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

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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 21, 2016	2016_360111_0013	013553-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KAWARTHA LAKES
26 Francis Streeet LINDSAY ON K9V 5R8

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

VICTORIA MANOR HOME FOR THE AGED
220 ANGELINE STREET SOUTH LINDSAY ON K9V 4R2

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

LYNDA BROWN (111), DENISE BROWN (626), MARIA FRANCIS-ALLEN (552), PATRICIA MATA (571), SAMI JAROUR (570)

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): June 13 to 17, 20 to 22 & 24, 2016

The following inspections were completed concurrently during the RQI inspection: follow-up log # 006933-16 related to abuse; critical incident logs # 031697-15, 001182-16, 001354-16004311-16, 008211-16, 012151-16, 0011308-16, 001899-16, 016265-16, 016362-16, 018408-16 related to abuse; critical incident logs # 013401-16-16 & 012615-16 related to injury which resident was taken to hospital and resulted in significant change in condition; critical incident log # 011598-16 related to missing resident less than 3 hours and complaint log # 001510-16 related to a fall.

During the course of the inspection, the inspector(s) spoke with Residents, families, Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Manager of Building Services, Maintenance workers, Dietary Aides (DA), Scheduling Clerk, Dietitian, Physiotherapist, Manager of Dietary Services, Housekeeping, Resident Council President and Family Council Chairperson.

During the course of the inspection, the inspector(s) also observed residents, reviewed health records of current and deceased residents, reviewed the home's investigations, reviewed staff training records, maintenance records, and the following policies: Infection Prevention and Control, Prevention of abuse and neglect, catheter care, bed rails, manufacturer's instructions on bed rails and therapeutic surfaces, Personal Assistive Safety Devices (PASD's), Nutrition and Hydration, and Restraints.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_360111_0002	552

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. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Re: Complaint log # 001510-16 for resident #042:

Interview of the POA and the home's complaints indicated on a specified date, the home received a verbal complaint from the Power of Attorney (POA) of resident #042 regarding a fall. The fall occurred on a specified date and time but no injury was sustained by the resident. The fall occurred when the resident fell from the bed.

Review of the home's investigation and interview of staff indicated a therapeutic surface was in place prior to the incident and was not used as per manufacturer's instructions, and the bed rails were not assessed related to the use of a therapeutic surface and the use of full side rails resulting in the resident falling from bed.

Interview of the maintenance #115 indicated when a resident requires a therapeutic surface, nursing staff are to submit a work order to the ward clerk so that maintenance can install the therapeutic surface and the correct bed frame/ bed rails. Maintenance #115 indicated when the therapeutic surface mattress is to be used, the QD2000ML bed frame is to be used to accommodate the higher bed rails for the air surface if full bed rails are ordered/consented to be used. The maintenance worker also indicated an entrapment audit is also then completed. The maintenance worker indicated they were directed to switch all the bed frames with a therapeutic surface to the QD2000ML bed frame.

Interview with maintenance worker #134 indicated entrapment audits are not completed on residents with therapeutic surfaces as they would all fail the audit.

An observation was completed of all residents in the home on therapeutic air surfaces:
-resident #63 bed indicated a therapeutic surface was in place and was set to the specified setting and the correct bed frame was (QD2000ML) and with two full bed rails in the up position while the resident was in bed. There was a noticeable gap between the two side rail bars from the top of the therapeutic surface (potential entrapment risk) and no padding/bumpers in place. Interview of the spouse of resident #63 indicated the resident was admitted with a therapeutic surface and the resident had a near miss of falling our of bed and the bed frame was replaced with the QD2000ML. Interview of Maintenance #134 indicated nursing had called Maintenance #115 during the night shortly after resident #063 was admitted, to switch the bed frame as the resident only had half rails in place at that time with therapeutic surface. Maintenance #134 indicated the bed frame was switched to a QD2000 ML bed frame "with 3/4 rails as the side rails are higher".
-Resident # 20, #062 and resident #064 were additionally observed to have a therapeutic surface in place that were set to the correct settings (as per the manufacturer's instructions). The bed frame in place was QD7000 and there were two full bed rails in the up position.

According to Health Canada "Adult Hospital Beds: Patient Entrapment Hazards, Side Guidance Document", best practice guidelines, (revised March 17, 2008):
-(page 12)Pressure Reduction Therapeutic Products Framed flotation therapy beds (powered air mattress replacements), and similar pressure reduction products that have therapeutic benefits such as reducing pressure on skin are easily compressed by the weight of a patient and may pose an additional risk of entrapment when used with conventional hospital bed systems. When these types of mattresses compress, the space between the mattress and the bed rail may increase and pose an additional risk of entrapment.
-(Page 13)The substitution of the original mattress for a surface such as a powered air mattress, or the addition to the existing mattress of, for example, a mattress overlay, may have an effect on the height of the top of the side rail above the surface the patient lies on. This may have an impact on the potential for patient falls, and the user should be aware of this and perform a proper risk assessment.
-As a point of information, recommendations vary among standards writing organizations regarding the minimum height of the top of the rail above the mattress. For hospital beds

specifically, the international hospital bed standard, IEC 60601-2-38, amended in 1999, recommends 220 mm. However, the U.S. Consumer Products Safety Commission in 16 CFR Parts 1213 and 1513, Consumer Product Safety Standard for Bunk Beds recommends 5 inches (127 mm) as the minimum height, as does the American Society for Testing and Materials (ASTM) in ASTM F1427-06.

The severity is high as the risk to resident safety for potential zones of entrapment and risk of falling out of bed was demonstrated one resident almost rolled out of bed and one resident actually rolled out of bed as a result. The scope was demonstrated as 4/5 residents with therapeutic surfaces did not have reassessments completed to ensure zones of entrapment were identified and preventative steps were taken to reduce the risk. [s. 15. (1) (b)]

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

During stage 1 of the Resident Quality Inspection (RQI), staff interview indicated the resident had an indwelling catheter. Upon chart review indicated the resident had an alteration in bowel elimination by the dietitian upon admission. The dietitian indicated the physician was to be notified to hold bowel medication. Approximately three weeks later, the physician was contacted regarding the alteration in bowel elimination since admission. Two days later, the physician ordered laboratory testing to rule out infection. The following day, the nurse indicated "waiting from Infection Control (RN #103) re:

proper specimen containers". Two weeks later, the laboratory testing was completed. The resident was also noted to have an alteration in skin condition as a result of the alteration in bowels. Approximately one week later the results of the laboratory testing was received by public health and the results were noted to be positive. The resident was then put on contact precautions. The following day, the physician was notified of the positive tests and ordered an altered diet and antibiotics. The POA was notified at this time of the alteration in bowels and treatments.

Interview with RPN #102 indicated awareness of resident #030 having alteration in bowels, positive lab results, was placed on contact precautions, and ordered antibiotics. The RPN indicated no further laboratory testing was completed post antibiotic treatment but the resident continued to remain on contact precautions.

Observation of resident #030 room indicated the resident remained on contact precautions.

Interview of RN #103 indicated is the infection control nurse (ICN). The ICN Indicated awareness of resident #30 having prior alteration in bowels and indicated the physician was notified and ordered laboratory testing. The ICN indicated physician orders were received for resident #30 when the lab results were received and the resident was placed on contact precautions at that time. The ICN indicated public health was also contacted for further direction as they were unfamiliar with the diagnosis. The ICN indicated awareness that resident #30 remained on contact precautions and acknowledged that no further testing had been completed post antibiotics to determine if the resident was still required to remain on contact precautions.

The home was issued a Voluntary Plan of Correction (VPC) during the RQI in September 2014 for Infection Prevention and Control under O.Reg. 79/10, s. 229. The severity was that Resident #030 was admitted on a specified date and was demonstrating signs of possible infection (related to altered bowels) and there was no indication staff were noting the symptoms every shift, and no actions were taken until approximately three weeks later when the physician was notified. Two days later, the physician ordered specific lab work to rule out infection and the lab work was not obtained for approximately three weeks (May 13, 2016). The results of the stool samples were received approximately one week later (May 20, 2016) and the resident was diagnosed with an infection requiring contact precautions and antibiotics. The resident was not tested post antibiotic to determine if antibiotic was effective and the resident continued to remain on contact precautions. Therefore, an Compliance Order was warranted. [s. 229. (5) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (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. The licensee has failed to comply with LTCHA, 2007, s. 6 (1) (a) by ensuring that the resident's written plan of care set out the planned care for resident #034 as it relates to the use of tilt wheelchair as a PASD.

Review of clinical records for resident #034 indicated the resident was dependent on staff for transfers and mobility.

Resident #034 was observed sitting in a tilt mobility aide on a specified date in a tilted position.

Review of the progress notes for resident #034 indicated the resident received a loaner tilt mobility aide from the physiotherapist approximately four months prior.

Interview with Physiotherapist indicated a loaner tilt mobility aide was provided to resident #034 to be used as a PASD as it did not have any restraining effect on the resident but did not document in the progress notes or updated the care plan to reflect the use of PASD. The physiotherapist further indicated that it is the registered nursing staff responsibility to complete a PASD assessment and update the care plan.

Interview with PSW #133 and #135 indicated the resident requires extensive assistance in ADLs and uses a tilt mobility aide for comfort and pressure relief. Both PSW's indicated that the tilt mobility aide is not considered as a PASD for resident #034 as there is no seat belt in use when the resident is sitting in mobility aide. PSW's indicated the resident is tilted in the mobility aide when the resident gets anxious from time to time. Both PSW's indicated the resident is repositioned every two hours when in the mobility aide.

Review of resident #034's current care plan failed to demonstrate that the resident is using a tilt mobility aide. The care plan does not identify the type of mobility aide in use, when to use the tilting feature of the mobility aide, and when to reposition the resident when sitting in mobility aide.

Interview with RN #103 indicated the use of tilt mobility aide as a PASD for resident #034 should have been included in the care plan.

Resident #034's written plan of care does not identify the use of tilt wheelchair and staff interventions related to the use of tilt mobility aide. [s. 6. (1) (a)]

2. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to resident #024 related to urinary device.

During stage 1 of the Resident Quality Inspection (RQI), interview with RN #104 indicated resident #024 had a urinary device in place but was unsure of type, size or reason for use.

Interview with RPN #105 indicated resident #024 had an urinary device insitu but could not indicate which type or size.. RPN #105 indicated the resident was sent to hospital for alteration in urinary function and "may have come back from hospital" with the urinary device.
Interview with RN #103 stated all residents with urinary devices "usually have them changed every 6 weeks and would be indicated on the MAR".

Review of the care plan for resident #024 indicated the resident had a urinary device but no indication why the device was being used, and type or size, or frequency of device changes. The care plan indicated a portion of the urinary device was to be changed weekly by the registered staff.

Review of the physician ordered a one time use urinary device on a specified date and if the resident had not voided, then a permanent urinary device was to be used. There was no clear direction as to which type or size of permanent urinary device was to be used. Approximately one week later, a new order was received to change the urinary device monthly. There was no indication which type or size of urinary device was to be used or the amount of N/S to be used for flushing. Approximately one month later, as a result of the inspection, a new order was received from the physician for a specified type and size of urinary device.

Review of the progress notes for resident #024 indicated the one time use urinary device was completed on the date the physician ordered the device. The following day, the staff noted the resident continued to have alteration in urinary function and applied the permanent urinary device without clear direction as to the type or size of device to be used. Approximately one week later, a second permanent urinary device was applied due to malfunction of the first device without clear direction on the type or size to be used.

The plan of care did not provide clear direction regarding the use of a urinary device, specifically which type or size of device that was to be used, and why the device was being used, or how much normal saline (N/S) was to be used for flushing. Additionally, the frequency of urinary device changes was not identified until two months after the urinary device was initially applied. Both urinary devices were applied without clear direction from the physician to indicate the type and size to be used and the frequency of changes until the result of the inspection, and a larger urinary device was ordered. [s. 6. (1) (c)]

3. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to resident #007 related to urinary device.

During stage 1 of the Resident Quality Inspection (RQI), interview with RPN #101 by Inspector #626 indicated resident #007 had a urinary device in place to prevent further skin break down.

Interview with RPN #105 could not indicate which type or size of urinary device resident #007 had insitu and indicated the resident was admitted with the device.
Interview with RN #103 (and ICN) stated all residents with permanent urinary devices "usually have them changed every 6 weeks and would be indicated on the MAR".

Review of the current care plan for resident #007 indicated a urinary device was applied due to current health status/injuries. Interventions included: urinary device. and see EMAR (electronic Medication Administration Record) for instruction/change date.

Review of the physician order for resident #007 indicated on a specified date, a urinary device to be applied and to be reassessed in 6 weeks. There was no indication of the type, or size of urinary device that was to be applied and there was no indication the urinary device was reassessed 6 weeks later.

Review of the progress notes for resident #007 indicated the resident was admitted on a specified date with alteration in skin integrity to a specified area and with mobility restrictions in bed. The resident required multiple staff for all transfers/repositioning as a result of physical limitations from an injury. Approximately one week later, the physician ordered a specified type of temporary urinary device for 6 weeks and then will reassess but did not provide clear direction as to the size to be used. Two days later the specified type of urinary device was applied. Approximately three months later, the resident complained the urinary device was not "working properly" and the device was changed. There was no clear indication which type of size of urinary device was used. Two days later, the resident "had complaints of pain" related to the urinary device and "a note was left in the physician's book to assess". As a result of the inspection, a new physician order was received for a specified type and size of urinary device but there was no indication of how frequent the urinary device was to be changed or reassessed.

The plan of care for resident #007 did not provide clear directions regarding the use of a urinary device, specifically which type or size of device was to be used, or the frequency of changes. The resident had a specified urinary device applied on two separate dates

without clear direction from the physician until the time of the inspection. [s. 6. (1) (c)]

4. The licensee failed to comply with LTCHA 2007, s.6 (2), by not ensuring that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of the resident related to pain.

Re: critical incident log #001899-16 for resident #065:

Critical Incident Report (CIR) was submitted on a specified date for an alleged staff to resident verbal abuse and neglect incident involving resident #065. As per CIR, resident #065 requested an analgesic at a specified time from a PSW who reported the request to RPN #100. The RPN stated the "resident is not a priority as she was not in the dining room". Housekeeping staff #142 overheard the conversation and reported the incident to RN #103 (Acting DOC at time of incident) two hours later.

Review of clinical records of resident #065 indicated the resident was admitted to the home on a specified date with pain related diagnoses.

Review of the CIR notes and licensee's investigation notes indicated that on a specified date and time, resident #065 requested analgesic for pain. The analgesic was not provided to the resident for approximately two hours when the resident was tearful and requested the analgesic again. The licensee's investigation notes indicated that the resident requested analgesic medication at least three times during a two hour period before it was administered to the resident.

Interview with RN #103 indicated that the expectation is that PRN analgesics should be given to residents within five minutes or within fifteen minutes if there is an other emergency. RN #103 confirmed that resident #065 did not receive the PRN analgesic for over two hours when first requested. RN #103 further confirmed that there was no emergency that day and RPN #100 was giving routine medications to residents in the dining room.

Review of the home's investigation confirmed RPN #100 confirmed analgesic was not given to resident #065 on a specified date as requested for a two hour period.

Therefore resident #065 was not provided with PRN analgesic as per the needs and preferences of the resident. [s. 6. (2)]

5. Re:Critical Incident log #016362-16 for resident #062:

A review of the resident's heath records indicated that resident # 062 was admitted to the home on a specified date with a diagnosis of cognitive impairment and required a secured unit.

Review of resident #062's progress notes and the home's investigation indicated that on a specified date, resident #062 was locked in the resident's room by an external locking device that was only able to be released from the outside of the resident's room. The investigation concluded that it was undetermined who applied the external locking device to the resident's room.

Interview with PSW #130 indicated awareness of the incident with resident #062 being locked in the resident's room and the time the incident occurred. The PSW indicated the locking device was removed approximately three weeks prior to inspection.

Interview with RPN #130 confirmed that there was an external locking device on resident #062's door, which was present prior to the admission of resident #062.

Review of the plan of care for resident #062 did not indicate the use of an external locking device to be used on the resident's door as a care intervention.

Interview with Administrator confirmed that the external locking device was applied as a care intervention for the previous resident that formerly occupied the room and was not removed when resident #062 was admitted. [s. 6. (2)]

6. The licensee failed to ensure the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker (SDM), are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was received from the SDM of resident #030 to the Director regarding lack of notification from the home with change in the resident's condition related to infection and treatment.

Review of the progress notes for resident #30 indicated the resident was admitted on a specified date. Approximately three weeks later, the physician was notified of alteration in bowels that had been in place since admission. Two days later, the physician ordered

laboratory testing to rule out infection. Approximately two weeks later, the laboratory specimens were collected. Staff noted the resident also had alteration to skin integrity during that time due to alteration in bowels. Approximately one week later the lab tests were positive for infection and the resident was placed on contact precautions. The physician also ordered a diet change and antibiotics. The SDM was then notified of alteration in bowel condition, diagnostic testing results and interventions to mange the infection. The family "expressed strong concerns that resident's symptoms were not addressed soon enough, states "three weeks and nothing was done".

Therefore, the SDM was not notified of the resident's change in condition (ongoing alteration in bowels), skin breakdown and new physician orders for diagnostic testing to rule out infection, and placed on contact precautions until approximately 6 weeks later when the resident was positively diagnosed with infection and prescribed antibiotics. [s. 6. (5)]

7. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring that the care set out in the plan of care was provided to resident's #043 as specified in the plan related to nutritional care.

Re: critical incident log #013401-16 for resident #043:

Review of clinical records for resident #043 indicated that the resident had multiple diagnoses including cognitive impairment and was considered a moderate nutritional risk due to swallowing difficulty.

Critical Incident Report (CIR) was submitted for a choking incident that occurred on a specified date and time involving resident #043.

Details of the CIR are as follows: Resident #043 was in the dining room for lunch eating a specified food item that was cut into quarters and not bite size pieces as per recommendations from the dietitian. As the resident attempted to exit the dining room, PSW #136 witnessed the resident non responsive to staff and appeared pale and cyanotic. RPN #107 performed an intervention to remove food and was able to remove the food item successfully to clear the resident’s airway. The resident was then sent to hospital and passed away on the following day.

Resident #043's care plan (in effect at time of the incident) detailed the following: resident requires assistance with eating related to cognitive deficit. The care plan under

interventions directs staff that the resident feed self with setup and supervision; cut up sandwiches into bite size pieces.

Interview with dietary aide #113 indicated that on the day of the incident, was working and must have prepared resident #043's lunch meal. The dietary aide #113 indicated that food item was cut into half and not into bite size pieces as was not aware of that requirement.

Interview with Dietitian indicated that resident's #043 was assessed on a specified date and the care plan was updated to cut specified food item into bite size pieces following a choking incident that occurred approximately two days prior. The dietary recommendations were also included on the Dining Selection Tool used by PSW staff to get meal orders from residents. The Dining Selection Tool is also used by the Dietary Aides to serve the meals for residents with appropriate texture. The dietitian explained that residents' on minced texture diet can have sandwiches with minced filling and no crust; the standard is to cut from corners to four pieces but that is not a bite size; bite size is smaller than the size of quarter sandwich.

Review of the Dining Selection Tool in place at time of incident, indicated under meal notes for resident #043: lunch – cut up sandwiches into bite size pieces.

Interview with Manager of Dietary Services confirmed that the Dining Selection Tool copy provided to inspector was in effect at time of incident; The Manager of Dietary Services indicated that dietary aide #113 did not follow the instructions as per the Dietary Selection Tool.

Review of the licensee's investigation notes for the incident indicated that dietary aide staff #113 did not cut the sandwich provided to resident #043 into bite size pieces as directed in the care plan and the Dining Selection Tool.

Interview with the DOC and the Manager of Dietary Services both indicated it is the expectation that dietary staff follow the directions/dietary recommendations as indicated in the Dining Selection Tool.

Interviews with the Dietitian, DOC and the Manager of Dietary Services indicated at the time of the incident dietary aide #113 did not follow the dietary recommendations documented in the Dining Selection Tool when dietary aide #113 did not cut the sandwich provided to resident #043 into bite size pieces. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the resident's written plan of care sets out the planned care for residents related to use of tilt wheelchairs used as PASDs, the plan of care sets out clear directions to staff and others who provide care to residents with catheters to indicate the type, size of catheter to be used, reason for use and the frequency of changes,the plan of care is based on an assessment of the resident as relates to pain, the SDM is given an opportunity to participate in the plan of care related to changes in condition and treatments, and the plan of care is provided to residents related to nutritional care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg.79/10, s. 97(1) by not ensuring the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

Re: Critical incident Log # 004311-16 for resident #052 & #053:

A Critical Incident Report (CIR) was submitted to the Director on a specified date indicating two weeks earlier at a specified time, a PSW reported to an RPN that resident #052 was found sitting in mobility aide outside resident #053's room and calling the resident. Three staff went to the resident's room to remove resident #052. Resident #053 "appeared scared and shaking" and was removed to another unit for "safety and security".

Review of the CIR and clinical health records indicated resident #053's SDM was not informed of the incident.

Interview with the DOC stated "it is an expectation that the resident's SDM should have been informed" of the incident that occurred. [s. 97. (1) (a)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 97 (2) by not ensuring that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion

Re:Critical incident log #001899-16 for resident #065:

Critical Incident Report (CIR) was received by the Director on a specified date for an allegation of abuse involving resident #065. As per the CIR, resident #065 requested an analgesic at a specified time to the PSW who reported the request to RPN #100. The RPN stated the resident "is not a priority" as was "not in the dining room". Housekeeping staff #142 overheard the conversation and reported the incident to Acting DOC (RN #103) two hours later.

Review of the licensee's investigation notes indicated the investigation was concluded three days later and that a disciplinary letter was issues to RPN #100.

Review of resident #065's clinical records, the critical incident documentation and the licensee's investigation failed to indicate that resident # 065 or their Substitute Decision Maker were notified of the results of the investigation into the allegation of verbal abuse and neglect directed toward resident #065.

Interview with RN #103 (Acting DOC at time of incident) indicated that she did not notify the resident of the results of the investigation as she was not aware of the outcome.

Interview with the Manager of Residents and Family Services (acting Administrator at time if incident) indicated that she had met with the family but could not confirm if it was about this incident or another incident. [s. 97. (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 resident's SDMs and any other person specified by the resident is immediately notified upon becoming aware of any alleged, suspected or witnessed incidents of abuse or neglect and are notified of the results of the home's investigation immediately upon completion, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

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

ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg.79/10, s.104(2) Subject to subsection(3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

Re: Critical incident log # 008211-16 for resident #061:

A Critical Incident Report (CIR) was submitted by the home on a specified date indicating that approximately 27 days earlier, at a specified time, resident #60 wandered into resident#061's room. Resident #060 was then witnessed by a staff member physically abusing resident #061. Resident #61 then pushed resident #061 and the resident fell and sustained an injury to a specified area. Resident #060 was sent to the hospital due to the injury to the specified area. The CIR indicated the staff called the Director to inform of the incident but did not send a written report to the Director within the time lines specified in the legislation.

During an interview with the DOC, she confirmed that the written report was not sent to the Director until 27 days later (552). [s. 104. (1)]

2. The licensee has failed to ensure that in making a report to the Director under subsection 23(2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected, or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:2. A description of the individuals involved in the incident, including:ii.Names of any staff members or other persons who ere present at or discovered the incident.

Re: Critical incident log # 011308-16 for resident #065:

A critical incident report (CIR) was received by the Director on a specified date for an allegation of staff to resident emotional abuse by a PSW that occurred. The CIR indicated the specified date and time, resident #65 reported to a family member that a PSW had been emotionally abusive and "the resident was upset at the time". The CIR did not include the name of the staff members who were present at the incident.

Review of the home's investigation and interview of staff indicated both PSW #122 and PSW #143 were present during the alleged staff to resident emotional abuse incident (111).

3. Re: Critical incident log #001899-16 for resident #065:

A Critical Incident Report (CIR) was received by the Director on a specified date for an alleged staff to resident verbal abuse and neglect incident. The CIR indicated resident #065 requested an analgesic at a specified time from a PSW staff who reported the

request to RPN #100. RPN#100 stated the resident "is not a priority as "was not in the dining room". Housekeeping staff #142 heard the conversation and reported the incident to RN #103 (Acting DOC at time of incident) at two hours later. Review of the CIR indicated that the licensee did not include the name of the PSW who reported to RPN #100 resident #065's request for analgesic. Review of the home's investigation indicated PSW #140 was identified as the PSW reporting the request to RPN #100.

Interview with RN #103, who submitted the CIR, indicated that the CIR should have been updated to include the name of the PSW as it was identified in the investigation notes (570). [s. 104. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee make a report to the Director within 10 days of becoming aware of any alleged, suspected or witnessed incidents of abuse and/or neglect, and included the names of any staff members or other persons who were present at or discovered the incident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the Director is notified of an unexpected or sudden death, including a death resulting from an accident, the report to the Director included the names of any staff members or other persons who were present at or discovered the incident.

Re: Critical incident log # 013401-16 for resident #043:

Critical Incident Report (CIR) was submitted for a choking incident that occurred on a specified date and time involving resident #043 who passed away at the hospital the following day. The CIR indicated an employee failed to follow the Dining Selection Tool and was terminated as a result of the home's investigation. The CIR did not include the name of the employee who was terminated as a result of the home's investigation.

Interview with DOC identified the employee as dietary aide staff #113 and confirmed the name of the dietary aide staff #113 was not included in the CIR submitted to the Director. [s. 107. (4) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the report to the Director includes the names of any staff members who were present at or discovered an incident of an unexpected or sudden death, including a death resulting from an accident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use as specified by the prescriber.

Resident #030 was admitted on a specified date and was ordered a high risk liquid medication on admission to be administered twice daily.

Review of the Medication Administration (MAR) records for resident #30 for a one month period indicated:
-the first six days there was no signatures to indicate the resident received the medication.
-The remainder of the month the drug was signed as not given and/or drug not available.

Review of the progress notes for resident #30 indicated six days after admission, the pharmacy was contacted to have the medication delivered by pharmacy but was not received. Two weeks later, RPN #102 indicated the medication was still not available and has not been available since admission. The physician was notified that the resident had not received the medication as ordered since admission but blood levels at admission were within therapeutic range.The Pharmacy was contacted again and indicated the medication was not delivered as it was government supplied medication (and is ordered by the home). The RPN went to the government stock supply and the medication was not available. The RPN requested the RN to contact the emergency pharmacy. Approximately 6 weeks later, the medication was received by pharmacy and was then given to the resident.

Interview of RPN #102 indicated recalled noting on a specified date that resident #30 had not received the medication as ordered since admission and called the pharmacy to have some sent because could not find any in the government stock.

Observation of the government stock indicated there was none of medication available.

Interview of RN #103 indicated the government stock is ordered by the ward clerk but medication is ordered based on need. Indicated that medication was not ordered because it was always expiring and not being used. Indicated only resident #30 was on the medication so it was ordered from pharmacy.

Therefore, resident #030 did not receive the medication for approximately 6 weeks later

when it was delivered by the pharmacy. [s. 131. (2)]

2. Re:Critical Incident log #016362-16 for resident #007:

Review of the resident's progress notes, observation of the resident, and review of the home's investigation indicated resident # 007 was admitted to the home on a specified date with pain related diagnoses. Resident # 007 used a mobility aide for mobility and is unable to do so independently. On a specified date and time, resident #007 was taken to a specified area by a co-resident's family member. The resident remained in the specified area for one and half hours. During that time, the resident did not receive their scheduled narcotic analgesic.

Interview with RN#104 confirmed that resident #007 did not receive the scheduled narcotic analgesic as the resident was in the specified area. RN #104 also confirmed resident #007 and was provided with a narcotic analgesic approximately 3 and half hours later.

Review of the Medication Administration Record (MAR) for resident #007 indicated on a specified date, the resident did not received the scheduled dose of narcotic analgesic at the specified time until three and half hours later when the resident received a PRN dose.

Interview with Administrator confirmed that the home's investigation into the incident resulted in disciplinary action towards RPN #137 for failing to administer narcotic analgesic medication to resident #007 as prescribed. [s. 131. (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 drugs are administered to residents in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported, is immediately investigated:(i)abuse of a resident by anyone and appropriate actions are taken to reduce the risk to the resident.

Re: Critical incident log # 011308-16 for resident #065:

A critical incident report (CIR) was received by the Director on a specified date for an allegation of staff to resident emotional abuse by a PSW. The CIR indicated on a specified date and time, resident #65 reported to a family member that a PSW had been emotionally abuse to the resident. The resident "was upset at the time". The manager on call was immediately notified. The CIR indicated PSW immediately put on Administrative leave while investigation was conducted.

Review of resident # 065 progress notes and the home's investigation indicated RPN #137 and RN #104 were aware of the allegation of staff to resident emotional abuse on a specified date but the investigation into the allegation was not initiated until six days later.

Interview of the Administrator indicated she began the investigation when she became aware of the allegation six days later when resident # 065 family member reported the allegation to the Administrator and indicating the incident occurred six days earlier. The Administrator indicated that the allegation was determined to be unfounded and when she interviewed the resident7 days later, the resident did not recall the incident. The Administrator indicated no further actions were taken. The Administrator was informed that according to the resident progress notes and the investigation, both RPN # 137 and RN #104 were made aware of the allegation six days before the investigation was initiated. The Administrator indicated that the RPN #137 no longer worked in the home and no action was taken regarding the RN failing to take immediate action, immediately investigate, immediately report the allegation to the Director and police, and immediately investigate. [s. 23. (1) (a)]

2. The licensee has failed to comply with LTCHA, 2007, s. 23. (2) by not ensuring that the results of the abuse or neglect investigation were reported to the Director.

Related to Log #001899-16 for resident #065:

Critical Incident Report (CIR) was received by the Director on a specified date for an allegation of abuse/neglect for an incident involving resident #065. The CIR indicated resident #065 requested analgesic for pain at a specified date and time to a PSW who reported the request to RPN #100. The RPN stated the resident "is not a priority" as "was not in the dining room". Housekeeping staff #142 heard this conversation and reported the incident to Acting DOC (RN #103) two hours later. The CIR indicated the results of the licensee’s investigation were not reported to the Director. The CIR was completed by RN #103.

Interview with RN #103 (Acting DOC at time of incident) indicated that she did not amend the CIR to include the results of the investigation as she was not aware of the outcome of the investigation.

Interview with the Manager of Residents and Family Services (acting Administrator at time if incident) indicated that she was involved in the investigation of this incident but did not amend the CIR to include the results of the investigation as she did not have access to the CIR system.

No further actions are required as the issues identified in these WN's were addressed under Compliance Order (CO) #001 which was issued in March 2016 for LTCHA, 2007,

s.19(1) duty to protect, and included LTCHA, 2007, s.23 during inspection #2016_360111_0002 with a compliance date of May 2016. [s. 23. (2)]

WN #9: 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 had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident that resulted in harm or risk of harm.

Re: Critical incident log #018408-16 for resident #004:

A critical incident report (CIR) was submitted to the Director on a specified date and time for a fall which cause resident #004 being transferred to the hospital and diagnosed with an injury to a specified area. In this CIR, an incident of alleged abuse that occurred on a specified date was mentioned. The family of resident #004 indicated that the resident was pushed by another resident.

A review of the progress notes for resident #004 indicated that on a specified date and

time, when RN #104 was assessing the resident for injury as a result of the fall, the RN was informed by resident #004 that the resident was pushed by another resident.

In an interview, the DOC confirmed that the incident of alleged abuse was investigated the day after the incident occurred when the DOC was made aware of a fall occurring the day before. The alleged abuse was reported the day after the incident occurred.. Therefore, the licensee failed to report an allegation of abuse immediately to the Director. [s. 24. (1)]

2. Review of progress notes for resident #050 indicated two incidents of alleged sexual abuse as follows:
- On a specified date, progress note entry indicated an incident of alleged sexual abuse between resident #050 and resident #051;both residents were found by staff engaging in sexually inappropriate responsive behaviour.
- Six days later, progress note entry indicated an incident of alleged sexual abuse between resident #050 and resident #061, resident #061 is cognitively aware; both residents were found by staff engaging in sexually inappropriate responsive behaviour.

Review of progress notes for residents #050, 051 and 061 indicated:
- On a specified date and time, progress note entry for resident #050 indicated resident #050 and resident #051 were found engaging in sexually inappropriate responsive behaviours. The manager on call was called and determined no need for a critical incident report; "follow up must be done to determine if resident can make own decisions on forming relationships".
- The same day, progress note entry for resident #051 indicated the incident of sexually inappropriate responsive behaviour towards resident #050 was reported to the registered nurse (RN) and resident #051 is able to have relationships "as per POA".
- Six days later, progress note entry for resident #050 indicated the resident was found engaging in sexually inappropriate responsive behaviour with resident #061 and that resident #050 "has permission from POA". The home did not assess the resident's ability to consent.
- The same day, progress note entries for resident #061 indicated the resident was seen engaging in sexually inappropriate responsive behaviour with another resident prior to lunch, "both residents are doing okay but resident's POA needs to be made aware"; resident #061 is own POA.

Interview with Administrator, with DOC present, indicated both incidents were not reported to the MOHLTC as both incidents were consensual as residents were fine and

in no distress; The Administrator further indicated residents were not asked if they consented to sexual responsive behaviour at the time but they have the right to form intimate relationships and their POAs consented to sexually responsive behaviours.

The licensee did not report two incidents of alleged sexual abuse when consent was not determined at the time when the incidents were discovered. [s. 24. (1)]

3. Re: Critical incident log # 011308-16 for resident #065:

A critical incident report (CIR) was received by the Director on a specified date for an allegation of staff to resident emotional abuse by a PSW that occurred. The CIR indicated that at a specified time, resident #065 reported to a family member that a PSW had been emotionally abusive to the resident and the resident "was upset at the time".

Review of resident # 065 progress notes and the home's investigation indicated RPN #137 and RN #104 were aware of the allegation of staff to resident emotional abuse on the day it occurred but the incident was not reported to the Director until six days later, when the family reported the incident to the Administrator.

No further actions are required as the issues identified in these WN's were addressed under Compliance Order (CO) #001 which was issued in March 2016 for LTCHA, 2007, s.19(1) duty to protect, and included LTCHA, 2007, s.24 during inspection #2016_360111_0002 with a compliance date of May 2016. [s. 24. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 33. (4) 1 by not ensuring that alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

Related to resident #034:

Review of clinical records for resident #034 indicated the resident was admitted to the home with multiple diagnoses including cognitive impairment and the resident was dependent on staff for transfers and mobility.

Resident #034 was observed sitting in a tilted mobility aide on a specified date in a tilted position.

Review of the progress notes for resident #034 indicated the resident received a loaner tilted mobility aide from the physiotherapist approximately two months prior.

Review of clinical records for resident #034 failed to demonstrate that an assessment was completed to determine if the tilt wheelchair was being used as a (PASD) or a restraint and whether alternatives have been considered.

Interview with Physiotherapist indicated a loaner tilt mobility aide was provided to resident #034 to be used as a PASD as it did not have any restarting effect on the resident but did not document in the progress notes or updated the care plan to reflect the use of PASD. The physiotherapist further indicated that it is the registered nursing staff responsibility to complete a PASD assessment and update the care plan.

Interview with RN #103 confirmed that resident #034 uses a tilt mobility aide for positioning and pressure relief and the resident was not assessed to determine if the tilt mobility aide was being used as a PASD. [s. 33. (4) 1.]

2. The licensee has failed to comply with LTCHA, 2007, s. 33. (4) 4 by not ensuring that the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #034 was observed sitting in a tilt mobility aide on a specified date and time; the chair was tilted about 25 degrees.

Review of the progress notes for resident #034 indicated the resident received a loaner tilt wheelchair from the physiotherapist on March 8, 2016.

Review of clinical records, electronic and paper chart, for resident #034 failed to indicate the resident or their substitute decision maker (SDM) provided consent for the use of their tilt wheelchair as a PASD or restraint.

On June 17, 2016, interview with RN #103 confirmed there was no consent signed from the resident or their SDM for use of tilt wheelchair as a PASD and if there was a verbal consent it would have been documented in the progress notes. [s. 33. (4) 4.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is offered a minimum of three meals daily.

Re: Critical Incident Log #016265-16 for resident #007:

The licensee has failed to ensure that the resident is offered a minimum of three meals daily.

Re: Critical Incident Log #016265-16 for resident #007:

A review of the resident's health records indicated that resident # 007 was admitted to the home on a specified date with specified diagnoses. Observation of Resident # 007 indicates the resident uses a mobility aide and is unable to do so independently due to physical impairment and pain.

Review of the resident's progress notes and the home's investigation indicated that on a specified date, resident #007 was taken into the Smoking Room by a visitor just before supper. The resident remained in the Smoking Room until after supper when the resident was removed from the smoking room by another resident. During that time resident #007 did not receive dinner.

Interview with PSW #139 indicated that RPN #137 advised the PWS's not to assist resident #007 out of the Smoking Room. PSW #139 also stated that "residents who utilize the Smoking Room should do so independently". PSW#139 also indicated that the resident was aware that dinner was being served and staff might have put aside a plate of food for the resident.

Review of the point of care(POC) documentation for food intake on a specified date and time, PSW #139 documented that resident #007 refused the dinner meal.

Interview with resident #007 confirmed that on the specified date, after leaving the Smoking Room, a request was made to RPN #137 for something to eat and was not provided with a supper meal. [s. 71. (3) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Specifically failed to comply with the following:

s. 305. (1) A licensee of a long-term care home shall not commence operation of the home under a new licence or approval until the Director has approved the home and its equipment. O. Reg. 79/10, s. 305 (1).

Findings/Faits saillants :

1. The Licensee failed to receive approval from the Director before commencing alterations, additions and renovations to the home.

On June 13, 2016 during the initial tour of the home, the following observation were noted related to tub rooms:
- two tub rooms located at the end of the hall in the four resident care units, (eight tub rooms in the entire facility) were converted to seven storage areas and one office
-Macmillan House: Tub room #149 was converted to a storage area and tub room #137 was converted into a Life Enrichment Supplies room.
-Victoria House: Tub room #137 was converted into the Behavioural Support Office(BSO) and tub room #149 had the sign Tub Room on the door but was storing Mechanical Lifts.
-Vaga House: Tub room #E237 had a sign on the door indicating Lift Storage. Tub room #E249 had the signage of Bath on the door but was storing Mechanical Lifts.
-Elford House: Tub room #W249 had the signage Tub Room on the door but was storing four lifts and one wheel chair. Tub room #W239 had the signage of Storage on the door.

Interview with PSW #108 confirmed that the identified tub rooms on MacMillan House were being used as a storage area.

Interview with Manager #114 stated "according to the Administrator, there are enough shower and tub rooms for the amount of residents on each unit, therefore the Director was not notified of this change".
Interview with the Administrator also stated "there are enough shower and tub rooms for the amount of residents on each unit therefore, the Director was not informed". The administrator also indicated that the Director’s Environmental Department was contacted by telephone in regards to the conversion of the tub rooms as the plan began in 2012. The Administrator stated "it was indicated by the Ministry that the home was not required to submit a plan for this change".

Consultation with the Director’s Environmental Department and CIATT, indicated there has been no documented evidence that a telephone enquiry was made by the home related to conversion of tub rooms to storage or office space. [s. 305. (1)]

Issued on this 8th day of August, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), DENISE BROWN (626), MARIA FRANCIS-ALLEN (552), PATRICIA MATA (571), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2016_360111_0013
Log No. / Registre no:	013553-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 21, 2016
Licensee / Titulaire de permis :	THE CORPORATION OF THE CITY OF KAWARTHA LAKES 26 Francis Streeet, LINDSAY, ON, K9V-5R8
LTC Home / Foyer de SLD :	VICTORIA MANOR HOME FOR THE AGED 220 ANGELINE STREET SOUTH, LINDSAY, ON, K9V-4R2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pamela Kulas

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

To THE CORPORATION OF THE CITY OF KAWARTHA LAKES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(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).

Order / Ordre :

The licensee shall prepare, implement and submit a corrective action plan to include the following:
1.complete a bed entrapment audit on all residents with therapeutic air surfaces and with use of half or full bed rails to determine potential areas of entrapment zones; to be completed immediately.
2.Take appropriate steps to prevent resident entrapment, taking into consideration all potential zones of entrapment as per the audit, and address any other safety issues (specifically residents risk for falling out of bed) related to the use of bed rails , including addressing height reliability; to be completed immediately.
3.Re-train all nursing and maintenance staff of the use of bed rails, risks of entrapment in accordance with evidence-based practice and, if there are none, in accordance with prevailing practices to minimize the risk to the residents.

This corrective action plan is to be submitted to Lynda Brown, LTCH Inspector (Nursing) via email at OttawaSAO.MOH@ontario.ca by August 7, 2016.

Grounds / Motifs :

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

Re: Complaint log # 001510-16 for resident #042:

Interview of the POA and the home's complaints indicated on a specified date, the home received a verbal complaint from the Power of Attorney (POA) of resident #042 regarding a fall. The fall occurred on a specified date and time but no injury was sustained by the resident. The fall occurred when the resident fell from the bed.

Review of the home's investigation and interview of staff indicated a therapeutic surface was in place prior to the incident and was not used as per manufacturer's instructions, and the bed rails were not assessed related to the use of a therapeutic surface and the use of full side rails resulting in the resident falling from bed.

Interview of the maintenance #115 indicated when a resident requires a therapeutic surface, nursing staff are to submit a work order to the ward clerk so that maintenance can install the therapeutic surface and the correct bed frame/ bed rails. Maintenance #115 indicated when the therapeutic surface mattress is to be used, the QD2000ML bed frame is to be used to accommodate the higher bed rails for the air surface if full bed rails are ordered/consented to be used. The maintenance worker also indicated an entrapment audit is also then completed. The maintenance worker indicated they were directed to switch all the bed frames with a therapeutic surface to the QD2000ML bed frame.

Interview with maintenance worker #134 indicated entrapment audits are not completed on residents with therapeutic surfaces as they would all fail the audit.

An observation was completed of all residents in the home on therapeutic air surfaces:
-resident #63 bed indicated a therapeutic surface was in place and was set to the specified setting and the correct bed frame was (QD2000ML) and with two full bed rails in the up position while the resident was in bed. There was a noticeable gap between the two side rail bars from the top of the therapeutic surface (potential entrapment risk) and no padding/bumpers in place. Interview of the spouse of resident #63 indicated the resident was admitted with a therapeutic surface and the resident had a near miss of falling our of bed and the bed frame was replaced with the QD2000ML. Interview of Maintenance #134 indicated nursing had called Maintenance #115 during the night shortly after

resident #063 was admitted, to switch the bed frame as the resident only had half rails in place at that time with therapeutic surface. Maintenance #134 indicated the bed frame was switched to a QD2000 ML bed frame "with 3/4 rails as the side rails are higher".
-Resident # 20, #062 and resident #064 were additionally observed to have a therapeutic surface in place that were set to the correct settings (as per the manufacturer's instructions). The bed frame in place was QD7000 and there were two full bed rails in the up position.

According to Health Canada "Adult Hospital Beds: Patient Entrapment Hazards, Side Guidance Document", best practice guidelines, (revised March 17, 2008):
-(page 12)Pressure Reduction Therapeutic Products Framed flotation therapy beds (powered air mattress replacements), and similar pressure reduction products that have therapeutic benefits such as reducing pressure on skin are easily compressed by the weight of a patient and may pose an additional risk of entrapment when used with conventional hospital bed systems. When these types of mattresses compress, the space between the mattress and the bed rail may increase and pose an additional risk of entrapment.
-(Page 13)The substitution of the original mattress for a surface such as a powered air mattress, or the addition to the existing mattress of, for example, a mattress overlay, may have an effect on the height of the top of the side rail above the surface the patient lies on. This may have an impact on the potential for patient falls, and the user should be aware of this and perform a proper risk assessment.
-As a point of information, recommendations vary among standards writing organizations regarding the minimum height of the top of the rail above the mattress. For hospital beds specifically, the international hospital bed standard, IEC 60601-2-38, amended in 1999, recommends 220 mm. However, the U.S. Consumer Products Safety Commission in 16 CFR Parts 1213 and 1513, Consumer Product Safety Standard for Bunk Beds recommends 5 inches (127 mm) as the minimum height, as does the American Society for Testing and Materials (ASTM) in ASTM F1427-06.

The severity is high as the risk to resident safety for potential zones of entrapment and risk of falling out of bed was demonstrated one resident almost rolled out of bed and one resident actually rolled out of bed as a result. The scope was demonstrated as 4/5 residents with therapeutic surfaces did not have reassessments completed to ensure zones of entrapment were identified and preventative steps were taken to reduce the risk. [s. 15. (1) (b)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required.
O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee shall prepare, implement and submit a corrective action plan to include the following:
1.Reassess all current residents to determine if any other residents are demonstrating symptoms of the presence of infection and ensure they are monitored and symptoms are recorded, and immediate actions are taken as required in accordance with evidence-based practices.
2.Retrain all Nursing staff on their responsibilities of the requirements of monitoring & reporting of symptoms indicating the presence of infection on every shift, according to evidence-based practices, and if there are none, in accordance with prevailing practices.
3.Retrain Registered Nursing staff on responsibilities related to completion of specimens as per physician orders and updated the SDM when the residents are demonstrating symptoms indicating the presence of infection.

This corrective action plan is to be submitted to Lynda Brown, LTCH Inspector (Nursing) via email at OttawaSAO.MOH@ontario.ca by August 7, 2016.

Grounds / Motifs :

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

During stage 1 of the Resident Quality Inspection (RQI), staff interview indicated the resident had an indwelling catheter. Upon chart review indicated the resident had an alteration in bowel elimination by the dietician upon admission. The

dietician indicated the physician was to be notified to hold bowel medication. Approximately three weeks later, the physician was contacted regarding the alteration in bowel elimination since admission. Two days later, the physician ordered laboratory testing to rule out infection. The following day, the nurse indicated "waiting from Infection Control (RN #103) re: proper specimen containers". Two weeks later, the laboratory testing was completed. The resident was also noted to have an alteration in skin condition as a result of the alteration in bowels. Approximately one week later the results of the laboratory testing was received by public health and the results were noted to be positive. The resident was then put on contact precautions. The following day, the physician was notified of the positive tests and ordered an altered diet and antibiotics. The POA was notified at this time of the alteration in bowels and treatments.

Interview with RPN #102 indicated awareness of resident #030 having alteration in bowels, positive lab results, was placed on contact precautions, and ordered antibiotics. The RPN indicated no further laboratory testing was completed post antibiotic treatment but the resident continued to remain on contact precautions.

Observation of resident #030 room indicated the resident remained on contact precautions.

Interview of RN #103 indicated is the infection control nurse (ICN). The ICN Indicated awareness of resident #30 having prior alteration in bowels and indicated the physician was notified and ordered laboratory testing. The ICN indicated physician orders were received for resident #30 when the lab results were received and the resident was placed on contact precautions at that time. The ICN indicated public health was also contacted for further direction as they were unfamiliar with the diagnosis. The ICN indicated awareness that resident #30 remained on contact precautions and acknowledged that no further testing had been completed post antibiotics to determine if the resident was still required to remain on contact precautions.

The home was issued a Voluntary Plan of Correction (VPC) during the RQI in September 2014 for Infection Prevention and Control under O.Reg. 79/10, s. 229. The severity was that Resident #030 was admitted on a specified date and was demonstrating signs of possible infection (related to altered bowels) and there was no indication staff were noting the symptoms every shift, and no actions were taken until approximately three weeks later when the physician was

notified. Two days later, the physician ordered specific lab work to rule out infection and the lab work was not obtained for approximately three weeks (May 13, 2016). The results of the stool samples were received approximately one week later (May 20, 2016) and the resident was diagnosed with an infection requiring contact precautions and antibiotics. The resident was not tested post antibiotic to determine if antibiotic was effective and the resident continued to remain on contact precautions. Therefore, an Compliance Order was warranted. [s. 229. (5) (b)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 21st day of July, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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