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

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Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 6, 2014	2014_330573_0015	O-000854-14	Resident Quality Inspection

Licensee/Titulaire de permis

MOHAWK COUNCIL OF AKWESASNE
P.O. Box 579, CORNWALL, ON, K6H-5T3

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

TSIIONKWANONHSOTE
70 Kawehnoke Apartments Road, Akwesasne, ON, K6H-5R7

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

ANANDRAJ NATARAJAN (573), AMANDA NIXON (148), JOANNE HENRIE (550), KATHLEEN SMID (161), SUSAN WENDT (546)

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): September 22,23,24,25,26,29, 30 and October1, 2 ,2014

During the course of the inspection, the inspector(s) also conducted 2 Complaints inspection log O-000770-14 and O-000821-14.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, Chair of Residents' Council, Personal Support Workers (PSW), Dietary Aides, Housekeeping Aides, Maintenance staff member, Physiotherapy Assistant, Registered Practical Nurses (RPN), Registered Nurses (RN), Physiotherapist, Maintenance Supervisor,Food Service,Housekeeping and Laundry Manager, Activity Director, RAI MDS Coordinator, Director of Care (DOC) and the Administrator.

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

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9. (1) 2., whereby the licensee did not ensure that all doors leading to non-residential areas are equipped

with locks, and that those doors leading to non-residential areas that are equipped with locks are kept closed and locked when they are not being supervised by staff.

Non-residential areas are those in which residents do not customarily receive care and/or services.

On September 25, 2014, in the company of the home's Maintenance Supervisor, Inspector #148 observed the following doors that lead to non-residential areas were not equipped with locks to restrict unsupervised access to those areas by residents:
2 doors, #122, leading to "clean utility room"
2 doors, #121, leading to "soiled utility room"
Door #140, leading to "soiled utility room"

On September 25, 2014, in the company of the home's Maintenance Supervisor, Inspector #148 observed that while the following doors that lead to non-residential areas are equipped with locks, the doors were not kept locked when they were not being supervised by staff:
2 doors, #120, leading to "linen room"
Door #128, leading to "linen room"
Door #131, leading to "linen & carts"
Door #W116 leading to "soiled linen room",
Door #W117, leading to "housekeeping closet"

On September 25, 2014, Inspector #148 observed that while Door #W143 and Door #148, both of which lead to non-residential areas, are equipped with locks, the doors were not kept closed and locked when not being supervised by staff, rather both doors were observed to be propped open by a door stopper.

These rooms were confirmed by the Maintenance Supervisor to be non-residential areas and were noted to be storage spaces for a variety of items such as soiled laundry, clean laundry, housekeeping supplies, nursing care supplies and resident equipment.

With the exception of door #148, each of the doors noted above were described in an Inspection Report (#2014_304133_0015) issued to the home on May 7, 2014 with a Voluntary Plan of Correction (VPC).

In addition, Inspector #148 observed a set of double doors located near the dining

room (room #145), the doors were not equipped with a lock. The double doors lead to a hallway where there are various office spaces and storage areas which were observed to be unlocked and accessible. On September 22, 2014, Inspector #148 entered through the double doors and observed accessible storage and office areas and at the time of the observation the area was not being supervised by staff. On September 25, 2014, the Maintenance Supervisor confirmed the area beyond the double doors to be a non-residential area.

On September 25, 2014 the Maintenance Supervisor and Director of Care both indicated that the home currently has obtained quotes for magnetic lock systems to be installed on the doors identified by the Inspector. At this time the quotes and plans for installation are with the Technical Department. [s. 9. (1) 2.]

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is 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.

Tsi Ion Kwa Nonth So'te is a 50 bed LTC Home. On October 1, 2014, Inspector #546 met with the Director of Care (DOC) to review the Home's staffing. The DOC acknowledged that there was no written staffing plan. Upon review, the Inspector #546 asked if the Home had a contingency or back-up plan in case a Registered Nurse called in sick or could not be replaced; the DOC confirmed that there was no plan to replace the Registered Nurse if she/he calls in sick or is a no-show. The DOC indicated that the Home was not using a nursing agency at the time to ensure 24 hour Registered Nursing coverage, nor is it at present.

A photocopy of the nursing staff schedule was provided by the DOC for the period of July 7 to September 28, 2014. Upon review, the Inspector noted that there was no Registered Nurse on duty on the following:
• Day shifts (8-hour Shift) of July 14, July 18, July 19, July 20, July 25, July 26, July 27, July 29, July 31, August 2, August 3, August 11, August 16, August 17, August 31, September 8, September 10, September 13, September 14, September 26, September 27, September 28, 2014
• Evening shifts (8-hour Shift) of July 10, July 15, July 16, July 18, July 29, July 31, August 1, August 8, August 12, August 14, August 15, August 23, August 24, August 29, September 6, September 7, September 9
Registered Nurse coverage on nights was consistent.

On October 2, 2014, the Director of Care (DOC) confirmed that the shifts not being covered by a Registered Nurse are not a result of an emergency; she confirmed that the home was not able to ensure that one Registered Nurse was on duty and present in the home at all times . As such, the exceptions to the requirement that at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff are not applicable as per O. Reg 79/10 s. 45 (1) (1) [s. 8. (3)]

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 O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

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).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written staff plan for the nursing and personal support services program.

Tsi Ion Kwa Nonth So'te is a 50 bed LTC Home. On October 1, 2014, Inspector #546 met with the Director of Care (DOC) to review the Home's staffing. The DOC acknowledged that there was no written staffing plan. Upon review, the Inspector asked if the Home had a contingency or back-up plan when nursing and personal support services staff called in sick or could not be replaced; the DOC confirmed that

there was no written staffing plan. The DOC indicated that the Home was not using a nursing agency.

The DOC conveyed to the Inspector #546 that the Home is staffed as follows:
Day Shift - one RN for the day shift, one to 2 RPNs, 5 PSWs
Evenings Shift - one RN for the day shift, one to 2 RPNs, 5 PSWs
Nights Shift - one RN, 3 PSWs [s. 31. (2)]

2. The licensee has failed to ensure that there was a contingency staffing plan in place, whereby the staffing plan must include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage) and, that the plan be evaluated and updated at least annually in accordance with evidence-based practise and, if there are none, in accordance with prevailing practices.

Inspector #546 reviewed a complaint from a concerned person, who wished to remain anonymous, received on July 28, 2014 and a complaint from a concerned resident received on August 1, 2014, alleging the Home was short-staffed and that residents were not receiving care as planned or indicated.

During this RQI inspection, Inspector #148 interviewed a resident, who wished to remain anonymous, who indicated that the Home was frequently short-staffed. The resident reported the following recent observations to the inspector:
1. Resident #014 being lifted by one person instead of two persons with a mechanical lift;
2. On September 22, 2014, Resident #029 sat wet in his/her chair all afternoon in the main hall;
3. On September 21, 2014, Resident #012 soiled her/him self, the PSW staff knew and just covered her/him with a blanket
4. Resident #028 is frequently left on the toilet unattended; that Resident #028 yells, sometimes up to 20 minutes, before someone comes; Resident #011 added that Resident #028 had previously fallen off the toilet.

Inspector #546 met and spoke with the concerned person in regards to the care provided in the Home. The complainant had reported that baths were not being given as reported, that mouth care was not being done as reported, that repositioning was not occurring as planned or indicated, that residents who should not be in incontinence products were being put in briefs because there was simply no time for

the residents to be toileted. The complainant also stated that documentation of the care was not being done as should be. The complainant stated that staffing and resident centred care have improved in the past few weeks, with the new administrator and since the inspectors are in the Home. The complainant will keep observing and reporting if (s)he notices an increase in short staffed shifts and that care levels diminish.

On October 1, 2014, the Director of Care (DOC) acknowledged that there was no written staffing plan. Upon review, the Inspector asked if the Home had a contingency or back-up plan when nursing and personal support services staff called in sick or could not be replaced; the DOC confirmed that there was no written staffing plan; the DOC indicated that the Home was not using a nursing agency. The DOC stated that the Home's staffing mix was consistent with residents' assessed needs for safe care and the scheduling of such staff shifts. However, the DOC expressed the challenges of filling the frequent absentee calls when staff do not come to work as scheduled and planned. The DOC confirmed she had no evidence of a contingency plan or an evaluation of the current situation.

During the period between July 7 to September 28, 2014, the Inspector #546 noticed that a total 93 shifts were short in the nursing and personal care program, in addition to 39 shifts where there was no Registered Nurse on duty and present in the Home.

Thus, the Licensee failed to provide a staffing plan which meets the criteria as set out in O. Regs r. 31. [s. 31. (3)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

On September 24th, 2014 during the Family interview at stage 1 RQI, Resident's SDM indicated to the Inspector #573 that Resident #32 was not served with proper texture food. SDM stated that, On September 22rd, 2014 Resident #32 was not able to have his/her meals since he/she was served with regular texture meat and noodles. SDM also mentioned that resident #32 is supposed to have minced texture for meat and the vegetables should be well cooked for cut up texture. She/He further stated resident has no teeth and does not have both upper and lower dentures.

Resident #32 current plan of care dated June 18th, 2014 was reviewed by Inspector #573 and under Dietary / Eating it states that "Provide supervision with minimal set up or assistance i.e. cut food for resident and Provide modified regular diet with soft - cut up texture"

Inspector #573 observed on September 25th, 2014 that Resident #32 was served Regular texture meals - chicken and vegetables stir fry and on September 26th, 2014 Resident #32 was served with Regular texture meals - beef meat balls , potato and Rhubarb.

On September 29th, 2014 the Food Service Manager stated during an interview with the Inspector #573 that Resident's #32 SDM requested for soft cut up texture and the dietary staff should have cut up the meat balls, noodles, vegetables and chicken strips when served to the Resident #32.

Resident #32's plan of care regarding the texture of food was not provided to the resident as specified in the plan. [s. 6. (7)]

2. Resident #01 has multiple diagnoses,Contributing to pain and weakness Resident #01 was triggered for RQI stage 2 inspection regarding Pain.

The Inspector #573 reviewed the Resident #01 plan of care in effect and recent physiotherapy quarterly assessments. The Resident #01 both plan of care and quarterly physiotherapy assessments identifies that the resident is in physiotherapy treatment and the frequency of the interventions indicates 3 times a week.

Upon reviewing the physiotherapy daily attendance sheets for 3 months period from July to September 2014, the resident #01 was only seen 4 times for physiotherapy treatments

On 29th, September 2014 the PTA staff mentioned during an interview with Inspector #573 that Resident #01 was not seen for physiotherapy treatment 3 times per week since resident was not available for the physiotherapy treatments and busy with other activities and programs.

On 1st, October 2014 during an interview with Inspector #573 the home's physiotherapist stated that the expectation of PTA staff is to see the resident 3 times a week for 1:1 physiotherapy treatment unless otherwise resident refuses treatment or resident is sick.

For Resident #01 the physiotherapy treatments set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the resident reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #12 has had 11 falls in the last 3 months and is at high risk for fall as per the FRAT fall assessment.

Resident was observed by Inspectors #550 and Inspector #148 on different occasions between September 22 and 29, 2014 using a wheelchair for mobility.

During an interview PSW staff #111 indicated to Inspector that Resident #12 has been using a wheelchair for mobility for a few weeks now. RPN staff #108 indicated to Inspector the resident is now using a wheelchair for mobility.

The resident's current written plan of care is dated April 29, 2014 and indicates Resident #12 is using a 4 wheeled walker for mobility. [s. 6. (10) (b)]

4. Inspector # 550 revised Resident #02's written plan of care and it indicates staff are to provide constant supervision and assist. Ensure clothing and footwear is clean and appropriate.

During an interview, PSW staff #116 indicated to Inspector #550 Resident #02 does not dress him/her self at all and he/she has to be dressed completely by one staff. Inspector indicated to the PSW the written care plan indicates to provide constant supervision and assist. PSW staff #116 indicated this is not accurate as Resident #02 now requires to be totally dressed by staff. She/He indicated this change occurred a few months ago when resident condition deteriorated. [s. 6. (10) (b)]

5. The Resident #34 was triggered for Stage 2 inspection regarding Toileting Decline through MDS data. Inspector # 573 reviewed Resident #34‘s written plan of care in effect dated September 4th, 2014 under TOILETING interventions it states “Verbally instruct the resident and use physical signals. Use verbal cues for each step of the process. Adjusting clothing, transfer to the toilet, cleansing, transfer off the toilet, readjusting clothing, hand washing. TOILETING - One person constant supervision and physical assist for safety i.e. Adjust clothing, wash hands / pericare.”

During an interview PSW staff #116 mentioned to Inspector #573 that Resident #34 is total care with incontinent of bowel and they don’t transfer resident to the toilet.

On September 30th, 2014 the Home’s Rai co-coordinator who confirmed to Inspector # 573 that resident #34 present written plan of care regarding toileting intervention was based on resident previous health status and it was not revised based on resident current needs.

The licensee has failed to ensure that the Resident #34 written plan of care regarding toileting interventions is reviewed and revised when resident‘s care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and when resident is reassessed the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.16, whereby the licensee did not ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

During initial observations of resident rooms during Stage 1 of the Resident Quality Inspection, Inspectors observed windows in resident bedrooms to open more than 15 centimetres.

Over the course of the inspection Inspector #148 specifically observed resident bedrooms #106, #108, #110, #112, #113, #114 and #115 to have one or two windows in each room that opened between 35-37 centimetres.

On September 25, 2014, Inspector #148 spoke with the Maintenance Supervisor who confirmed that all windows in resident bedrooms are capable of an opening larger than 15 centimetres. In addition, Inspector #148 observed there to be windows that open to the outside in the two resident dining rooms and activity area. At the time of the inspection windows in the large dining room (#145) and activity area were not equipped with handles. Upon acquiring a handle, Inspector #148 confirmed that the windows in both dining areas and the activity room, opened more than 15 centimetres and windows in the large dining room (#145) were not equipped with screens. The Maintenance Supervisor reported that the windows in the large dining room (#145) are not used, as there is an air conditioning unit present. He did indicate that the windows in the activity area are used as staff have a handle to use and will open these windows, as needed.

On September 25, 2014, both the Maintenance Supervisor and Director of Care indicated to Inspector #148, that they were unaware of the requirements of section 16.

On September 26, 2014, the Maintenance Supervisor indicated several possible window modifications that would enable the home to maintain the maximum of a 15 centimetre opening. [s. 16.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care include an order by the physician or the registered nurse in the extended class.

This resident was admitted to the home on a specified in 2013. Resident requires two 3/4 bed rails up when she/he is in bed as per her/his written care plan and interview with Registered Practical Nurses staff #101. Inspector #550 was unable to find a physician or nurse in the extended class order for the bed rails in Resident #02's health record.

During an interview, the Director of Care indicated to Inspector #550 that all restraints requires a physician's order prior to the application of the restraint. She indicated no physician order was obtained for the two bed rails restraint for this resident. As per

MDS data dated May 19, 2014 Resident #02 requires two bed rails up when she/he is in bed. [s. 31. (2) 4.]

2. Resident #31 was triggered for RQI stage 2 inspection regarding potential side rail restraint. Resident #31 current plan of care dated July 3rd 2014 was reviewed by Inspector #573 and under Risk for falls, it states "Put 2 side rails up at all times, when in bed for safety"

Resident #35 current plan of care dated June 20th 2014 was reviewed by Inspector #573 and under Risk for falls, it states "Put 2 side rails up at all times/when in bed for safety"

Resident #31 and Resident #35 health care record was reviewed by Inspector#573 and there was no order written by either the Physician or Registered nurse in the extended class for the use of the two full bed rails as a restraint.

On September 29th 2014, during an interview with the Home's Rai co-coordinator who indicated to Inspector #573 that for Resident #31 and Resident #35 they consider the use of two full bed rails as a restraint and confirmed both the residents doesn't not have an order from Physician or Registered nurse in the extended class for the use of the two full bed rails as a restraint. [s. 31. (2) 4.]

3. The licensee has failed to ensure that the restraint plan of care include the consent by the resident or if the resident is incapable, by the SDM.

Resident #02 requires two bed rails up at all times when he/she is in bed for safety as per his/her written plan of care dated September 4th, 2014. Inspector #550 was unable to find a consent for the bed rails restraint in Resident #02's health record. During an interview, Registered Nursing staff #S105 indicated to Inspector #550 she/he could not find a consent for the restraint in this resident's health record. During an interview, the Director of Care indicated to Inspector # 550 Resident #02 did not have a consent by the resident's substitute decision maker for the bed rail restraint. [s. 31. (2) 5.]

4. Resident #31 was triggered for RQI stage 2 inspection regarding potential side rail restraint. Resident #31 current plan of care dated July 3rd 2014 was reviewed by Inspector 573 and under Risk for falls, it states "Put 2 side rails up at all times, when in bed for safety"

Resident #35 current plan of care dated June 20th 2014 was reviewed by Inspector 573 and under Risk for falls, it states "Put 2 side rails up at all times/when in bed for safety"

Resident #31 and Resident #35 health care record was reviewed by Inspector #573 and there was no consent by the resident or by the SDM for the use of the two full bed rails as a restraint.

On September 29th 2014, during an interview with the Home's Rai co-coordinator who indicated to Inspector #573 that for Resident #31 and Resident #35 they consider the use of two full bed rails as a restraint and confirmed both the residents doesn't not have an consent from the resident or by the SDM for the use of the two full bed rails as a restraint. [s. 31. (2) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a physician or a registered nurse in the extended class has ordered or approved the restraining; that consent by the Resident or if the Resident is incapable, by the SDM for the use of physical device as restraint, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s.73(1)10, whereby the licensee did not ensure that proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

On September 22, 2014, Inspector #148 observed the lunch meal service in the large dining room (#145). During this meal observation Resident #14 was provided total feeding assistance by a PSW staff member. Due to diagnosis and related physical limitations, Resident #14 is unable to maintain an upright position for eating meals. The resident is known to spend most time in his/her chair in a semi-Fowlers position and the plan of care indicates a risk of choking with the most recent choking episode in late August 2014 along with increased coughing noted at meals. During the meal, Inspector #148 observed the PSW staff member to feed the resident while standing, providing a spoonful of food to the resident then leaving to perform another duty, returning to provide another spoonful and so on. At a point during the meal observation the resident began to cough and was not able to initially able to catch his/her breath. The PSW staff member reacted and the Registered Nurse provided care, including the need for suctioning. The PSW staff member indicated that the resident choked on the food.

On September 23, 2014, Inspector #148 observed Resident #14 in the dining room for the lunch meal service. A second PSW staff member was observed to feed the resident while standing. Inspector #148 approached the staff member, who reported she/he was aware of the choking incident yesterday but that the resident will "swat at you" if you sit down. Inspector #148 observed this behaviour during the meal observation regardless of the staff standing or sitting.

Staff members are not using proper feeding techniques when feeding Resident #14, who is at risk for choking.

On September 23, 2014, Inspector #148 observed the lunch meal service in the large dining room (#145). During this meal observation Resident #16 was provided total feeding assistance by a PSW staff member. Resident #16 has a diagnosis of dysphagia and tends to have his/her neck hyper-extended. During the meal, Inspector #148 observed the PSW staff member to feed the resident while standing. In addition, from this position the staff member poured fluids into the resident's mouth.

The staff member did not use proper feeding techniques when feeding Resident #16, who has a known diagnosis of dysphagia. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that proper techniques are used when assisting Residents #14 and # 16 with eating, including safe positioning, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, annually on:

4. How to minimize the restraining of residents and, where restraining is necessary how to do so in accordance with this Act and the regulations.

The Director of Care provided a copy of the training that was offered to staff on minimizing of restraints on March 17, 19 and 21, 2014. 18% of the staff (13/70 employees) attended the training sessions. [s. 76. (7) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive training on the home's restraint policy annually, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that once in every calendar year:

-conduct an evaluation to determine the effectiveness of the policy, and
-identify what changes and improvements are required to minimize restraining and ensure that restraining is done in accordance with the Act and Regulation.

Inspector #550 revised the home's Restraint policy dated August 2008. No revision of the policy was done since this date.

During an interview the Director of Care indicated to Inspector #550 the home does not conduct an evaluation of the policy to determine the effectiveness and identify what changes and improvements are required to minimize restraining and ensure that restraining is done in accordance with the Act and Regulation. [s. 113. (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 home's restraint policy is revised annually to determine the effectiveness of the policy and that changes and/or improvements are documented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a member of the registered nursing staff permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only if:
(a) The staff member has been trained by a member of the registered nursing staff in the administration of topical.

During an interview the Director of Care indicated to inspector the PSW's are expected to apply topical creams to residents.

During an interview, PSW staff #116 indicated to inspector she/he has been working in the home for 3 years and she/he never received training on how to administer a topical. She/He indicated it is part of her/his duties to administer topical to residents.

PSW staff #117 indicated to inspector it is the home's expectation that she/he apply topical creams to residents. She/He indicated she/he has been working here for 13 years and never received training on this.

PSW staff #115 indicated to inspector she/he does apply topical to residents but has never received any training. [s. 131. (4)]

2. During an interview on October 1st, 2014 Registered Nursing staff #105 indicated to Inspector #550 she/he did an education session on Application of topical for PSW's last winter. She/he indicated to inspector she/he does not recall the exact date because she/he did not keep any written documentation on this and that only 2 PSW's attended the training.

During an interview, the Director of Care confirmed that non-registered staffs are administering topical to residents and that they have not received training. [s. 131. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that PSW(s) who as part of their duties are required to apply topical to residents are trained in the administration of topical by a registered staff, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control Program is evaluated and updated at least annually.

Inspector #573 reviewed the Home's Infection control policy manual, in that latest review date indicated December 2011.

On October 1st, 2014 the Director of Care confirmed to Inspector #573 that the Infection Prevention and Control policy's last revision was done on December 2011 and since then they have not evaluated or updated the Infection Prevention and Control program. [s. 229. (2) (d)]

2. The licensee has failed to comply with O.Reg 79/10 s. 229 (10) 1 in that each resident admitted to the Home was not 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.

A review of the home's policy regarding Resident TB Testing (Infection Control 9:10 Tuberculosis page 3) it directs "that all resident admitted to the home is given a two – step Mantoux skin test for tuberculosis. The first is given within 14 days of admission to the facility, unless there are previous documented results within the last year or the skin test is medically contraindicated. The second test 7 to 21 days after the first test".

Review of health record indicated:
Resident #36 was admitted and was not administered TB screening Skin Test (Step 1) until 40 days and there is no evidence or data regarding (Step 2) test.
Resident #37 was admitted and was not administered TB screening Skin Test (Step 1) until 28 days and there is no evidence or data regarding (Step 2) test.
Resident #38 was admitted and was not administered TB screening Skin Test (Step 1) until 63 days and there is no evidence or data regarding (Step 2) test.

On September 30th, 2014 the home's Director of Care and Registered Nursing Staff #105 confirmed during an interview with Inspector #573 that the Resident #36, #37 and #38 was not screened for tuberculosis within 14 days of admission and also mentioned that the tuberculosis screening test Step 2 was not done for any of those residents identified by the Inspector # 573. [s. 229. (10) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Infection Prevention and Control Program is evaluated and updated at least annually and each resident admitted to the Home is 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, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Between September 22nd and October 2nd, 2014 Inspectors #550 and #573 observed the following throughout the home:

Inspector #550:

The hand rails in hallways in main entrance and west wing area the varnish is worn off exposing the grain of wood.

In West wing:
Room 130: acupuncture clinic/therapy room: tiles were removed from the wall. The wall was plastered but it is not painted. Pipes where a tub used to be are sticking out

of the wall.
The exit door near room W101 the wall beside the keypad has a two screw holes and a bigger one the size of a nickel, exposing the gyprock.
The hallway near mechanical and sprinkler room has two flooring tiles broken exposing the cement subfloor.
The flooring in the hallway where the fire doors are is cracked and has broken floor tiles exposing cement subfloor.
The handicap male washroom has paint chipped off the wall exposing the gyprock near both handrails and on the wall left of the toilet, next to the wall garbage and under the hand paper disposal. The grout is cracked on the flooring tiles in the right and left corner of the room.
The handicap female washroom the grout on the floor tiles are cracked in the right hand side corner, under the sink and along the wall between the sink and the door.
The hallway near mechanical and sprinkler room has two flooring tiles broken exposing the cement subfloor.
In the soiled linen room: the wall where the water hose is, is damaged, the paint is removed exposing the plaster. Approximately 3 ½ feet long. The wall behind the door has several indentations exposing the gyprock.
In front of room W111 the flooring tiles are broken exposing the cement subfloor.
On the wall near room W128 where the computer monitor is installed there are 5 screw holes above the monitor, and the wall under the screen has an indentation of approx. 3 feet long exposing the gyprock.
In room W132 the flooring in front of door is missing a tile.

Inspector #573:

Common area tub room 104 in the south wing: the tiles on the bottom of the wall between the shower area and the tub are removed (approximately 10 inches by 58 inches) exposing the gyprock. The corner of that same wall has many titles removed, exposing the gyprock. The corner is covered with a board that is taped to the wall with duct tape. There is an open area (approximately 1 inch) between the wall and the flooring tiles exposing the subfloor. There are broken tiles behind the tub and on the wall on the left hand side of the tub exposing the gyprock underneath. There is a whole in the wall where a switch used to be and it is not covered.

During an interview, the Maintenance Supervisor indicated he was aware of many of the issues identified. He indicated they just did not get around to fixing them. They already have a work order opened to fix the tub and shower room in the south wing.

[s. 15. (2) (c)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.37 (1)(a), whereby the licensee did not ensure that each resident of the home has his or her personal items, labelled within 48 hours of admission and of acquiring, in the case of new items.

On September 24, 2014, Inspector #148 observed the following personal items in the South tub room without a label:
one set of nail clippers
two small container of vita-rub (used)
one container of petroleum jelly (used)
three deodorants (used)
one small container of Vitamin E skin cream (used)
one comb with visible hair

Resident personal items are primarily stored in baskets which are kept in the resident's closet within the resident's bedroom. On September 26, 2014, Inspector #148 observed the following within the shared resident bedrooms, #106, #108, #125 and #135:Unlabelled toothbrushes
Unlabelled toothbrush in a basin on the sink counter (specifically room #135)
Unlabelled toothbrushes at resident bedside (specifically room #135)
Unlabelled hair combs and hairbrushes (used)
Unlabelled nail clippers (room #106 and room #108)

Inspector #148 spoke with a PSW staff member and Registered Practical Nurse, neither staff member could identify the process to ensure all resident personal items are labelled, or if the home had a process to ensure dentures and glasses were labelled. The PSW staff member indicated that labelling is usually done by staff member who is on light duties.

On September 26, 2014, the home's Director of Care reported that the labeling of personal items is the responsibility of the PSW staff. She further noted that during recent room audits, the lack of labelling of personal items was identified and will be discussed within the Infection Control Committee. [s. 37. (1) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has and that the staff of the home comply with, (c) a cleaning schedule for the food production, servery and dish washing areas.

On September 25, 2014 during an observation of the West wing servery and again on October 2, 2014, Inspector #550 observed the following:

The walls inside the servery are visibly dirty with webs and dried food splatters. The cupboards are made of melamine, they are visibly dirty and some of them have chips of melamine removed exposing the wood underneath. The inside of the cupboards are visibly dirty and some of them have the finishing edge damaged. The drawers are also made of melamine, and the finishing edge is damaged, exposing the wood. The metal shelf under the steam table is rusted and visibly dirty. The light switch plate and the wall above the sink is visibly dirty. The floor is visibly dirty with dust and dried food.

On October 2, 2014, Inspector # 550 did a tour of the servery with the Food Service Manager who is also the housekeeping manager. He indicated to inspector the cleanliness of the servery is unacceptable and that he should be more present in the servery to ensure the cleaning routine is done by his employees. All the identified housekeeping issues are part of the staff's cleaning routine done by the dietary department and the routine is not being followed. [s. 72. (7) (c)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)

(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8,

s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee has failed to ensure that the Resident Admission package does not include the following information:
-the long-term care home's policy to promote zero tolerance of abuse and neglect of residents [section 78 (2)(c)]
-an explanation of the duty under section 24 of the LTCHA, Reporting Certain Matters to the Director, to make mandatory reports [section 78 (2)(d)]
- the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director or the name, telephone number of a person designated by the Director to receive complaints [section 78 (2)(f)]
-a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents [section 78 (2)(n)]
-an explanation of the protections afforded by section 26 of the LTC Homes Act regarding Whistle-blowing protection [section 78 (2)(q)]

During the course of the Inspection, the home's Director of Care mentioned to the Inspector #573 that the admission package does not contain the following information related to Section 78 (2).

On September 27, 2014 Inspector #573 reviewed the admission package with the home's Administrator and confirmed that the admission package does not include the legislative requirements listed above. [s. 78. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances labelled properly and kept inaccessible to residents at all times.

On September 24, 2014, Inspector #550 observed in the unlocked west wing tub and shower room in the unlocked cupboard in front of the tub the following hazardous products:

In the top cupboard 2 spray bottles of Mikro quat; one 18 ounces, the other 12 ounces. The bottom cupboard has 1 spray bottle containing 11 ounces of clear liquid labelled Mikro quat.

During an interview, Registered Practical Nurses staff #101 indicated he/she did not know these products had to be kept inaccessible to residents. He/she promptly removed the products from the cupboard.

On September 25, 2014, Inspector #550 observed in the unlocked west wing servery in the unlocked cupboards several hazardous products:

The cupboard under the sink contains a gallon of liquid Assure, a spray bottle of Lime Away, 2 bottles of Prolink cream cleanser and three bottles of Stainless Steel polish cleaner.

During an interview with the Activity Director who was replacing the Food service Manager during his absence indicated to inspector all the doors leading to the dining room which access the servery should be locked whenever staff are not present in these areas. At the time of the observation the dining room door from the hallway in TV area was unlocked therefore giving access to residents to the dining room and the servery.

During an interview, the Food service Manager who is also the housekeeping manager indicated to Inspector #550 that all hazardous products have to be kept locked and inaccessible to residents. [s. 91.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

5. The person who applied the device and the time of application,
6. All assessment, reassessment and monitoring, including the resident's response
7. Every release of the device and repositioning
8. The removal or discontinuance of the device, including time of removal or discontinuance and post-restraining care.

It was documented in Resident #02's written plan of care that he/she requires two bed rails up for safety at all time when he/she is in bed.

During a revision of Resident #02's health record, Inspector #550 observed there was no documentation on who applied the restraint and the time of application, all assessment, reassessment and monitoring, including the resident's response, when the device was released and the resident was repositioned and the removal or discontinuance of the device, including the time of removal or discontinuance. Inspector revised the documentation at point of care and observed there is no provision for staff to document the bed rails for this resident.

During an interview on September 25, 2014, PSW staff #113 indicated to Inspector #550 Resident #02 requires to have two bed rails up when he/she is in bed at all times for his/her safety. She/he indicated PSW's are supposed to document all restraints in Point of Care (POC) but there is no provision for the bed rails for this resident in POC. She/he indicated the nurses have to add this directive in POC so they can document it. The only directive they have for safety devices/restraints in POC at this time for this resident is the safety alarm to be applied in bed and in chair.

During an interview, Registered Nursing staff #105 indicated to inspector the reason the bed rails do not appear on Point of Care is because there is no physician's order for them. She/He indicated to inspector she/he will obtain a physician's order and add the bed rails in Point of Care for PSW's to document. [s. 110. (7) 5.]

Issued on this 6th day of October, 2014

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

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) :	ANANDRAJ NATARAJAN (573), AMANDA NIXON (148), JOANNE HENRIE (550), KATHLEEN SMID (161), SUSAN WENDT (546)
Inspection No. / No de l'inspection :	2014_330573_0015
Log No. / Registre no:	O-000854-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 6, 2014
Licensee / Titulaire de permis :	MOHAWK COUNCIL OF AKWESASNE P.O. Box 579, CORNWALL, ON, K6H-5T3
LTC Home / Foyer de SLD :	TSIIONKWANONHSOTE 70 Kawehnoke Apartments Road, Akwesasne, ON, K6H-5R7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	HELEN MCKENZIE

To MOHAWK COUNCIL OF AKWESASNE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9. (1) 2., Whereby the licensee did not ensure that all doors leading to non-residential areas are equipped with locks, and that those doors leading to non-residential areas that are equipped with locks are kept closed and locked when they are not being supervised by staff.

Non-residential areas are those in which residents do not customarily receive care and/or services.

On September 25, 2014, in the company of the home's Maintenance Supervisor, Inspector #148 observed the following doors that lead to non-residential areas were not equipped with locks to restrict unsupervised access to those areas by residents:
2 doors, #122, leading to "clean utility room"
2 doors, #121, leading to "soiled utility room"
Door #140, leading to "soiled utility room"

On September 25, 2014, in the company of the home's Maintenance Supervisor, Inspector #148 observed that while the following doors that lead to non-residential areas are equipped with locks, the doors were not kept locked when they were not being supervised by staff:
2 doors, #120, leading to "linen room"
Door #128, leading to "linen room"
Door #131, leading to "linen & carts"
Door #W116 leading to "soiled linen room",
Door #W117, leading to "housekeeping closet"

On September 25, 2014, Inspector #148 observed that while Door #W143 and Door #148, both of which lead to non-residential areas, are equipped with locks, the doors were not kept closed and locked when not being supervised by staff, rather both doors were observed to be propped open by a door stopper.

These rooms were confirmed by the Maintenance Supervisor to be non-

residential areas and were noted to be storage spaces for a variety of items such as soiled laundry, clean laundry, housekeeping supplies, nursing care supplies and resident equipment.

With the exception of door #148, each of the doors noted above were described in an Inspection Report (#2014_304133_0015) issued to the home on May 7, 2014 with a Voluntary Plan of Correction (VPC).

In addition, Inspector #148 observed a set of double doors located near the dining room (room #145), the doors were not equipped with a lock. The double doors lead to a hallway where there are various office spaces and storage areas which were observed to be unlocked and accessible. On September 22, 2014, Inspector #148 entered through the double doors and observed accessible storage and office areas and at the time of the observation the area was not being supervised by staff. On September 25, 2014, the Maintenance Supervisor confirmed the area beyond the double doors to be a non-residential area.

On September 25, 2014 the Maintenance Supervisor and Director of Care both indicated that the home currently has obtained quotes for magnetic lock systems to be installed on the doors identified by the Inspector. At this time the quotes and plans for installation are with the Technical Department.

(148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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 there is 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.

Grounds / Motifs :

1. The licensee has failed to ensure that there is 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.

Tsi Ion Kwa Nonth So'te is a 50 bed LTC Home. On October 1, 2014, Inspector #546 met with the Director of Care (DOC) to review the Home's staffing. The DOC acknowledged that there was no written staffing plan. Upon review, the Inspector asked if the Home had a contingency or back-up plan in case a Registered Nurse called in sick or could not be replaced; the DOC confirmed that there was no plan to replace the Registered Nurse if she/he calls in sick or is a no-show. The DOC indicated that the Home was not using a nursing agency at the time to ensure 24 hour Registered Nursing coverage, nor is it at present.

A photocopy of the nursing staff schedule was provided by the DOC for the period of July 7 to September 28, 2014. Upon review, the Inspector noted that there was no Registered Nurse on duty on the following:
• Day shifts (8-hour Shift) of July 14, July 18, July 19, July 20, July 25, July 26, July 27, July 29, July 31, August 2, August 3, August 11, August 16, August 17,

August 31, September 8, September 10, September 13, September 14, September 26, September 27, September 28, 2014
• Evening shifts (8-hour Shift) of July 10, July 15, July 16, July 18, July 29, July 31, August 1, August 8, August 12, August 14, August 15, August 23, August 24, August 29, September 6, September 7, September 9
Registered Nurse coverage on nights was consistent.

On October 2, 2014, the Director of Care (DOC) confirmed that the shifts not being covered by a Registered Nurse are not a result of an emergency; she confirmed that the home was not able to ensure that one Registered Nurse was on duty and present in the home at all times . As such, the exceptions to the requirement that at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff are not applicable as per O. Reg 79/10 s. 45 (1) (1)

The risk level associated with having several shifts over a short period of time without an RN on site could result in minimal harm or potential actual harm to residents.

The scope of harm and risk of harm is widespread because of the number of shifts where there were only RPNs on site to supervise the home of 50 residents.

The LTCH has no previous history of non-compliance related to 24 hr nursing.

(546)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Order / Ordre :

The licensee is hereby requested to prepare a written plan of correction for achieving compliance to fully address the criteria for the Home's written staffing plan for nursing and personal care services, including to ensure that a written contingency (back-up) staffing plan be put in place, whereby the staffing plan must include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage) and, that the plan be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. Steps need to be taken to ensure nursing and personal care coverage during all shifts by continuing recruitment and hiring process and by using nursing agency staff.

This plan must be submitted in writing to Susan Wendt and Anandraj Natarajan, LTCH Inspectors at 347 Preston St, 4th floor, Ottawa, ON, K1S 3J4 or by fax (613) 569-9670 on or before November 7th,2014.

Grounds / Motifs :

1. The licensee failed to ensure that there was a contingency staffing plan in place, whereby the staffing plan must include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage) and, that the plan be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Inspector #546 reviewed a complaint from a concerned person, who wished to remain anonymous, received on July 28, 2014 and a complaint from a concerned resident received on August 1, 2014, alleging the Home was short-

staffed and that residents were not receiving care as planned or indicated.

During this RQI inspection, Inspector #148 interviewed a resident, who wished to remain anonymous, who indicated that the Home was frequently short-staffed. The resident reported the following recent observations to the inspector:
1. Resident #014 being lifted by one person instead of two persons with a mechanical lift;
2. on September 22, 2014, Resident #029 sat wet in his/her chair all afternoon in the main hall;
3. on September 21, 2014, Resident #012 soiled her/him self, the PSW knew and just covered her/him with a blanket
4. Resident #028 is frequently left on the toilet unattended; that Resident #028 yells, sometimes up to 20 minutes, before someone comes; Resident #011 added that Resident #028 had previously fallen off the toilet.

Inspector #546 met and spoke with the concerned person in regards to the care provided in the Home. The complainant had reported that baths were not being given as reported, that mouth care was not being done as reported, that repositioning was not occurring as planned or indicated, that residents who should not be in incontinence products were being put in briefs because there was simply no time for the residents to be toileted. The complainant also stated that documentation of the care was not being done as should be. The complainant stated that staffing and resident centered care have improved in the past few weeks, with the new administrator and since the inspectors are in the Home. The complainant will keep observing and reporting if (s)he notices an increase in short staffed shifts and that care levels diminish.

On October 1, 2014, the Director of Care (DOC) acknowledged that there was no written staffing plan. Upon review, the Inspector asked if the Home had a contingency or back-up plan when nursing and personal support services staff called in sick or could not be replaced; the DOC confirmed that there was no written staffing plan; the DOC indicated that the Home was not using a nursing agency. The DOC stated that the Home's staffing mix was consistent with residents' assessed needs for safe care and the scheduling of such staff shifts. However, the DOC expressed the challenges of filling the frequent absentee calls when staff do not come to work as scheduled and planned. The DOC confirmed she had no evidence of a contingency plan or an evaluation of the current situation.

During the period between July 7 to September 28, 2014, the Inspector noticed that a total 93 shifts were short in the nursing and personal care program, in addition to 39 shifts where there was no Registered Nurse on duty and present in the Home.

Thus, the Licensee failed to provide a staffing plan which meets the criteria as set out in O.Regs r. 31. (2)

(546)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

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 6th day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Anandraj Natarajan

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