Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Jun 6, 2014	2014_201167_0015	H-000553-14	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

BAYWOODS PLACE
330 MAIN STREET EAST, HAMILTON, ON, L8N-3T9

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

MARILYN TONE (167), BERNADETTE SUSNIK (120), JESSICA PALADINO (586), LESLEY EDWARDS (506)

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): May 21, 22, 23, 26, 27, 28, 29, 30, June 3, 2014

Critical incident Inspection H-000401-14 was conducted simultaneously with this inspection and will be included in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Associate Directors of Care (ADOC), Resident Services Co-ordinator (RSC), Activation Manager, Environmental Manager, Food Services Manager, the Resident Assessment Instrument Co-ordinator (RAI Coordinator) , the Registered Dietitian, registered staff and personal support worker staff (PSWs), dietary aides, identified residents and family members.

During the course of the inspection, the inspector(s) conducted a review of the health files for identified residents, reviewed relevant policies and procedures, observed care on resident home areas, conducted tours of the home, observed meal and snack service and other relevant documentation provided by the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Training and Orientation

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. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

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

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

Findings/Faits saillants :

1. The licensee did not ensure that all staff received training related to skin and wound management.

The home's "Tracking Staff Completion of Mandatory Training" sheet provided by the home showed that only five percent of the home's staff had received training related to skin and wound management in 2013 and 2014.
The Resident Services Co-ordinator/Staff Educator confirmed that not all staff had received training related to skin and wound management in 2013 and 2014. [s. 221. (1) 2.]

2. The licensee did not ensure that staff received training related to physical restraining devices or monitoring of residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.

The home's "Tracking Staff Completion of Mandatory Training" sheet provided by the home showed that only five percent of the home's staff received training for the use of physical devices including the application of physical devices and the use of and potential dangers of these devices in 2013 and 2014. The Resident Services Co-ordinator/Staff Educator confirmed that not all staff had received training in 2013 and 2014 related to the use of physical restraining devices. [s. 221. (1) 5.]

3. The licensee did not ensure that all staff received training related to the use of Personal Assistive Service Devices (PASDs).

The home's "Tracking Staff Completion of Mandatory Training" sheet provided by the home showed that only five percent of the home's staff received training in 2013 and 2014 related to the use of PASDs including the application of PASDs and the use of and potential dangers of the PASDs. The Resident Services Co-ordinator/Staff Educator confirmed that not all staff had received training in 2013 and 2014 related to the use of PASDs. [s. 221. (1) 6.]

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. 6. Plan of care

Specifically failed to comply with the following:

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. (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).

Findings/Faits saillants :

1. [LTCHA s.6(4)a] was previously issued as a Compliance Order on April 2, 2014 (Inspection # 2014_205129_004). The compliance date for this order has not yet expired. The findings identified in this written notification will be additional evidence related to this order.

The licensee did not ensure that staff and others involved in different aspects of care of the resident collaborated with each other in the assessment of a resident so that their assessments were integrated, consistent with and complemented each other.

Resident #002's treatment record indicated that the resident had a Stage II skin tear to an identified area on their right side and the progress notes indicated that the resident had a Stage IV pressure ulcer on the identified area on their right side. The resident's plan of care indicated that the resident had a Stage II skin tear to the identified area on their right side and the weekly wound assessments indicated that the resident had a skin tear to their left side. In the progress notes, it identified assessments for the resident's area on their left side when it should have said the resident's right side. The registered staff confirmed that the Stage II skin tear was indeed on the resident's right side and confirmed that the assessments were not consistent and did not complement each other. [s. 6. (4) (a)]

2. Resident #010's Falls Assessment completed in March 2014 indicated that the resident was at high risk for falls. The Physiotherapist (PT) assessed the resident as being a moderate risk for falls in March 2014, and the nurse assessed the resident as being low risk for falls in March 2014 on the Resident Assessment Protocol (RAP) assessment. The ADOC confirmed that the assessments were not consistent and did

not complement each other. [s. 6. (4) (a)]

3. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [S.6(7)]

The most current plan of care for resident # 004 indicated that the resident required staff to shave them with the resident's electric razor.
- During observation of the resident on three consecutive dates in May 2014, it was noted that the resident had a significant amount of stubble on their face in the morning and it was still present after lunch.
- A review of the Point of Care (POC) documentation completed by staff providing care indicated that the resident was independent during the day shifts on two of the identified dates related to shaving and brushing teeth, combing hair, washing and drying face, hands and perineum. On a third identified date, the documentation indicated that the resident received supervision and oversight.
- During an interview with the PSW who had provided care to the resident the morning of one of the identified dates, they indicated that they had not yet shaved the resident but later on in the day indicated to the inspector that they had set the resident up so they could shave themselves.
- Staff did not provide the amount of assistance required related to hygiene and grooming as specified in the resident's plan of care. [s. 6. (7)]

4. The plan of care for resident #007 indicated that the resident required extensive assistance from two staff to provide for their personal hygiene, dressing, bed mobility, transfers and toileting.
- During observation of the resident on three days during the inspection, it was noted that the resident had a significant amount of stubble on their face each day.
- A review of the (POC) documentation completed by staff indicated that the resident received extensive assistance with their personal hygiene including shaving on the identified days.
-During an interview with the Personal Support Worker (PSW) caring for the resident on one of the identified dates, the PSW indicated that they had not yet shaved the resident and would do this later on.
- Resident # 007 did not receive the assistance required as per their plan of care related to shaving. [s. 6. (7)]

5. The licensee did not ensure that that resident #007 received care related to restraint use as per their plan of care.

A) During observation of the resident on two days during the course of this review, it was noted that the resident had a front fastening seat belt fastened in place and the resident was not able to demonstrate their ability to undo it.
- The plan of care for resident #007 indicated that the resident used one one-quarter rail on the open side of the bed to provide support for bed mobility, the bed was to be kept at lowest level and in locked position, a bed sensor and a falls mat were to be used. The resident was also identified as requiring a personal posey alarm when up in their wheelchair, but there was no direction for staff to apply a front fastening seat belt for the resident when in their wheel chair.
- The most current Minimum Data Set (MDS) assessment completed in March 2014 confirmed that the resident did not use any type of limb or trunk restraint.
- Staff interviewed confirmed that the resident was not to have a seat belt in place when in their wheelchair. [s. 6. (7)]

6. The licensee did not ensure that the care set out in the plan of care was provided to the residents as specified in their plans of care related to their diet plans.

Resident #002's care plan required 125 ml pureed prunes to be added to their oatmeal, however observation of breakfast meal service on an identified date during this inspection revealed pureed prunes were not available and the resident did not receive the item until the Inspector made staff aware.
- Resident #022's care plan states that the resident is to receive 110 ml yogurt at breakfast, however observation of breakfast meal service on an identified date during this inspection revealed that the resident did not receive yogurt at breakfast. The labelled yogurt remained in the refrigerator after the resident left the dining room. [s. 6. (7)]

7. The plan of care for resident #019 indicated that the resident was to have a specific intervention in place during all fire alarm testing as this would trigger a negative response in the resident. The registered staff confirmed that on an identified date in 2014, the resident sustained a fall because this intervention was not in place.[s. 6. (7)]

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. 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 did not ensure proper feeding techniques were used to assist residents with eating at meals.

On an identified date in May 2014, resident #005 was being fed in a chair that was tilted backward with the resident's head fully extended back. The resident did not have any teeth or wear dentures, and required a minced diet as well as full assistance with feeding, putting them at high choking risk. The resident's care plan stated that to minimize the risks of choking and aspiration, staff must ensure the resident is in an upright position (90 degree angle) during meals and snacks and 30 minutes post meals and snacks. Staff indicated the resident preferred to be tilted back, otherwise, they complained of feeling like they were falling. When questioned about why the resident's head was so far back, staff stated this was due to the resident's Broda chair pillow sliding down and confirmed this was inappropriate. The staff subsequently positioned the pillow to keep the resident's head in an upright position without any complaints from the resident. [s. 73. (1) 10.]

2. On an identified date in May 2014, resident #020 was being fed in a chair that was tilted backward with the resident's chin untucked, creating a risk for choking. The resident's care plan stated that to support the resident with eating and swallowing, their tilt chair was to be adjusted so their chin was level and slightly tucked, and to be positioned at a 90 degree angle and remain upright for 30-45 minutes after each meal. Staff did not correct the positioning until the Inspector went to the table at the lunch meal to intervene. The RPN and PSW confirmed the resident was improperly positioned. [s. 73. (1) 10.]

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. 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).

Findings/Faits saillants :

1. The licensee did not ensure that a resident was treated with courtesy and respect and that their dignity was respected.

During breakfast service in an identified dining room at the home on an identified date in 2014, a nursing staff member was observed using an inappropriate intervention in attempting to get the resident to eat. During the lunch service, the nursing staff again used an inappropriate intervention to wake the resident who was sleeping in their wheelchair. The resident was visibly startled. The identified staff did not treat the resident with dignity and respect. [s. 3. (1) 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 all residents are treated with courtesy and respect and that their dignity is respected., to be implemented voluntarily.

WN #5: 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 did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home's policy titled "Revera Skin and Wound Care Program LTC-E-90, revised date of August 2012" indicated that all residents exhibiting altered skin integrity were to be be assessed weekly. Resident #002 had an identified skin tear to their side on an identified date in 2013. The area was not assessed weekly until two months later when the weekly wound assessment was initiated. Resident #002 also had a second skin tear to their left side on an identified date in 2014 and was not assessed again until the wound was healed approximately one month later. The Wound Care Champion confirmed that the staff were not following the policies and procedures for skin and wound care.

B) The home's policy title "Revera Personal Assistive Service Devices (PASD)/Assistive Devices LTC-J-30, revision date August 2012" indicated that all residents using a PASD would have documentation every shift on the use of the PASD/Assistive Devices and that documentation must also be completed for residents who could not reposition themselves. Resident #005 had an order for a PASD since January 2014. The staff were not completing documentation every shift on the use of the PASD or documenting that the resident received positioning every two hours as required in the policy. The ADOC confirmed that this was an oversight and should have been added to the PSW's flow sheet documentation. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff comply with the home's policies, protocols and procedures related to Skin and Wound Management, Personal Assistive Service Devices, mandatory training related to heat risk management and the home's strategies to address the adverse effects of excessive heat on residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Where bed rails were in use, steps were not taken to prevent resident entrapment taking into consideration all potential zones of entrapment.

On two identified dates during this inspection, a resident was observed to be lying on a therapeutic air surface with both bed rails elevated or in the guard position. Due to the compressible nature of the mattress, several zones of entrapment were present on the bed, in and around the rails. The resident's most current plan of care identified that the resident sleeps on a regular foam mattress and not a therapeutic mattress and that the resident has to have both ¾ rails. The plan did not identify why the resident requires the rails. No interventions were employed by staff on either date to decrease the risks of entrapment to the resident and the resident was not re-assessed when their bed system changed.

An example of some interventions would have been to place a gap filler between the bed rail and the mattress, keeping the rails down or replacing or modifying the air mattress so that it could pass the required zones of entrapment.

On an identified date in 2014, another bed was also identified to have a therapeutic air mattress on the frame and both assist rails were in the elevated position. The resident was observed being assisted to bed at the time of inspection and no bolsters or gap fillers were noted on the bed. When the personal support workers were asked why the rails were elevated, one replied that the housekeeper raises them to clean under the bed and that they will put them down when the resident is in bed. On an identified date during the inspection, the resident's bed was observed to be unoccupied with both rails elevated. The resident's current plan of care identified that the resident is to have a "quarter side rail on the open side of their bed" and no explanation was given as to the reason. The bed was not up against a wall and therefore did not have an "open side". The plan of care was not accurate or reflective of the resident's current situation. (120)(506)

The home's beds were tested for entrapment zone risks in March 2014 by an external auditor and all were noted to have passed (except the 2 beds with the therapeutic air mattresses). The home staff did not have access to their own measuring tool for ongoing bed system evaluations. During the inspection, it was observed that various beds had loose rotating assist rails in the guard position (horizontal) or in the vertical or transfer position. Residents were not in these beds at the time of observation. The rails were unstable and very wobbly and not safe for resident transfers. Loose rails may also contribute to entrapment zone risks and in this case, the home was not in a position to re-test them as they did not have a measuring tool at their disposal. [s. 15. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are in use, that steps are taken to prevent resident entrapment, taking into consideration all potential zone of entrapment, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 15. (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 did not ensure that the furnishings at the home were kept clean and sanitary.

- During the initial tour of the home, it was observed that the couch in the Den area on Bayfront house was soiled. The couch remained soiled throughout the course of the inspection.(506)
- On an identified date during the inspection, it was observed by inspector #506 during room observations that the chairs in the residents' rooms were visibly soiled in identified rooms. These chairs remained soiled throughout the course of the inspection.
- Resident's night tables were observed to be heavily soiled in seven identified rooms and resident's comfortable chairs were stained or soiled in seven identified rooms in May 2014.
- The night tables and chairs remained soiled after the housekeeper completed cleaning the rooms.
- A deep cleaning schedule was reviewed and confirmed by a housekeeper that each room is deep cleaned every 2 weeks and furnishings are cleaned at that time.
- According to corporate housekeeping policy and the supervisor for housekeeping, surfaces that are visibly soiled are to be cleaned as needed during daily cleaning routines. [s. 15. (2) (a)]

2. The licensee did not ensure that the home was maintained in a good state of repair.

- Serveries were inspected on 3rd and 4th floors only and both were observed to have split flooring material in May 2014. The split was running parallel to the steam table

and was over 1 cm wide and over 8 cm long in both serveries.
- The shower/tub rooms on 3,4,5 and 6th floors did not have the transition between the shower surround and the flooring material adequately sealed in May 2014. A large gap (about 3 cm wide) was observed along with water and embedded debris in the gap.
- Lifting flooring material was observed in the tub/shower room on the 3rd floor on two identified days in May 2014. When reviewed again four days later, the condition was still present. A maintenance person was present at the time of inspection and was informed of the condition.
- A bathroom door in an identified room was observed by an inspector to be badly damaged on an identified date in May 2014. When the maintenance supervisor was asked nine days later when the door would be repaired they were not aware of the issue.
- On an identified date in May 2014, the bathtub located in the 7th floor tub room was observed to be in poor condition. The bottom surface was observed to be very rough and coated in what appeared to be a build-up of water scale. The tub appeared to be functional and ready for use. Nine days later, the bathtub was observed to be in the same condition and ready for use. Four days after that, staff interviewed on the 7th floor confirmed that the tub was ready for use and if any resident requested a bath, they would use that particular tub. The Associate Director of Care (ADOC) reported that their tub repair service provider tried to remove the build-up and was not successful and stated that it could not be resurfaced. Yet, the tub remained in service until the inspector questioned the ability of the tub to be adequately cleaned and disinfected. Post inspection, the Environmental Services Supervisor locked out the tub and disconnected the drain. The ADOC stated that no residents on the 7th floor currently use the bathtub and that alternatives would be arranged for residents who do wish to use the tub in the future. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that furnishings at the home were kept clean and sanitary, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

s. 20. (2) The licensee shall ensure that, if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents. O. Reg. 79/10, s. 20 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home's written hot weather related illness prevention and management plan was implemented when required to address the adverse effects on residents related to heat.

A) The home's plan related to hot weather related illness prevention and management was reviewed and noted to be developed in accordance with current best practices developed by the Ministry of Health and Long Term Care. However, home staff did not adequately monitor environmental conditions within the home to determine when a heat alert should be issued and did not ensure that residents had access to a designated cooling area . During the week of May 21, 2014, the home's hot water boiler system had just been shut off as outdoor conditions warmed up. Residual heat in the system required several days to dissipate before the water could be cooled for air conditioning. As a result, indoor conditions were much more uncomfortable and warmer than outdoor conditions.

Inspectors observed that air temperature and humidity gauges were posted in tub rooms and lounge areas on all but one of the 5 floors occupied by residents. Temperature charts were posted and observed, however the charts were not all fully completed and the charts were not all the same. Some were using the prescribed chart found in the home's hot weather plan and others were using a chart that did not take into account the humidity levels. Where humidity and temperatures were taken, a Humidex was calculated and it was identified that a Humidex of 32 was achieved over the course of several days. According to Environment Canada, the outdoor Humidex on May 21, 2014 for the City of Hamilton was 28, much lower and more comfortable than within the home. A Humidex of 32 creates uncomfortable

conditions which can lead to heat related symptoms such as lethargy, feeling faint, breathing issues and nausea. Communication was provided to all staff on April 23, 2014 reminding them that the Humidex was to be calculated and that certain measures were to be followed, however no mention was made of any available cooling space. The home management staff did not ensure that all staff were following the directives for the heat alert and that measures would be instituted, such as additional fluids being offered and that an alternative space would be available for residents to cool off in. The dining rooms, which were equipped with portable air conditioners at the time, were noted to feel more comfortable than the surrounding rooms and common spaces, were kept inaccessible to residents. Residents were not seen in these dining areas in order to gain any relief from the heat. (120)

B) The licensee did not ensure that all staff received training annually related to "Heat Risk and Weather related Protocols" as required by the home's annual mandatory training policy and in accordance with evidence-based best practices
- On four identified dates in May 2014, it was noted that the home was very hot posing a risk of heat related illness to residents on the care units.
-During interviews with registered staff and PSW staff on the resident care areas, it was noted that staff did not appear to be clear or consistent in their approach related to the monitoring of residents at increased risk for heat related illness or interventions to be in place to assist with the prevention.
- During a review of the training and education provided to staff in 2013 and 2014, it was noted that staff at the home had not received training related to prevention of heat related illness over that time period.
- "Heat Risk and Weather related Protocols" was identified as being one of the home's mandatory training programs that was required to be done annually.
- It was confirmed by the home's Resident Services Co-ordinator/Staff Educator that this training was not provided in 2013 and has not yet been provided in 2014. [s. 20. (1)]

2. The licensee did not ensure that, when the central air conditioning was not available in the home, the home had at least one separate designated cooling area for every 40 residents.

On identified dates in May 2014, the temperature in the lounge areas where residents are seated beside the nurses' stations on every resident home area was noted to be extremely warm. The thermometer located on the wall in this area read approximately 30 degrees celsius on each home area.

- During an interview with the Environmental Manager, it was confirmed that the home does have air conditioning, but that it takes three days for the heating to be off before the "chill system" can be turned on. The Environmental Manager also indicated that they would be able to have the cooling system turned on within three days.
- The temperatures in residents' rooms and other common areas accessible to residents felt very warm and residents were noted to be sweating and complaining about the heat. Only a few rooms were noted to have fans.
- It was noted that in the dining room on every home area, there was a window air conditioner to cool that area. Although the dining rooms felt cooler with the air conditioning units running, it was noted that the dining room doors were kept locked except during meal service and therefore residents did not have access to this cooler area.
- Registered staff and personal support worker staff were interviewed on each floor and it was confirmed that the doors to the dining rooms on every floor were generally kept locked, therefore not allowing access by the residents. [s. 20. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance a) to ensure that the home's hot weather related illness prevention and management plan that meets that needs of residents is developed in accordance with evidence-based practices and, if there are none in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat.
b) to ensure that when the home's central air conditioning is not available, the home has at least one separate designated cooling area that is accessible for every 40 residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee did not ensure that the plan of care for resident #101 addressed their vision needs. The Minimum Data Set (MDS) assessment and the Resident Assessment Protocol (RAP) indicated that the resident had a visual impairment. A plan of care was not in place to address the resident's visual impairment as indicated in the RAP. The ADOC confirmed that this information should be in the resident's plan of care. [s. 26. (3) 4.]

2. The licensee did not ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Health conditions, including allergies, pain, risk of falls and other special needs.

The plan of care for resident #101 did not address the resident's fall risk after the resident sustained a fall in 2013 with an injury. The ADOC confirmed that after a resident fall, it was the expectation that the plan of care should address the resident's fall risk and provide interventions for staff to follow and implement to prevent further falls. [s. 26. (3) 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 the plan of care for residents are based on at a minimum an interdisciplinary assessment with respect to their vision, health conditions, allergies, pain, risk for falls, and other special needs, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee did not ensure that resident #030 received individualized personal care, including hygiene care and grooming on a daily basis.

During observation on an identified floor in May 2014, it was noted that resident #030 had a significant amount of stubble on their face. This stubble had been noted for three days and had become increasingly more significant over that time period. The resident's hair appeared to be greasy and unkempt and their nails long and unclean on each of the days observed.
- During an interview with the resident, they indicated that they had not had a shower or bath or been shaved for about a week. They also indicated that it was not their choice to have a beard and would not have refused to be shaved.
- The Point of Care (POC) documentation indicated under the tab titled: How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum, that the resident received extensive assistance on the day shift to provide for shaving on the identified days.
- There were no documented refusals for any hygiene or bathing areas noted in the month of May 2014.
- The resident had not been shaved , nails cleaned and trimmed as the documentation indicated in the POC system. [s. 32.]

2. Resident #001 was observed not to be shaved on two consecutive days in May 2014. The resident's plan of care indicated that the resident was to receive limited assistance for personal hygiene which included shaving. On one of the identified days, the POC documentation indicated that the resident received limited assistance for personal hygiene, however there was no documentation to indicate that the resident refused to be shaved on this date. On the other identified day, the POC documentation indicated that the resident completed the task independently, however resident was not shaved and did not receive the assistance as per the plan of care. [s. 32.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis., to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that resident #030 was bathed, at a minimum twice a week by the method of their choice.

Resident #030's plan of care indicated that the resident preferred to have a shower on bath day.
- The documentation in the POC system indicated that the resident received a sponge bath on two out of three recorded bath days in May 2014.
- There were no documented refusals of the shower on any dates in May 2014.
- Personal support workers interviewed were not able to provide an explanation as to why the resident received a sponge bath instead of a shower. [s. 33. (1)]

Additional Required Actions:

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

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee did not ensure that resident #030 received fingernail care, including the cutting of fingernails.

On an identified date in May 2014, it was noted that resident #030's fingernails were very long and were not clean.
- The document that the home refers to as the care plan for the resident indicated that the resident's fingernails were to be kept short and cut straight across to prevent the resident from scratching.
- The POC documentation for the resident indicated that the resident's fingernails had been trimmed and cleaned two days prior.
- There was no evidence of any refusals of nail trimming.
- The resident's fingernails had not been trimmed and cleaned on the date indicated in the POC documentation.
- The resident's long nails were also observed and confirmed by the ADOC when brought to their attention.
- During an interview with PSW staff on the evening shift, they indicated that the resident refuses to be shaved and have their nails trimmed. The resident did however consent to be shaved that evening and verbally agreed to have their nails trimmed and cleaned.
- One of the staff interviewed indicated that they did not realize that all male residents required shaving daily or at least must be offered a shave every day and that if it was the resident's preference to be shaved less frequently, this must be added to the resident's plan of care. [s. 35. (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 residents receive fingernail care, including cutting of fingernails, to be implemented voluntarily.

WN #13: 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 did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On an identified date in 2013, resident #002 was noted to have a skin tear to specified area. On an identified date in 2014, staff identified another skin tear. Staff interviewed and documentation confirmed the resident's skin was not assessed on these dates, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment the end of February 2014 when the wound care champion completed the assessment. [s. 50. (2) (b) (i)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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 #14: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the home's nutrition care and hydration programs included a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

The home did not ensure that resident's heights were taken annually as evidenced by review of the home's clinical records. This was confirmed by the Registered Dietitian and ADOC. The home's Weight Management Policy did not include the requirement to take the resident's heights annually. This was confirmed by the Registered Dietitian, ADOC and Administrator. [s. 68. (2) (e) (ii)]

Additional Required Actions:

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

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure the cleaning and disinfecting of resident supplies and devices, including personal assistive services devices, assistive devices and positioning aids.

On May 22, 2014, residents' #005, #015, #016 and #024, and between May 26 and

30, 2014, resident #007 were observed to be seated in wheelchairs that were visibly soiled. Resident #017's wheelchair was very odourous in addition to being visibly unclean on May 22 and 30, 2014. Housekeeping staff confirmed on May 28, 2014 that this resident's wheelchair was typically very odourous and suspected that it was not cleaned regularly. As per the unit's wheelchair cleaning schedule, resident #007's wheelchair was to be cleaned on the evening of May 28, 2014, however on the morning of May 29, 2014, the wheelchair did not appear to have been cleaned. The home's "Cleaning, Disinfecting or Sterilizing of Resident Equipment Policy IPC-C-10 dated as last revised in May 2014" stated that residents' wheelchairs were to be cleaned and disinfected when soiled. [s. 87. (2) (b)]

2. The licensee did not ensure that their cleaning and disinfection policy and procedure "Cleaning, Disinfecting or Sterilizing of Resident Equipment Policy IPC-C-10 dated as last revised in May 2014" for urinals was implemented. The procedure requires that staff rinse and clean resident urinals (known as a personal care device) on a daily basis. Heavily stained urinals were observed in identified rooms on May 30, 2014. The stains were observed inside the urinals which were created after urine had been left to dry inside the urinals. [s. 87. (2) (b)]

3. The licensee did not ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours, specifically those related to bodily fluids and body odours. Odours related to urine and body odour appeared to be the predominant issue during the inspection.

- It was noted during tours of the home areas over the course of this inspection that on the third floor there was a significant odour of urine and of lack of cleanliness on the 3rd floor. This odour appeared to permeate one entire wing. (167)
- The home had instituted air and odour filtration units in corridors a number of years ago and the administrator reported that they had already started a program to change out mattress covers and/or replace mattresses that were odourous. However, odours were noted over the course of multiple days that did not dissipate with the ventilation system in the building or after cleaning by the housekeeping staff.
- On May 30, 2014, strong urine odours were identified to be lingering in an identified room which was unoccupied at the time. One resident's mattress in particular was noted to be odourous. The mattress cover was heavily stained and once unzipped, urine odours were detected within the foam. The mattress was replaced once identified, however the urine odours persisted in and around the bed area. Additional urine odours were detected behind the resident's night table and head of the bed. It

was suspected that urine had seeped under the baseboards as no visible urine could be seen.
- Other areas that were also detected to have lingering urine odours over the course of the day on May 30, 2014 included the bathroom in an identified rooms(suspected that urine seeped under the toilet), a second identified room (both mattresses were mildly odourous of urine), a third identified room (source could not be determined). These areas were unoccupied at the time of the visit and did not have any visible urine on the floor or furnishings. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's procedures for cleaning and disinfection of resident care equipment, supplies and devices, including personal assistance service devices, assistive aids and positioning aids and addressing odours in the home are implemented., to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee did not ensure that residents' bed linens were changed at least once a week, and more often as needed.

A) On May 29, 2014, resident # 004's bed linens were noted to be heavily soiled and the pillow case on the resident's bed was noted to be a yellowish-brown colour in the center from where the resident's head had rested. The same discolouration and dirty sheets were noted on May 26, 27 and 28, 2014 and the bed linen had not been changed.
B) On May 29, 2014, between 0930 and 1030 hours, resident #032's bed linens were noted to be visibly soiled. The resident's bottom sheet had a ring of urine stain and there was a noticeable odour coming from the area. A review of the resident's bed linen took place again at 1400 the same day and the urine stain was still present. A review of the resident's bed linens took place again on May 30, 2014 and it was noted that the urine stain on the resident's bottom sheet was still present.
C) On May 29, 2014 at between 0930 and 1030, Resident #033's bed linens were noted to be soiled. A review of the resident's bed linens at 1400 the same day revealed that the bed linens had not been changed.
D) During an interview with one staff member by Inspector #586, it was identified that nursing staff do not always change the residents' bed linens when they are soiled and that at times the staff member indicated that it had been necessary for them to strip the bed themselves because the bed has been made without changing the dirty linen.
E) PSW staff interviewed confirmed that the resident's bed linens were to be changed on bath days and as required. [s. 89. (1) (a) (i)]

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' bed linens are changed at least once a week and more often as needed, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
2. Residents must be offered immunization against influenza at the appropriate time each year. O. Reg. 79/10, s. 229 (10).

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

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in home`s infection prevention and control program related to hand hygiene.

During lunch meal observation on an identified date in May 2014, two staff members were observed clearing dirty dishes, then proceeded to serve and feed residents without having washed their hands. One PSW was observed rinsing their hands with water, though no soap or hand sanitizer was used. In another dining area, a staff member was observed picking a spoon up off the floor, then proceeded to serve the residents without having washed their hands. [s. 229. (4)]

2. The Licensee did not ensure that resident #011 was screened for tuberculosis within 14 days of admission.

Resident #011 was admitted to the home in 2013 and the resident did not receive their tuberculosis screening until approximately five weeks later. This information was

confirmed by the health record and the DOC. [s. 229. (10) 1.]

3. The licensee did not ensure that all residents were offered immunizations against influenza at the appropriate time each year.

Resident #011 did not receive immunization against influenza for the 2013-2014 influenza season. Immunization records, Community Care Access Centre (CCAC) vaccination history, and the home's admission checklists all indicated that the resident admitted in 2013, did not receive immunization against influenza. The DOC confirmed that the resident did not receive the annual influenza vaccination. [s. 229. (10) 2.]

4. The licensee did not ensure that all residents were offered immunization against pneumococcus, tetanus and diphtheria in accordance with publicly funded immunization schedules.

A) It was noted during a review of the immunization documentation for four identified residents at the home that these four residents were not offered immunization against tetanus and diphtheria.
-During an interview with the Director of Care they confirmed that the home had not been offering the tetanus and diphtheria vaccine as required to new residents or existing residents and that the home had just started to implement the tetanus and diphtheria immunizations.
B) It was noted during a review of the immunization documentation for four identified residents at the home that only two out of the four residents were offered immunization against pneumococcus.
-The Director of Care confirmed that not all residents have been offered their pneumococcal vaccination in accordance with publicly funded immunization schedule. [s. 229. (10) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the home's infection prevention and control program including: hand hygiene, the tuberculosis screening program and the home's immunization program with regards to influenza vaccine, pneumococcal vaccine and tetanus vaccine, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee did not ensure that the resident-staff communication and response system was easily seen, accessed and used by resident, staff and visitors at all times.

On May 22, 2014, the bathroom call bell cord in an identified room broke when pulled and could not be activated. Staff confirmed that the call bell was broke and could not be activated. Therefore, the communication and response system was not able to be used by residents in the room. [s. 17. (1) (a)]

WN #19: 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 did note ensure that a response was provided to the Resident's Council in writing within 10 days of receiving a concern.

During an interview with the President of the Resident's Council, they indicated that the Resident's Council had identified a concern. It was confirmed by the President of the Council that there had been no response from the licensee and that nothing had been done about the concern.
- A review of the minutes for 2013 confirmed that this concern was brought forward by the Resident's Council.
- It was noted that there was no written response found with the minutes and the Administrator and Activation manager were unable to produce the written response.
- During an interview with the Environmental Services Manager, they confirmed that sometime this summer, the entrances at the front of the home are being resurfaced and that the issue will be dealt with at that time.
. [s. 57. (2)]

WN #20: 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 did not ensure that all hazardous substances were kept inaccessible to residents at all times.

On an identified date in May 2014, it was noted that the housekeeping room at the end of the west hallway on the third floor was found with the door propped fully open. The room contained the housekeeping cart and a number of spray bottles including a container of "Concentrated Surface Cleaner- Virox 5" on a shelf in the room. There was no one in sight or in the adjacent hallway. [s. 91.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 69.	CO #002	2013_191107_0010	586

Issued on this 3rd day of July, 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) :	MARILYN TONE (167), BERNADETTE SUSNIK (120), JESSICA PALADINO (586), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2014_201167_0015
Log No. / Registre no:	H-000553-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 6, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BAYWOODS PLACE 330 MAIN STREET EAST, HAMILTON, ON, L8N-3T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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 : 001

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

Pursuant to / Aux termes de :

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

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that training related to skin and wound management, restraint use and the use of Personal Assistive Safety Devices is provided annually to staff as required.

The plan shall be submitted electronically to Marilyn.Tone@ontario.ca by June 20, 2014.

Grounds / Motifs :

1. The licensee did not ensure that all staff received training related to skin and wound management.
- The "Tracking Staff Completion of Mandatory Training" sheet provided by the home showed that only five percent of the home's staff had received training related to skin and wound management in 2013 and 2014.
- The Resident Services Co-ordinator/Staff Educator confirmed that not all staff had received training in skin and wound management in 2013 and 2014.

The licensee did not ensure that staff received training related to physical restraining devices or monitoring of residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
- The "Tracking Staff Completion of Mandatory Training" sheet provided by the home showed that only five percent of the home's staff received training for the use of physical devices including the application of physical devices and the use of and potential dangers of these devices in 2013 and 2014.
- The Resident Services Co-ordinator/Staff Educator confirmed that not all staff had received training in 2013 and 2014 related to the use of physical restraining devices.

The licensee did not ensure that all staff received training related to the use of Personal Assistive Service Devices (PASDs).
- The "Tracking Staff Completion of Mandatory Training" sheet provided by the home showed that only five percent of the home's staff received training in 2013 and 2014 related to the use of PASDs including the application of PASDs and the use of and potential dangers of the PASDs.
- The Resident Services Co-ordinator/Staff Educator confirmed that not all staff received training in 2013 and 2014 related to the use of PASDs.

(506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 11, 2014

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2013_191107_0010, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff provide care to residents at the home as per their plans of care including but not limited to: meal service, personal hygiene and grooming, restraint use and any potential triggers that may pose a risk to residents.

The plan shall be submitted electronically to Marilyn.Tone@ontario.ca by June 20, 2014.

Grounds / Motifs :

1. [LTCHA s.6(7)] was previously issued as a CO on June 22, 2011, October 25, 2012 and September 24, 2013.

The licensee did not ensure that the care set out in the plan of care was provided to the residents as specified in their plans of care.

The plan of care for resident #019 indicated that the resident was to have a specific intervention in place during all fire alarm testing as this would trigger a negative reaction in the resident. The RPN confirmed that on an identified date in 2014, the resident sustained a fall because the specified intervention was not in place during the home's monthly fire drill testing. (506)

2. The licensee did not ensure that meal service was provided to residents #002 and #022 as per their plans of care.

- Resident #002's care plan required 125 ml pureed prunes to be added to their

oatmeal, however observation of breakfast meal service on an identified date in May 2014 revealed pureed prunes were not available and the resident did not receive the item until the Inspector made staff aware.
- Resident #022's care plan states that the resident is to receive 110 ml yogurt at breakfast, however observation of breakfast meal service on the identified date revealed that the resident did not receive yogurt at breakfast. The labelled yogurt remained in the refrigerator after the resident left the dining room. (586)

3. The licensee did not ensure that that resident #007 received care related to restraint use as per their plan of care.

- During observation of resident #007 on identified dates in May 2014, it was noted that the resident had a front fastening seat belt fastened in place and the resident was not able to demonstrate their ability to undo it.
- The plan of care for resident # 007 indicated that the resident used one quarter rail on the open side of the bed to provide support for bed mobility, the bed was to be kept at lowest level and in locked position, a bed sensor and a falls mat were to be used. The resident was also identified as requiring a personal posey alarm when up in their wheelchair, but there was no direction for staff to apply a front fastening seat belt for the resident when in their wheel chair.
- The most current Minimum Data Set (MDS) assessment dated in March 2014 confirmed that the resident did not use any type of limb or trunk restraint.
- During interviews with PSW staff, it was confirmed that the resident was not to have a seat belt applied in their wheel chair.
- Staff interviewed confirmed that the resident was not to have a seat belt in place when in their wheelchair.
(167)

4. The plan of care for resident #007 indicated that the resident required extensive assistance from two staff to provide for their personal hygiene, dressing, bed mobility, transfers and toileting.

- During observation of the resident on identified dates in May 2014, it was noted that the resident had a significant amount of stubble on their face each day.
- A review of the (POC) documentation completed by staff indicated that the resident had received extensive assistance with their personal hygiene including shaving on the identified days.
-During an interview with the Personal Support Worker (PSW) caring for the resident the morning of another identified date in May 2014, the PSW indicated

that they had not yet shaved the resident and would do this later on.
- Resident # 007 did not receive the assistance required as per their plan of care related to shaving.
(167)

5. The most current plan of care for resident # 004 indicated that the resident required staff to shave them with the resident's electric razor.

- During observation of the resident on identified dates in May 2014, it was noted that the resident had a significant amount of stubble on their face in the morning and it was still present after lunch.
- A review of the Point of Care (POC) documentation completed by staff providing care indicated that the resident was independent during the day shifts on two of the identified dates related to shaving and brushing teeth, combing hair, washing and drying face, hands and perineum. On the third identified date, the documentation indicated that the resident received supervision and oversight.
- During an interview with the PSW who had provided care to the resident the morning of the third date, they indicated that they had not yet shaved the resident but later on in the day indicated to the inspector that they had set the resident up so they could shave themselves.
- Staff did not provide the amount of assistance required related to hygiene and grooming as specified in the resident's plan of care.
(167)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 11, 2014

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

Grounds / Motifs :

1. [O.Reg. s.73(1)] was previously issued as a VPC on December 6, 2013.

The licensee did not ensure proper feeding techniques were used to assist residents with eating at meals.

On an identified date in May 2014, resident #020 was being fed in a chair that was tilted backward with the resident's chin untucked, creating a risk for choking. The resident's care plan stated that to support the resident with eating and swallowing, their tilt chair is to be adjusted so their chin is level and slightly tucked, and to be positioned at a 90 degree angle and remain upright for 30-45 minutes after each meal. Staff did not correct the positioning until the Inspector went to the table at the lunch meal to intervene. The RPN and PSW confirmed the resident was improperly positioned. (586)

2. On an identified date in May 2014, resident #005 was being fed in a chair that was tilted backward with the resident's head fully extended back. The resident did not have any teeth or wear dentures, and required a minced diet as well as full assistance with feeding, putting them at high choking risk. The resident's care plan stated that to minimize the risks of choking and aspiration, staff must ensure the resident is in an upright position (90 degree angle) during meals and snacks and 30 minutes post meals and snacks. Staff indicated the resident preferred to be tiled back otherwise they complain of feeling like they are falling. When questioned about why the resident's head was so far back, staff stated this was due to the resident's Broda chair pillow sliding down and confirmed this was inappropriate. The staff subsequently positioned the pillow to keep the resident's head in an upright position without any complaints from the resident. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 20, 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 June, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARILYN TONE

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