administers a prn medication, an alert will automatically generate a response time in the e-mar for the nurse to document the effectiveness of the medication. The nurse is able to postpone the evaluation of the prn medication by clicking the OK button. The effectiveness needs to be documented and sometimes the nurse will respond on a later shift to eliminate the alert from continuing throughout the shift.

DOC is aware the documentation of pain medication effectiveness is not always being completed and the explanation to the effectiveness is not describing the resident's response to the medication. It is the home's expectation for the nurses to provide a detailed, timely response of the effectiveness of prn medication being administered.

The monitoring and documentation of Resident #12's response to the pain medication is not clear and documentation of the effectiveness of the pain medication was not always completed in a timely manner. [s. 134. (a)]

(601)

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

Ministére de la Santé et des Soins de longue durée

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

Directeur
a/s Coordinateur des appels
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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 10th day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DARLENE MURPHY

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