Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 11, 2016	2016_251512_0007	009357-16	Resident Quality Inspection

Licensee/Titulaire de permis

UNIONVILLE HOME SOCIETY
4300 Highway #7 MARKHAM ON L3R 1L8

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

UNION VILLA
4300 Highway #7 Unionville ON L3R 1L8

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

TILDA HUI (512), SARAN DANIEL-DODD (116), SUSAN SEMEREDY (501)

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): April 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 27, 28, 29, May 2, 3 and 4, 2016.

The following complaints were inspected concurrently with this inspection: 005912-14, 004299-15, 004550-15, 020532-15, 021999-15, 013613-15, 010662-16, 010484-16.
The following critical incidents were inspected concurrently with this inspection: 006965-14, 002192-15, 002634-15, 009135-15, 012831-15, 014366-15, 031853-15, 001392-15, 023462-15, 024494-15.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, Director of Nursing & Personal Care (DONPC), Nurse Manager (NM), Food Services Manager (FSM), Environmental Manager (EM), Social Worker (SW), Recreation Programs Supervisor, Registered Dietitian (RD), Registered Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Recreation Therapists, Resident Assessment Instrument (RAI) Coordinator, Residents, and Family Members.
During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including medication passes and meal delivery services, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **19 WN(s)**
- **8 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

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

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).

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 plan of care sets out clear directions to staff and others who provide direct care to the resident.

Review of a complaint email sent to the Ministry of Health and Long Term Care on an identified date, revealed resident #003's family member had various care issues.

Observations and interviews with PSWs #104 and #126 revealed resident #003 did not

ambulate or self-transfer, and was transferred using a mechanical lift. According to the PSWs, the resident no longer used incontinence equipment and products and staff no longer toileted the resident. Review of the Minimum Data Set (MDS) assessment at an identified date, revealed resident #003 was assessed as totally dependent for transferring.

A review of resident #003's written plan of care last reviewed on an identified date, revealed unclear directions related to the resident's ambulation, transfer status and toileting plan. Staff were to observe the resident's gait and report to registered staff any unsteadiness. In the falls section it stated not to allow the resident to ambulate without assistance. The resident needed total assistance for transferring with mechanical lift, without identifying the specific lift to use. Further, the written plan of care indicated the resident requires toileting before and after meals, and bed, and uses incontinence equipment and products. In the responsive behaviour section of the written plan of care it indicated staff to use a sit to stand lift for toileting.

Interview with the RAI Coordinator revealed the home used the term “mechanical” lift for the lifts that are not sit to stand, and toileting referred to as any incontinence product change. The RAI Coordinator did indicate that in general terms, this written plan of care did not provide clear direction to staff.

Interview with the DONPC revealed he/she was not aware staff were referring to the home’s different lifts as described by the RAI Coordinator, and toileting should refer to when a resident is put on the toilet. The DONPC confirmed that resident #003’s written plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Review of complaint intake identified concerns regarding infection prevention within the home.

The written plan of care for resident # 032 documented the need for respiratory system monitoring related to an identified respiratory condition. The interventions to manage the identified respiratory condition were in place to direct the staff.

The family member of resident #032 reported to the Inspector that on or around an identified date during the day shift, he/she observed resident #032 sitting with two other residents #’s 038 and #040 in the dining room who were experiencing an identified respiratory symptom. The family member requested for resident #032 to be isolated to

prevent resident #032 coming into contact with other residents with the identified respiratory symptom. The family member returned to the home during the evening of the identified date, and observed resident #032 seated at the table with resident #040 who was still experiencing the identified respiratory symptom.

Interviews with direct care staff members revealed they were unaware of any precautions in place to isolate resident #032 from other residents experiencing the identified respiratory symptom.

Interview with RPN #106 confirmed that the written plan of care did not set out clear directions to staff and others who provided direct care to the resident to ensure that resident #032 was not in contact with residents who were experiencing the identified respiratory symptom. Interview with the DONPC confirmed that the written plan of care should have been updated to include interventions to isolate resident #032 from other residents who had displayed the identified respiratory symptom and to set out clear directions to staff. [s. 6. (1) (c)]

3. The licensee has failed to ensure that staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Record review of a head to toe skin assessment conducted on resident #003 by RPN #118 on an identified date, indicated the resident had a staged altered skin integrity on two identified parts of his/her body. Skin assessment noted on the MDS assessment documented on the same day by RPN #103 indicated the resident's skin was clear and intact with no altered skin integrity.

Interview with RPN #103 confirmed that the resident did have a staged altered skin integrity on two identified parts of his/her body and that the RPN had missed them in his/her assessment. Interview with the RAI Coordinator and the DONPC confirmed RPN #118 and RPN #103 did not collaborate in the assessment of resident #003's skin. [s. 6. (4) (a)]

4. Review of resident #042's continence assessment in MDS on an identified date, indicated the resident was incontinent of bladder and was using incontinent products. Review of the resident's written care plan with the same date indicated the resident was continent of bladder.

Interviews with PSW #125 and RN #128 indicated the resident was continent and would asked to be toileted during days and evenings. However the resident asked not to be toileted during the night for fear of falling, and requested to use incontinent products to be changed in bed.

Interview with the resident's family member confirmed the resident was continent and was toileted during days and evenings, and would use incontinent products at night for safety.

Interviews with RPN #106, RAI Coordinator, and the DONPC confirmed the staff involved in the different aspects of care did not collaborate with each other in the assessments of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

5. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Interview with resident #003's family member revealed when he/she came to the home, the resident was often sitting alone in his/her room when he/she could have been taken to an activity. The family member also revealed that the resident used to be disruptive in some programs but recently has been calmer.

Review of resident #003's written plan of care revealed that the resident attended an identified activity program, and the MDS assessment on an identified date, revealed the resident liked the identified activity program. Interview with Recreation Therapist #119 revealed resident #003 enjoyed the identified activity program in groups and during one on one visits. The Recreation Therapist stated the resident liked the identified activity program in groups as long as they were not too loud.

On an identified date and time during the inspection, observation revealed resident #003 was lying in bed speaking with Recreation Therapist #119. Interview with the Therapist revealed the resident was interested in attending the first identified activity program session of the morning. but since he/she was in bed the Therapist was unable to bring him/her. Interview with PSW #104 revealed he/she was unaware that resident #003 was to attend the identified activity program and the resident was scheduled to receive an identified care procedure at around the time when the second identified activity program

session. The PSW indicated he/she could get the resident ready for this activity now that he/she was aware. Observation revealed resident #003 was in the identified activity program session, actively participating and smiling.

Interviews with the Recreation Program Supervisor, RAI Coordinator and DONPC confirmed that in the above mentioned situation, staff did not collaborate with each other in the development and implementation of the plan of care so resident #003 could attend a program that he/she enjoyed. [s. 6. (4) (b)]

6. The licensee has failed to ensure that 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.

Record review of resident #044 revealed the resident required extensive assistance of one staff to transfer and toilet, and ambulated with a walker. The resident had shown gradual deterioration of cognitive and physical functions in the past several months. The home's registered physiotherapist (PT) was referred to assess the resident's transferring and toileting needs on an identified date. The resident was assessed as not able to bear weight fully and required two staff to transfer and to toilet. The shower commode was recommended for toileting by the PT. Three weeks after the first assessment, the PT was again requested to conduct an assessment on the resident as staff were having difficulties with transferring and toileting the resident. The PT recommended use of the mechanical lift for transfer as the resident was assessed to have decreased muscle strength and at high risks for falls. The PT suggested not to toilet the resident in the shower commode for safety, and his/her incontinence would be managed by incontinent products changes in bed. The PT documented the assessment in point-click-care (PCC), revised the written plan of care, informed the nursing staff, and changed the transfer logo in the resident's room.

Interview with the resident's family member revealed the family was not informed of the change in transferring method for the resident. The family found out the change when they visited the resident two days later. The family member indicated concern the resident may feel frightened when up in the sling during transfer with the mechanical lift.

Interviews with RPN #102 and PT #124 confirmed the resident's family was not informed on or following the PT assessment on the second identified date, recommending using the mechanical lift when transferring the resident.

Interview with the DONPC confirmed that the resident's SDM has not been provided the opportunity to participate fully in the development and implementation of the plan of care related to the transferring methods used. [s. 6. (5)]

7. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

The written plan of care for resident #031 documented that the resident requires extensive assistance of two persons for toileting and bed mobility related to history of falls and decreased muscle strength.

Interview with PSW #121 revealed the PSW has been toileting the resident without the assistance of another staff member for a period longer than a month. PSW #121 indicated the resident previously required the assistance of two persons as a result of a sustained injury from a fall, however, the resident now has the strength to participate in transferring.

Interviews with RPN #122 and PT #124 revealed the resident was discharged from the falls prevention program as of an identified date, and reassessed as only requiring the assistance of one person for toileting and transferring, and confirmed that the written plan of care was not revised when the resident's care needs for transferring changed.

Interview with the RAI Coordinator confirmed the resident's written plan of care was not revised when the resident's care needs changed and care set out in the plan is no longer necessary. [s. 6. (10) (b)]

8. Review of resident #008's progress notes indicated the resident had a fall incident on an identified date and time when the resident was transferred to the toilet by a PSW in the washroom. Upon completion of the toileting, the resident was transferred back to the wheelchair. During the transfer, the resident lost balance and could not weight bear. The identified PSW assisted the resident to a kneeling position on the floor. The resident was assisted back to his/her wheelchair and no injury was noted.

Review of the resident's progress notes indicated the resident had a second incident six weeks after the first incident. The resident was sitting on the edge of the bed supported by a PSW while waiting for a second PSW to assist with the transfer from the bed to the

wheelchair. The resident fell back to the bed hitting his/her part of the body on the bed. The resident did not sustain obvious injury on his/her body at the time, however was observed to have visible injury on his/her body four days after the incident.

Review of the resident's current written plan of care indicated the resident required one staff to transfer. Observation of the transfer logo on the resident's room indicated the resident required two persons to transfer.

Interviews with PSW #148, RPN #147, and PT #124 revealed the resident currently required two staff to transfer. RPN #147 confirmed the resident's current written plan of care was not revised to reflect the change in resident's transfer assistance requirement. Interview with the DONPC confirmed the resident's written plan of care should have been revised when the resident's care needs changed. [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 plan of care sets out clear directions to staff and others who provide direct care to the resident, that staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, that the SDM and designate of the resident has been provided the opportunity to participate fully in the development and implementation of the plan of care, and that the resident is 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of critical incident report and interviews with resident #022's family members revealed staff members were rough with resident #022 when putting him/her to bed on an identified date, and the resident was observed to have altered skin integrity on identified parts of his/her body. Review of the progress notes revealed two physicians from the home examined resident #022 within the week and observed the resident had altered skin integrity on an identified part of his/her body which was consistent with finger marks from a forceful squeeze.

Interviews with the family members revealed that on an identified date and time, resident #022 was being resistive to going to bed because he/she was waiting to speak with a nurse manager regarding the conduct of his/her assigned PSW #139. Resident #022 liked to have a light on to turn down the bed and inadvertently pulled the call bell. PSW #139 entered the room and turned off the call bell without any explanation or redirection. The resident told the family members he/she had written a note describing some of the events that took place that evening. Review of this note revealed the resident was roughly handled by staff and heard laughter. The resident had mentioned to the family members that the staff and the resident were engaged in a physical altercation. The family members indicated that PSW #138 and #139 had been the ones who put the resident to bed and RPN #137 was supervising. The family members indicated that the resident and PSW #139 did not have a good rapport.

Interview with RPN #137 revealed that resident #022 was refusing to go to bed on the identified date. The RPN requested assistance from PSW #138 due to this PSW's past ability to persuade the resident to comply even though he/she was not assigned to that home area. The RPN described resident #022 as being uncontrollable, agitated and confused that evening. After PSW #138 took the resident to his/her room, the RPN heard the resident yelling "get out of here" so he/she went to try to calm the resident down. The RPN stated he/she observed PSW #139 holding and transferring the resident from the

wheelchair to the bed, while PSW #138 pulled back the wheelchair and did not witness either PSW being rough with the resident. RPN #137 stated he/she was aware resident #022 and PSW #139 had animosity towards one another and often had to intervene but had not reported this to the nurse manager.

Interview with the DONPC revealed the home concluded an assault did take place even though the three staff members denied any rough handling took place. The three staff members were disciplined following the investigation. Interview with the DONPC confirmed that the home failed to protect resident #022 from physical abuse on the identified date. [s. 19. (1)]

Additional Required Actions:

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

WN #3: 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 a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it was based, to the Director.

Review of critical incident report and interviews with resident #022's family members revealed that during the resident's shower on an identified date, staff members were rough and the resident was observed to have an altered skin integrity on an identified part of his/her body which was not there previously.

Interview with resident #022's family member revealed that on the identified date, when the resident was being showered, he/she heard screaming coming from the spa room. The family member stated when he/she entered the spa room, the resident was sitting on the commode chair with water and hair in his/her face. There were two PSWs providing the shower and PSW #140 was rough while drying the resident. The resident was observed to have an altered skin integrity on an identified part of his/her body after the drying process. The family member reported the incident to RPN #137.

Review of a progress note written by RPN #137 revealed he/she spoke with resident #022's family member on the identified date, regarding a shower resident #022 had that evening. The family member revealed to the RPN that a specific altered skin integrity was not on the identified part of his/her body before the shower and the staff could have been rough with him/her. The progress note documented there was the identified altered skin integrity on the identified part of the resident's body.

Interview with RPN #137 revealed the family member did report to him/her the identified altered skin integrity on resident #022's identified part of the body. The RPN also stated PSW #140 reported that the family member implied he/she was abusive with the resident. RPN #137 revealed he/she documented in the progress notes but did not report the incident to any manager of the home or the Ministry of Health and Long Term Care (MOHLTC).

Review of the home's policy #6602 titled "Resident Abuse/Neglect", last reviewed November 2015, stated all staff are required to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the MOHLTC.

Interview with the DONPC confirmed RPN #137 had reasonable grounds to suspect that abuse of a resident had occurred and failed to immediately report the suspicion and the information upon which it was based, to the Director. [s. 24. (1)]

2. A critical incident report was submitted by the home of a suspected physical abuse of resident #042 by PSW #129 on an identified date. Review of the CI report revealed the resident reported to his/her family that on the identified date, during an identified shift, a PSW refused to change his/her incontinent brief. The resident's family member submitted a written note the next day to the nurse on duty indicating that the resident alleged a PSW slapped an identified part of his/her body and threw a soiled incontinent product at the resident. The note was given to the DONPC two days later. The DONPC called the ActionLine number on the day he/she received the note, resulting in a complaint intake. The CI was received seven days after the incident occurred.

Interview with the resident's family member revealed the resident retracted his/her statement regarding being slapped by the PSW. However, the PSW was described by the resident to be repeatedly "shoving a soiled incontinent product to his/her face".

The Inspector interview PSW #129 who denied slapping the resident and shoving the soiled incontinent brief to the resident's face.

Interview with the DONPC confirmed the suspected abuse from staff to resident was not reported to the MOHLTC immediately after it was brought to the home's staff attention. [s. 24. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care is based on an interdisciplinary assessment with respect to the resident's health conditions including risk of falls.

Review of resident #008's progress notes indicated the resident had a fall incident on an identified date and time. The resident was transferred to the toilet by one PSW in the washroom at the time of incident. Upon completion of the toileting, the resident was transferred back to the wheelchair and he/she lost balance and could not weight bear. The identified PSW assisted the resident to a kneeling position on the floor. The resident was assisted back to his/her wheelchair and no injury was noted.

Review of the resident's progress notes indicated the resident had a second fall incident six weeks after the first incident. The resident was sitting on the edge of the bed supported by a PSW while waiting for a second PSW to assist with the transfer from the bed to the wheelchair. The resident lost trunk control and fell back to the bed hitting an identified part of his/her body on the bed. The resident did not sustain any injury on his/her head, however was observed to have an altered skin integrity on an identified part of his/her body four days after the incident.

Review of the resident's current plan of care did not reveal any interventions set up to address the resident's history and risks of falls.

Interviews with RPN #147, RAI-Coordinator and the DONPC confirmed the resident's plan of care was not based on an interdisciplinary assessment with respect to the resident's health conditions including his/her risk of falls. [s. 26. (3) 10.]

2. Record review of resident #043's progress notes indicated the resident suffered a fall on an identified date while on leave of absence (LOA) to his/her family member's home. The resident returned to the home and was observed by staff to have no appetite to eat and became passive and lethargic. Staff contacted the family and was informed of the resident's fall during the LOA. The resident was transferred to hospital six days after the fall incident and returned with an identified medical diagnosis. The resident returned to the home with no treatment. Review of the current plan of care at the time did not reveal any interventions set up to address the resident's history and risks of falls after the fall during LOA was made known to the staff.

Interview with RPN #106 indicated strategies were not developed to address the resident's fall risks. Interview with the DONPC confirmed the resident's plan of care was not based on an interdisciplinary assessment with respect to the resident's health conditions including risk of falls. [s. 26. (3) 10.]

3. The licensee has failed to ensure that the resident's plan of care is based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.

Interview with resident #008 and his/her family member indicated the resident had experienced an identified altered skin integrity in an identified part of his/her body and was sensitive to touch. The resident was also noted to have a second identified altered skin integrity on a second identified part of his/her body. The resident's family member thought the second identified altered skin integrity was probably caused by the fall on an identified date, when the resident fell back while sitting on the edge of the bed and hit an identified part of his/her body on the bed. At the time of the incident, the resident was supported by one PSW before being transferred out of bed.

Review of the resident's progress notes revealed the resident's second identified altered skin integrity was identified and recorded by registered staff on an identified date, while the first altered skin integrity was identified and recorded six days later. Review of the resident's current plan of care did not reveal any interventions set up to address the resident's two altered skin integrity.

Interviews with RPN #147 and Nurse Manager #146 confirmed the resident's plan of care was not based on an interdisciplinary assessment with respect to the resident's skin condition with altered skin integrity. Interview with the DONPC confirmed interventions to address the resident's altered skin integrity should be included in the resident's plan of care. [s. 26. (3) 15.]

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 resident's plan of care is based on an interdisciplinary assessment with respect to the resident's health conditions including risk of falls, and with respect to the resident's skin condition, altered skin integrity and foot conditions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of resident #031's written plan of care with an identified date, revealed that the resident was at risk for falls characterized by history of falls/ injury and multiple risk factors.

The resident sustained six falls over an identified period of one year. On an identified

date and time, a PSW discovered resident #031 on the floor beside his/her bed in his/her room. Record review revealed that on the incident date, a post fall huddle was completed and noted as an assessment in the progress notes. However, a clinical assessment using an appropriate instrument was not utilized for the purpose of assessing the resident after the fall. The resident was transferred to the hospital later the same day for further observation and was diagnosed with injuries.

Interviews with staff members and the DOC confirmed that a post fall assessment was not conducted using a clinically appropriate instrument specifically designed for falls when resident #031 experienced a fall on the identified date. [s. 49. (2)]

2. Review of the home's policy #15500 titled "Falls Management Policy" last revised April 2014, revealed a nurse manager/delegate will complete a Post Fall Huddle Report to investigate the contributing factors associated with the fall including location, time and related activity. A physiotherapy assessment will be conducted to determine corrective measures.

Interview with resident #003's family member revealed the resident had a significant change after a fall on an identified date.

Review of progress notes revealed resident #003 had a witnessed fall on the identified date, when he/she tried to self-transfer, became unstable and lowered him/herself to the floor. No injuries were recorded at the time. Thee days after the incident date, resident #003 had an unwitnessed fall and resident was found lying on the floor on his/her left side beside the bed. No injuries were reported and a head injury routine was initiated.

Record review revealed there was no post fall assessment for either of the resident #003's falls.

Interview with the PT revealed he/she had not assessed resident #003 after the two falls using a clinically appropriate assessment instrument that is specifically designed for falls.

Interview with the DONPC confirmed that post fall assessments had not been completed for the above mentioned falls. [s. 49. (2)]

3. Review of resident #008's progress notes indicated the resident had a fall on an identified date and time when the resident was being transferred to the toilet by one PSW in the washroom. Upon completion of the toileting, the resident was transferred back to

the wheelchair and he/she lost balance and could not weight bear. The identified PSW assisted the resident to a kneeling position on the floor. The resident was assisted back to his/her wheelchair and no injury was noted. Record review did not reveal any post-fall assessment conducted on the resident after the fall on the identified date.

Interview with RPN #147 and the RAI Coordinator confirmed there was no post-fall assessment conducted for the resident after the fall on the identified date. Interview with the DONPC confirmed a post-fall assessment using the home's post-fall assessment tool should have been conducted for the resident after the fall on the above mentioned date. [s. 49. (2)]

4. Record review of resident #043's progress notes indicated the resident suffered a fall on an identified date while on leave of absence to his/her family member's home. The resident returned to the home and was observed by staff to have no appetite to eat and became passive and lethargic. Staff contacted the family and was informed of the resident's fall during leave of absence. The resident was transferred to hospital six days after the fall incident and returned with an identified medical diagnosis. The resident returned to the home with no treatment. Record review did not reveal any post-fall assessment conducted on the resident after the fall during LOA was made known to the staff and prior to the resident being transferred to the hospital.

Interview with RPN #106 and the DONPC confirmed post fall assessment was not conducted on the resident after the above mentioned fall during LOA was made known to the staff. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #6: 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 ensure that the resident exhibiting altered skin integrity, including skin wounds, received 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.

Observation made by Inspector #501 on an identified date during the inspection period noted an identified altered skin integrity on an identified part of resident #014's body. Inspector #512 interviewed the resident six days later to follow up. The identified altered skin integrity had started to heal. The resident indicated that the altered skin integrity was causing discomfort but not painful, and it had been bleeding.

Review of the resident's written care plan and progress notes indicated the resident had history of multiple altered skin integrity on identified parts of his/her body, and was followed up by a dermatologist. The last documented skin and wound assessment was conducted on an identified date six months prior to this inspection. No documentation on any other skin assessment was noted.

Interview with RPN #108 indicated he/she was not aware of the identified altered skin integrity on the resident's identified part of the body until brought up by the Inspector. The RPN stated no skin and wound assessment was conducted on the resident for the above

mentioned altered skin integrity.

Interview with Nurse Manager #146 who was the skin and wound program lead, and the DONPC confirmed skin and wound assessment was expected to be conducted on the resident upon identification of altered skin integrity. [s. 50. (2) (b) (i)]

2. Interview with resident #008 and his/her family member indicated the resident had experienced an altered skin integrity in an identified part of his/her body and was sensitive to touch. The resident was also noted to have a second altered skin integrity on a second identified part of his/her body. The resident's family member thought the second altered skin integrity was probably caused by an incident on an identified date, when the resident fell back while sitting on the edge of the bed and hit an identified part of his/her body on the bed. At the time of the incident, the resident was supported by one PSW before being transferred out of bed.

Review of the resident's progress notes revealed the resident's second identified altered skin integrity was identified and recorded by registered nursing staff on an identified date, while the first identified altered skin integrity was identified and recorded six days later. Review of the resident's assessment lists and progress notes did not reveal any skin and wound assessment conducted on the resident's two identified altered skin integrity, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Interviews with RPN #147 and Nurse Manager #146 confirmed skin and wound assessments were not conducted for the resident's two identified altered skin integrity. Interview with the DONPC confirmed skin and wound assessments using the home's assessment tool should have been conducted for the resident upon identification of the above mentioned altered skin integrity. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review of resident #003 revealed the resident was identified with a staged altered skin integrity on an identified part of his/her body as of an identified date. Topical medication was ordered for the resident to apply twice daily. Review of the resident's assessments indicated no evidence of weekly skin and wound assessments conducted for the resident for four identified periods of time.

Interviews with RPN #103 and RAI Coordinator #120 confirmed weekly skin and wound assessments were not conducted for the resident for the above mentioned periods. Interview with the DONPC confirmed weekly skin and wound assessment were expected to be conducted for the resident exhibiting staged altered skin integrity. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin wounds, received 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of Residents' Council meeting minutes revealed that the home had not responded in writing within 10 days of receiving concerns as follows:
• In December 2015, there was a concern about less programming on a particular home area
• In February 2016, there was a concern with not having enough staff on evening shifts
• In January 2016, there was a concern with residents not being allowed to have a mini fridge in their rooms.

Interview with the Recreation Program Supervisor revealed he/she did not respond in writing to the concern in December because he/she attended all meetings and discussed these issues during the meetings. The Recreation Program Supervisor confirmed that he/she should have responded in writing to the Residents' Council within 10 days.

Interview with the acting Administrator confirmed that if the Council Communication Form did not include a response to the above mentioned concerns for January and February 2016, then it was not responded to by the previous Administrator. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee responds in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #8: 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. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required.

Review of a complaint intake identified concerns regarding infection prevention within the home.

The home's policy titled 'Infection Control- Infection Signs and Symptoms Respiratory, index# IFC b15-05, indicated that each respiratory outbreak required its own definition.

The written plan of care for resident # 032 documented the need for respiratory system monitoring related to an identified respiratory condition. The family member of resident #032 reported to the inspector that on or around an identified date and time, the family member observed resident #038 and #040 having an identified respiratory symptom in the dining room while seated amongst other residents on the unit. The family member requested for resident #032 to be isolated to prevent resident #032 coming into contact with other residents who displayed the same symptom. The family member returned to the home during the evening of the identified date, and observed resident #032 seated at the table with resident #040 who was still experiencing the respiratory symptom.

Review of the health record for residents #038 and #040 revealed and interview with RPN #149 confirmed that resident #038 and #040 presented with the identified respiratory symptom the day before the observation date, and resident #039 further developed additional symptom on the observation date. Interviews with RPN #149 and the DONPC confirmed that although the symptoms of infection were recorded for all residents affected, immediate action was not taken as required. [s. 229. (5) (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 staff on every shift record symptoms of infection in residents and take immediate action as required, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted.

Review of critical incident report revealed resident #020 reported that a PSW changed his/her brief against his/her will at an identified date and time.

Interview with PSW #130 revealed he/she changed resident #020's brief without his/her consent on the identified date. According to the PSW, the resident when asked for consent stated "no, no, no." The PSW proceeded to change the brief because it was soaking wet and believed that this would be best for the resident. The PSW admitted he/she did not respect resident #020's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

Interview with DONPC confirmed resident #020 was not treated with respect and dignity in the above mentioned incident. [s. 3. (1) 1.]

2. A critical incident report was submitted by the home on an identified date. Resident #006's family member reported to the former Administrator a variety of concerns about the care and conduct of PSW #105. The family member reported that on the day before the identified date, resident #006 required a brief change and inquired with RPN #106 if anyone was available to do so. The RPN asked PSW #105 who was the assigned caregiver to provide resident #006 with a brief change. According to the family member, the PSW became visibly upset, objected and stated "why do I always have to change him/her". The RPN had to ask the PSW three times before the PSW agreed to provide care to the resident however, stipulated the care would be rendered after receiving shift report.

Interview with PSW #105 revealed that he/she did not feel his/her actions were in violation of the Residents' Bill of Rights. Interview with RPN #106 revealed that the incident occurred at the nursing station in front of resident #006, several family members and staff at the home. Interviews held with RPN #106 and the DONPC confirmed that the actions of PSW #105 did not uphold resident #006's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

The home initiated an internal investigation and deemed the assertions to be founded. As a result, PSW #105 was disciplined. [s. 3. (1) 1.]

3. The licensee has failed to ensure that every resident's personal health information within the meaning of the Personal Health Information Protection Act, 2004 was kept

confidential in accordance with that Act.

Review of a complaint intake identified concerns regarding confidentiality of resident #038's personal health information.

During an interview the family member of resident #004 informed the Inspector that on an identified date, a staff member of the home provided an envelope of resident #004's medication record as per request. A copy of resident # 038's medication record was also enclosed in the envelope. Resident #038 has no relation with this family.

Interview with the DONPC confirmed that resident #038's personal health information was compromised and disclosed to the family of resident #004. Resident #038's personal health information was not kept confidential in accordance with the Act. The staff member responsible for the error received discipline. [s. 3. (1) 11. iv.]

4. The licensee has failed to ensure that every resident has the right to have his or her lifestyle and choices respected.

Interview with the Residents' Council President revealed that there were many residents who would like to have a mini fridge in their room.

Interview with resident #004 revealed he/she would like to have a mini fridge in his/her room in order to have ice cold water and a place to store food brought in by family members. The resident stated he/she really enjoyed this food because it was more of what he/she was used to. Family had brought in food the previous evening and put it in the communal resident and family fridge in the dining room but someone had taken it which she stated often happen.

Interview with resident #021 revealed he/she would like to have a mini fridge in his/her room because he/she needed to drink constantly and he/she disliked the juice that was served. The resident stated when his/her family brought in food and put it in the resident and family fridge in the dining room, it often got taken and got soggy because the temperature of the fridge was not right. The resident further stated his/her family wanted to buy him/her a fridge and he/she would be able to maintain it.

Interview with resident #024 revealed he/she would like to have a mini fridge in his/her room because he/she wanted nice cold beverages at the bedside and he/she would be able to maintain it. The resident further stated that the resident and family fridge in the

dining room was too small to accommodate all residents who wanted to store food and beverages.

Observations on two occasions during the inspection period revealed the resident and family fridges in the third floor dining rooms were small and three quarters full.

Interview with the Recreation Program Supervisor revealed this issue of residents wanting to have a fridge in their rooms was an ongoing issue that got discussed regularly at Residents' Council meetings. Review of the home's policy #16330 titled "Equipment Cleaning/Repairs", last revised September 2015, stated personal fridges in resident rooms were no longer allowed. Those residents who did have one in place will be allowed to keep it providing the resident/family were able to keep it clean and ensure food had not exceeded its expiry date.

Interview with the acting Administrator revealed that he/she was aware of the issue of residents wanting fridges in their rooms and believed since the home had a policy regarding not allowing these fridges and communicates this policy upon admission, then it was not a violation of their rights. [s. 3. (1) 19.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy on medication administration was complied with.

The home's policy titled Medication Administration, policy number 15601, review date June 2011, was reviewed. In the OUTCOME section, it was stated that Medication Administration Record (MAR) and Treatment Administration Record (TAR) are to be current and accurate.

Observation of medication storage was conducted on an identified date and time during the inspection period of the narcotic cupboard on an identified home area of the home. The narcotic cupboard was located in a separate locked compartment of the medication cart. The narcotic count sheets were reviewed against the narcotic medication stored. The count for an identified oral medication for resident #040 was noted to be one less than what was recorded on the count sheet: the package contained 10 tablets while the count sheet indicated 11.

Interview with RPN #103 indicated he/she had administered a tablet of the identified narcotic medication to the resident before the inspector arrived on the home area. The RPN indicated the resident had an order for the identified narcotic medication three times a day by mouth to be given at specific identified times. The RPN stated the resident was going out to a medical appointment on the morning of the observation, and was administered the identified narcotic medication before being picked up by his/her family member. The RPN stated that he/she did not sign in the narcotic count sheet when removing the medication from the package. The RPN proceeded to complete the count sheet in the presence of the Inspector, and wrote the time of the medication administration as the identified time that the medication was given.

Further review of the resident's electronic medication administration record (eMar) revealed the identified narcotic medication was signed off by RPN #103 with the administered time as the regular scheduled time, and not as the time that the medication was given which was one and a half hour ahead of the scheduled time, as confirmed by the RPN and as documented in the narcotic count sheet.

Interview with RPN #103, Nurse Manager #146, and the DONPC confirmed that the narcotic count sheet and the resident's eMAR were not accurately maintained as per the home's policy. [s. 8. (1) (b)]

WN #11: 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.

Record review of the registered nursing staff schedule revealed on an identified date, the registered nurse scheduled for work was ill for an identified shift and was replaced by an identified registered nursing staff.

Interview with the DONPC confirmed that the identified registered nursing staff reported to duty for the identified date and shift was a Registered Practical Nurse (RPN). A second RPN was scheduled to be on duty for the same shift. There was no registered nurse on duty for the above mentioned date and shift. [s. 8. (3)]

WN #12: 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:
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.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors that residents do not have access to must be kept closed and locked.

Observation on an identified date during the inspection revealed that the spa room door on an identified home area was not locked. Interview with PSW #143 revealed that the spa door should be locked.

On a second identified date during the inspection period, the spa room door on a second identified home area was not locked. Interview with the Environmental Supervisor (ES) revealed and demonstrated that a key mechanism below the key pad could be used to unlock the door when the key pad malfunctions. If the key was turned and left in a certain position, the door would remain unlocked rendering the key pad disabled. The ES revealed he/she assumed that this was what occurred with the two identified home areas' spa room doors.

Interview with the Environmental Supervisor confirmed that when the spa room doors are not locked it poses a hazard to residents as the rooms contain sharp utensils and residents can fall on wet floors. [s. 9. (1)]

WN #13: 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,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are provided with a range of continence care products based on their individual assessed needs.

The written plan of care for resident #037 documented that the resident was occasionally incontinent of bladder and required an incontinent product for the night and family requested to use a different incontinent product during the day. The continence product screening form completed on an identified date, indicated the resident required the incontinent product identified by the family for the day and night.

Interviews with RPN #103 and PSW #104 revealed that the family supplied the resident with the requested incontinent product. An interview with resident #037's family member indicated that since admission the family had been providing the resident with the requested incontinent product, as the resident was assessed to be continent and deemed not to require the use of incontinent products. The family member revealed that he/she was unaware that the home is to supply continence products based on the resident's assessed need.

Interviews with NM #145 who was the continence care lead, and the DONPC confirmed the home is required to provide continence care products to residents based upon their assessed needs. [s. 51. (2) (h) (i)]

2. The written plan of care for resident #035 documented that the resident was incontinent of bladder and required the use of an identified incontinent product during the day which was supplied by the family. The continence product screening form completed on an identified date indicated the resident required the identified incontinent product during the day and night.

Interviews with RPN #118 and PSW #104 revealed the family supplied the resident with the identified incontinent product. Interview with resident #035's family member indicated that they have been providing the resident with the identified incontinent product and were unaware that the home was to supply continence products based on the resident's assessed need.

Interviews with NM #145 who was the continence care lead, and the DONPC confirmed that previously the home was not providing residents with the identified incontinent product. However, the home is required to provide continence care products to all residents based upon their assessed needs. [s. 51. (2) (h) (i)]

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. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The license has failed to ensure that all food and fluids in the food production system were served using methods to prevent adulteration, contamination and food borne illness.

On an identified date during the inspection period, observations in an identified home area's dining room revealed show plates were being served to residents during the dinner meal. These show plates were uncovered and when a resident chose a particular plate they were served this immediately. The other plate if not chosen, went back to the servery after the residents were shown the plate close to their face and mouths. These plates were subsequently offered and potentially served to other residents.

Interview with the Food Service Manager (FSM) revealed that these meals should have been covered by a clear dome which is the new procedure in this home area since the residents have complained about the clear plastic obstructing their view. The FSM confirmed that using and serving show plates that were uncovered was not a method that prevented adulteration, contamination and food-borne illness. [s. 72. (3) (b)]

WN #15: 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: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

On an identified date during the inspection period, observation in an identified home area's dining room revealed a hot spinach quiche lunch entree was plated at an identified time. This plate which was to be used as a show plate, sat covered on the counter for six minutes and was then put on the divider between steam table wells for another six minutes. This plate was then served to a resident in an adjacent home area 12 minutes after it was plated.

Interview with the Food Services Manager (FSM) revealed that plating before serving is not the standard practice of the home. The FSM confirmed that the meal served had the potential to be served at a temperature that was not safe and palatable to the residents. [s. 73. (1) 6.]

WN #16: 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 a package of information that complies with this section (s.78 of the LTCHA, 2007) is given to every resident and to substitute decision maker of the resident, if any, at the time that the resident is admitted. The package of information shall include information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package.

Interview with the Family Council representative revealed that the home had not included in the admission package minutes of Family Council meetings as requested. Review of meeting minutes revealed the Family Council had asked for these to be included in the admission package on an identified date, and there was no response from the home.

Interview with the acting Administrator revealed he/she was not aware until recently that the Family Council had made such a request. The acting Administrator confirmed that if the meeting minutes showed that the Family Council had asked for these to be included previously and the home had not responded, then the Family Council's meeting minutes were not included in the admission package information provided by the Family Council. [s. 78. (2) (p)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that, electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum.

During a walk-through on an identified home area, the following was observed:
- bottom portion of the sit to stand lift was observed with particles of a brown substance and not clean.
- the plastic cover which encases the lift bar on a mechanical hoyer lift was observed to be cracked with corrugated rough edges.

Interviews with staff members from different departments including housekeeping, direct care and maintenance provided conflicting information related to who was responsible to clean the mechanical lifts and the process in place to identify mechanical lifts that were not kept in good repair.

Review of the home's policy titled Cleaning of Lifts indicated cleaning of lifts. However, the procedures did not identify or outline the procedure for staff to follow to ensure the cleanliness of mechanical lifts.

Interview with the Environmental Manager (EM) indicated nursing department was responsible for ensuring the cleanliness of the mechanical lifts, and maintenance ensured they were kept in a good state of repair. Interview with the DONPC indicated the housekeeping/maintenance staff were responsible for the cleaning and maintenance of the mechanical lifts. The EM confirmed the home currently did not have procedures in place and implemented to ensure that mechanical lifts are kept in good repair, and maintained, and cleaned at a level that met manufacturer specifications, at a minimum. [s. 90. (2) (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with and a documented record was kept in the home that includes the nature of each verbal complaint.

Interview with resident #022 and the resident's family members revealed that the resident expressed concern regarding temperature regulation in the resident's room. The family members revealed they had spoken to the EM about this and were willing to purchase supplies to assist in the resolution of the issue.

Interview with the EM revealed he/she was aware the family of resident #022 was unhappy with the current situation and believed he/she had brought this to the attention of the former Administrator. Review of the home's complaint binder found there was no documented record of this complaint. The EM stated he/she thought the Social Worker was involved with this complaint. Interview with the Social Worker revealed he/she had communicated with the family regarding moving the resident to another room due to another concern and the family refused.

Interview with the DONPC revealed that he/she was aware of the family's concern regarding the temperature issue but believed the former Administrator dealt with the matter and confirmed the home had not kept a written document of this complaint. [s. 101. (2)]

WN #19: 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 ensure that drugs were stored in a medication cart that was used exclusively for drugs and drug-related supplies.

Observation made on an identified date during the inspection period on an identified home area noted two pair of eye glasses stored inside one of the drawers of the medication cart among the drugs and drug-related supplies.

Interview with RPN #103 indicated the eye glasses belong to residents and were being kept in the medication cart for safe keeping. Interview with the DONPC confirmed non-drug related items were not to be stored in the medication cart. [s. 129. (1) (a)]

Issued on this 14th day of September, 2016

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

Original report signed by the inspector.