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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 26, 2016	2016_449619_0002	001026-16	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF ERIN MEADOWS
2930 Erin Centre Boulevard MISSISSAUGA ON L5M 7M4

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

SAMANTHA DIPIERO (619), DARIA TRZOS (561), KATHLEEN MILLAR (527), MICHELLE WARRENER (107), PHYLLIS HILTZ-BONTJE (129)

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): January 19-22, 25-29, 2016.

The following complaint inspection was completed along with the RQI: 004715-14.

The following Critical Incident inspections were completed along with the RQI: 00773-15, 006170-14, 027769-15, 036129-15, 002229-15, 013023-15, 014330-15, 023660-15, 008252-15, 002718-15, 017349-15.

During the course of the inspection, the inspector(s) spoke with the interim General Manager (GM), interim Director of Nursing Care (DONC), interim Assistant Director of Nursing Care (ADONC), Social Worker (SW), Behavioural Support Ontario Nurse (BSO), Administrative Assistant, Physiotherapist (PT), Registered Dietician (RD), Family Council Spokesperson, Resident Council Spokesperson, Manager of Facilities, Activation staff, Registered Nurses (RN) and Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping aides, dietary aides, family members and residents.

During the course of the inspection, the inspectors toured the home, observed the provision of care, observed meal service, reviewed health care records, reviewed relevant policies, procedures, and practices, maintenance and housekeeping practices, and food production systems, interviewed residents, family members, and staff.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with 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 failed to ensure that where bed rails were used, the residents were assessed, his or her bed system was evaluated in accordance with prevailing practices, and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

a)The licensee failed to ensure when bed rails were used, all bed systems were evaluated in accordance with prevailing practices. On December 8, 2015, staff #129 and a "Facility Entrapment Inspection Sheet" confirmed that the home completed a bed system audit. Staff #129 confirmed that they completed this audit after being trained by an outside vendor during the audit completed the previous year on two dates in December 2014. Staff #129 and documentation confirmed that 16 bed systems were not assessed. The bed systems that were not assessed were beds equipped with air surfaces identified as "Zephaire" and "Other Air". On an identified date in January 2016, staff #129 and the LTC inspector reviewed three of the 16 bed systems that were not assessed that were equipped with air surfaces and the plans of care for the residents using these beds identified the use of bed rails as a care intervention.

Resident #071's bed system with bed frame #125 identified as an "Other Air" air surface with a full bed rail on the right side and a half bed rail on the left side was reviewed. The air surface was easily depressed with upper body pressure to almost the bed frame deck, creating potential entrapment zones for the resident. Staff #129 checked the blower providing air to this surface and found the filter to be completely clogged with dust/lint which negatively affected the performance of the blower and resulted in the surface malfunctioning.

Resident #067's bed system was equipped with an "Other Air" air surface and one assist bed rail. The air surface was easily depressed with upper body pressure nearly to the bed frame deck, creating potential entrapment zones for the resident. Staff #129 checked the blower providing air to this surface and found the filter to be completely clogged with dust/lint which negatively affected the performance of the blower and resulted in the surface malfunctioning and creating a potential risk for entrapment.

Resident #046's bed system was equipped with a "Zephaire" and two bed rails. The air surface was easily depressed with upper body pressure, nearly to the bed frame deck, creating potential entrapment zones for the resident. Staff #129 checked the blower providing air to this surface and found the filter to be completely clogged with dust/lint which negatively affected the performance of the blower and resulted in the surface malfunctioning and creating a potential risk for entrapment.

b)The licensee failed to ensure when bed rails were used residents were assessed according to prevailing practices.

According to prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003", (developed by the US Food and Drug Administration and adopted by Health Canada), residents were to be evaluated by an interdisciplinary team over a length of time while in bed, by answering a series of questions to determine if the bed rail was a safe device for resident use. The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would include the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or by the resident's Substitute Decision Maker (SDM), about the necessity and safety of a bed rail (medical device). The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

Staff #111, #130, #116 and clinical documentation confirmed that at the time of the

inspection the home had not developed or implemented an assessment in accordance with the above noted prevailing practices to be used when the use of bed rails were being considered as a care intervention for residents. Staff #111 confirmed that she was unaware of the prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Staff #130 and #116 confirmed that the assessment staff in the home used was the Personal Assistive Devices/Restraint assessment which did not meet the requirements for assessment of a resident when bed rails were used. Fourteen random residents were reviewed, staff #120, #130, #116 and clinical documentation confirmed that these 14 resident's plans of care directed staff providing care to use bed rails when the resident was in bed. (Residents reviewed included: resident #041, #064, #065, #066, #067, #068, #008, #069, #070, #071, #043, #046, #025 and #072). Staff #120, #130 and #116 confirmed that none of the fourteen residents reviewed were assessed according to prevailing practices prior to the use of bed rails as a care intervention.

c)The licensee failed to ensure steps were taken to prevent entrapment, taking into consideration all potential entrapment zones.

During stage one of the home's Resident Quality Inspection it was noted by LTC Inspectors that several of the mattresses in use slid easily from side to side on the bed frames. LTC Inspector #527 specifically identified that resident #010's mattress was sliding, there were no mattress keepers and the resident's bed was equipped with a quarter bed rail in the raised position on the left side of the bed. The resident was interviewed and they stated that the bed rail was always up so that when they sat on their bed the mattress would not slide off the frame. The Facility Entrapment Inspection Sheet was reviewed for December 2015 and indicated the resident's bed system had failed for zones 2, 3, and 4. Staff #129 and a bed system audit completed on December 17, and 18, 2014, indicated 59 identified bed systems failed to pass one or more entrapment zones. The reason for failures of the majority of these beds related to the beds not being equipped with mattress keepers resulting in the mattresses sliding from side to side on the bed frame deck. Staff #129 and a bed system audit completed on December 8, 2015, indicated that 41 identified bed systems failed to pass one or more entrapment zones. A review of each bed system that failed to pass during the December 2014 audit and the December 2015, audit indicated that 37 of the same beds that failed during the December 2014, audit continued to fail the same zones of entrapment during the December 2015 audit. Staff #129 confirmed that corrective action was not taken to eliminate the risk of bed entrapment for the 37 residents in the identified beds that continued to fail over the course of a year. [s. 15. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident had his or her personal health information, within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act.

On January 22, 2016, between 0745 hours ,and 0845 hours, on the Dundas home area, during an observation of the medication pass, it was noted that discarded medication pouches that identified residents by name, and their prescribed medications, were being disposed of in the regular garbage. RPN #132 had indicated that this was the current process in the home. The Interim ADONC was interviewed and confirmed that the empty medication pouches should have been separated and placed in a destruction bin in the medication room to protect personal health information. The home failed to ensure that each resident had his or her personal health information kept confidential in accordance with that Act. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with s. 3(1)(11)(iv) Every licensee shall ensure that the following rights of residents are fully respected and promoted: (11) Every resident has the right to, (iv) have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, to be implemented voluntarily.

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. (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).

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

Findings/Faits saillants :

1.The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #054 had a fall on an identified date in 2014 and sustained an injury. The clinical record had indicated that the resident returned to the home from hospital on an identified date in 2014. Three days after the resident returned from hospital, progress notes indicated that the Physiotherapist (PT) had assessed the resident and recommended six identified interventions. Interviews with the RPN #132 and the interim DONC confirmed that these interventions were implemented after the resident returned

from the hospital. The written plan of care in effect post re-admission from hospital included only two of the six identified interventions. The interventions recommended by the PT were added to the written plan of care on an identified date in 2015 and this was confirmed by Resident Assessment Instrument - Quality Indicator (RAI-QI) Nurse #120. The home failed to ensure that the written plan of care set out the planned care for resident #054. [s. 6.(1)(a)] (561)

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Nursing staff and therapy staff did not collaborate in the assessment of resident #041 when it was identified that a positioning issue, when the resident was sitting in the wheelchair, placed the resident at risk of falling. Registered staff #130 and an "Alternatives to PASD/Restraint Assessment" completed by nursing staff on an identified date in 2015, confirmed that nursing identified a certain strategy to deal with posture and positioning. The specific strategy was considered to be a personal assistive device (PASD). The homes policy titled "Restraint and PASD Procedures in LTC", #04-52, revised January 25, 2015, indicated that nursing staff and therapy staff must collaborate on the resident's restraint assessment. It was confirmed that consultations had not occurred with any of the therapy disciplines related to the assessment of the use of this strategy. Therapy staff #135 who coordinated the falls prevention program in the home, confirmed that they did not collaborate with nursing in the assessment of resident #041 in relation to the use of this strategy and safety concerns identified by nursing staff related to the risk of the resident for falling. [s. 6.(4)(a)] (129)

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #025 had a history of responsive behaviours, which included wandering into co-resident rooms, and displayed physical and verbal expressions by hitting co-residents. Resident #025 entered resident #049's room on an identified date in 2015, at 1830 hours, pulled resident #049 out of bed and dropped them on the floor. Resident #049 required sustained injury and was transferred to hospital. The home's policy called "Responsive Behaviour/Aggression Prevention", #06-26, revised March 2014, directed staff to implement behaviour mapping using the Dementia Observation Scale (DOS) on

each shift for seven days. The DOS monitoring for resident #025 required the staff to check the location of the resident and assess the resident's behaviour every half hour. PSW #157 and #159 were interviewed and were unsure if the resident was checked every half hour on an identified date in 2015, and stated that if the resident was checked every half hour, they would have documented it in the DOS flow sheet. The clinical record was reviewed and identified that there was no DOS monitoring of resident #025 on the identified date in 2015, for a period of eleven hours. Staff #116, #122, #155, #158, the Behavioural Support Officer (BSO) and the Neighbourhood Coordinator confirmed that they were expected to monitor resident #025 every half hour as specified in their policy and as expected from the resident's plan of care, and this was not done. [s. 6.(7)] (527)

4. The licensee has failed to ensure that the resident had their plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

During the months of December 2015, and January 2016, resident #023 had ongoing responsive behaviours resulting in refusals of care. The plan of care for resident #023 related to personal expressions directed staff to administer as needed (PRN) medication to reduce aggressive episodes. Registered staff #116 and #130 confirmed that the resident was no longer receiving the medication and that the medication had been discontinued. The Medication Administration Record (MAR) and physician orders back to 2014, did not include the administration of PRN medication. Registered staff #130 confirmed the resident's plan of care had not been revised when the medication was discontinued. [s. 6. (10)(b)] (107)

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

The progress notes dated August 2014, indicated that resident #054 was assessed by the Occupational Therapist (OT) for mobility. The OT had indicated in the progress note that the resident was not able to use their mobility device and may benefit from an alternate device. The progress note had also indicated that the OT recommended a safety device to alert nursing to resident's attempt to stand and to monitor resident's tolerance of the device. Resident #054's health records were reviewed and did not

indicate that this intervention was implemented. The interview with the Interim Director of Nursing Care (DONC) indicated that the OT recommendations should have been implemented and confirmed that this was not done. Resident # 054 sustained a number of falls after August 2014 and on an identified date in 2014, sustained an injury. Two strategies were implemented after resident returned from hospital in December 2014. The home had failed to ensure that the resident's plan of care was revised after his care needs changed. [s. 6.(10)(b)] (561)

6. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Resident #027 was admitted to the home with a cognitive performance (CPS) score of 6/6, and required extensive assistance to complete all activities of daily living. The resident was seen by the Speech Language Pathologist (SLP) two months after admission, in relation to the ongoing swallowing risks; the 2013 SLP assessment and intervention documentation was not available at the time of the inspection. On review of the 2013 written plan of care, the document stated "Ensure correct diet is followed and feeding instructions as per SLP consult", however no SLP interventions related to the diagnosis, feeding or positioning techniques were identified in the plan of care. An interview with registered staff #130 confirmed that an SLP assessment had been completed in October 2013, but that the recommendations and interventions as they related to the diagnosis were not updated in the written plan of care until October 2015, when a second SLP assessment had been completed after the resident was sent to hospital with respiratory issues. An interview with the homes Interim DONC confirmed that written plans of care were to be updated when there was a change in a resident's care needs but that this was not completed. [s. 6.(10)(b)] (619)

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 with s. 6(1)(a), s. 6(4)(a), s. 6(4)(b), s. 6(7), and s. 6(10)(b), to be implemented voluntarily.

WN #4: 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 failed to ensure that where the Act or this Regulation requires the licensee of a longterm care home to have, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol, procedure was complied with.

a) Staff did not comply with the home's policy "Restraint & PASD Procedures in LTC", located in the Nursing Manual, identified as Tab 04-52 and dated January 25, 2015. This policy directed that "the team needs to consider and evaluate alternatives to the use of a physical device". Registered staff #130, clinical documentation, and resident observations confirmed that resident #041 had a front fastening seat belt applied as a PASD to address what nursing staff identified as a positioning issue while the resident was seated in the wheelchair that placed the resident at risk of falling. Registered staff #130 and clinical documentation confirmed that this policy was not complied with when alternatives to the use of this device were not considered prior to the application of the device.

b) Staff did not comply with the home's policy "Skin/Wound Care" located in the Nursing Manual, identified as Tab 04-78 and dated January 9, 2015. This policy directed that "any resident, whose skin integrity has been compromised, will have a plan of care based on their identified risk". Registered staff #110, #130, clinical documentation, and resident observations confirmed that resident #022's skin integrity had been compromised when it was noted that the resident had impaired skin integrity on both hands. Registered staff #110, #130 and clinical documentation confirmed directions contained in the home's Skin/Wound Care policy had not been complied with when it was identified that this resident did not have a plan of care based on the identified risk related to impaired skin integrity. [s. 8.(1)(b)] (129)

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's policy called "Fall Prevention & Management", dated February 2013, indicated the following: "When a fall is discovered (witnessed or un-witnessed), follow the procedures below:
1. The Team Member who discovers the fall immediately calls the Registered Team Member on the Resident's Neighbourhood. The Registered Team Member assesses the Resident for injury and proceeds with medical attention if necessary.
2. If the resident hits their head or there were no witnesses to the fall, the Head Injury Routine is followed.
3. In all cases, the family or Power of Attorney (POA) is notified of the fall, as well as the Physician".
Resident #052's health records were reviewed and indicated that the resident had a fall in June 2015 with injury. The post fall progress notes on the date of the fall, indicated that resident did not have any bruises or bumps only aches and pain for which medication was given. The investigation notes were reviewed and indicated that RPN #146 who discovered the resident did not document the complete assessment in progress notes or Post Fall Incident Report. Upon assessment the resident was not able to weight bear and unable to push the leg against palm. The interim DONC indicated that according to these findings the physician should have been called right away and the POA should have been notified right away. Furthermore, the interview with the Interim DONC indicated that it was the expectation of the home to assess residents before they are moved from the floor. The investigation notes indicated that the resident was transferred to bed before the assessment was completed by RPN #146. The Interim DONC also stated that the Medical Director of Health had provided training to all registered staff on the proper

assessment post fall including expectation not to move residents until they are assessed. It was confirmed that RPN #146 attended the training. RPN #146 did not follow the home's policy and procedures related to falls. [s. 8.(1)(b)] (619)

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 r. 8(1)(b) 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, is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) During a tour of the home the morning of January 19, 2016, the door to the servery area was left open and unlocked without supervision on the Meadowvale unit (secure area). A resident was in the Meadowvale dining room unsupervised while the area was left unlocked and unattended. Hazardous chemicals, including Lemon Eze Disinfectant cleaner (corrosive symbol), were observed and accessible in the identified servery area. A hot water machine and hot steam tables that were observed to be on, were also accessible in the servery area. Director of Food Services #128 and Director of Environmental Services #129 confirmed the servery areas were to be locked when unsupervised. Both doors to the servery area on Meadowvale were found open and accessible to residents on January 22, 2016, at 1010 hours. The same hazardous chemicals were found in an unlocked cupboard under the sink and the steam tables were hot to the touch. The hot water machine was also accessible. Dietary Aide #152 confirmed the area was supposed to be locked when not attended; however, also stated that the staff member was unable to use the locking mechanism due to its location on the door (too high to reach).

B) When conducting the initial tour of the home on January 18, 2016, the LTC Inspector identified that hazardous substances were accessible to residents in the servery on the Trafalgar and Howland units. The home's policy "Equipment and Supplies", #03-03, revised May 11, 2015, directed staff to "ensure that all chemicals will be stored in WHMIS labeled containers, which were kept inaccessible to residents". In the servery on the Trafalgar and Howland units, the cupboard where disinfectants were stored were unlocked. The Food Services Manager and the Manager of Environmental Services were interviewed and confirmed that the servery doors were not locked and were unsupervised; therefore the hazardous disinfectants were accessible to residents in a non-residential area. [s. 9. (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 r. 9(1)2, All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home shall protect residents from abuse by anyone.

Resident #045 was verbally abused by PSW #152. Registered staff #156 became aware of the abuse directly from the resident. On review of the homes internal investigation records, and interview with the GM, it was confirmed that PSW #152 had previously been disciplined in relation to an incident with a different resident in July 2014. It was also confirmed by the homes GM that the home was unable to provide any documentation that PSW #152 received any coaching or re-training as it pertained to staff to resident abuse, and that no monitoring or supervision was put in place for this employee when they returned to their duties. An interview with the GM confirmed that in July 2014, PSW #152's training record related to abuse training was up to date, and confirmed that after the suspension no re-training was offered to PSW #152. The GM also confirmed that as of December 2014, PSW #152's abuse training was out of date and that at the time of the incident with resident #045 in December 2014, PSW #152 had still not completed their abuse policy training as required by the home. [s.19.(1)] (619)

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 with s. 19(1), every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the policy to promote zero tolerance of abuse was complied with.

On a specified date in August 2014, resident #047 was given a specific intervention by PSW #149 who then exited the resident's room as they were relieved for break by PSW staff #150 and #107. PSW #149 informed PSW's #150 and #107 that the resident required assistance after the treatment was completed. After PSW #149 left the hallway area, resident #047 reportedly heard PSW #107 make derogatory comments about the resident. The resident was upset by these comments, and did not inform staff of this incident until later that afternoon when the resident was prompted to share their feelings by registered staff #145. Resident #047 later informed the Interim DONC of this incident via e-mail on an identified date in August 2015. An interview with the Interim DONC confirmed that an internal investigation was initiated, and that PSW #107 was put on paid suspension. The DOC confirmed that the results of the investigation were inconclusive and that PSW #107 denied making the statements and that PSW #150 denied hearing those statements. The DOC confirmed that the homes policy titled "Prevention of Abuse in Long-Term Care", #04-06, revised July 2015, stated that "Upon receiving a report of suspected abuse, the team member will immediately involve their charge nurse or neighbourhood coordinator" and that registered staff #145 failed to do this. The Interim DONC also confirmed that a critical incident report was not submitted to the Director until an identified date in September 2014, a total of 13 days after the alleged verbal abuse occurred and confirmed that the homes abuse policy stated "when receiving a report of suspected abuse, the team member will immediately involve their nurse manager and notify the Ministry" and that this was not complied with. The DOC confirmed that registered staff #145 did not respond to allegation of verbal abuse in a manner that complied with the homes policy and procedure as it related to abuse. [s. 20. (1)] (619)

2. The licensee failed to ensure that the policy to promote zero tolerance of abuse of residents was complied with.

In December 2014, resident #045 reported an incident of staff to resident abuse to registered staff #156. In an interview, resident #045 stated on an identified date in December 2014, they were verbally abused by PSW #152. The resident reported the abuse to registered staff #156 who, acting as night shift charge nurse, failed to report the allegation of staff to resident abuse to the home. An interview with the GM confirmed that the homes policy titled "Prevention of Abuse in Long Term Care" #04-06, revised July 2015, stated that "any team member with reasonable grounds to suspect that any type of abuse or neglect has occurred must immediately report…and immediately involve their charge nurse or neighbourhood coordinator…or on-call leadership if after hours". The GM confirmed that the homes leadership became aware of the allegation of abuse when resident #045 reported it to the Interim DONC during business hours on an identified date in December 2014, and that they were not notified of the incident by the homes staff as per the abuse policy. The GM confirmed that the staff failed to comply with the homes policy as it related to the prevention of abuse. The homes abuse policy also stated that "the on-call leadership team member will report the incident to the Ministry of Health and Long Term Care immediately", however on review of the critical incident, it was determined that it was not submitted to the Director until an identified date in January 2015, a total of fourteen days after the incident occurred. An interview with the homes GM confirmed that this time frame did not comply with the homes abuse policy which instructed leadership to report suspected or witnessed abuse immediately. [s. 20. (1)] (619)

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 with s. 20(1)- without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #8: 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:
12. Dental and oral status, including oral hygiene. 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:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene.

The plan of care for resident #018 did not include directions for staff based on an interdisciplinary assessment of the resident's hygiene requirements. Part time PSW staff #138, who was providing care to resident #018, stated they were unsure of whether the resident had dentures and they had not seen any dentures for the resident. PSW #138 stated they used a facecloth or a toothbrush with mouthwash to clean the resident's mouth. PSW #113 who routinely provided care to the resident stated the resident had dentures and they used a toothbrush with toothpaste to clean the resident's teeth and used tablets for the dentures. The plan of care did not include oral hygiene interventions and was not based on an interdisciplinary assessment of the resident's oral hygiene requirements with directions for staff in the provision of oral hygiene. [s. 26. (3)12.]

2. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of special treatments and interventions.

a) Registered staff #112 and clinical documentation confirmed that resident #071's plan of care was not based on an assessment related to the use of a specialized air surface. Resident #071's bed was equipped with a specialized air surface identified as an "Other" air surface. The resident's care plan directed that the resident was to have an intervention to manage the risk for skin breakdown and pain management. During a tour

of the home with staff #129 it was noted that this specialized surface was able to be easily compressed to almost the level of the bed frame deck and that the surface blower was set at a very low level, which may have resulted in an increased risk of bed entrapment for this resident. Registered staff #129 confirmed that at the time of this inspection they were not aware of an assessment, in accordance with the manufactures specifications that was completed for this resident in relation to the blower setting required for the comfort and safety of this resident. It was also confirmed that there were no directions in the resident's room or in the plan of care related to required blower setting for this resident.

b)Registered staff #130, #116 and clinical documentation confirmed that resident #046's plan of care was not based on an assessment related to the use of a specialized air surface. Resident #046's bed was equipped with a specialized air surface identified as a "Zephaire" air surface. The resident's care plan directed that the resident was to have management an intervention to manage a risk of skin breakdown and during a tour of the home with staff #129 it was noted that this specialized surface was able to be easily compressed to almost the level of the bed frame deck and that the surface blower was set at a very low level, which may have resulted in an increased risk of bed entrapment for this resident. Registered staff #130 and #116 confirmed that at the time of this inspection they were not aware of an assessment, in accordance with the manufactures specifications that was completed for this resident in relation to the blower setting required for the comfort and safety of this resident. It was also confirmed that there were no directions in the resident's room or in the plan of care related to required blower setting for this resident.

c) Registered staff #120 and clinical documentation confirmed that resident #067's plan of care was not based on an assessment related to the use of a specialized air surface. Resident #046's bed was equipped with a specialized air surface identified as an "Other" air surface. A review of the resident's care plan did not indicate that the resident was to have an air surface on their bed, however, during a tour of the home with staff #129 it was noted that the above noted specialized surface was on the resident's bed and this specialized surface was able to be easily compressed to almost the level of the bed frame deck and that the surface blower was set at a very low level, which may have resulted in an increased risk of bed entrapment for this resident. Registered staff #120 confirmed that at the time of this inspection they were not aware of an assessment, in accordance with the manufactures specifications that was completed for this resident in relation to the blower setting required for the comfort and safety of this resident. It was also confirmed that there were no directions in the resident's room or in the plan of care

related to required blower setting for this resident. [s. 26.(3)18.]

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 with r. 26(3)(12)- A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 12. Dental and oral status, including oral hygiene and r. 26(3)(18) - A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 18. Special treatments and interventions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy to minimize the restraining of residents was complied with.

Resident #053 had a physician order dated August 2015 for a 24 hour safety device. The home's policy, "Restraint & PASD Procedures in LTC", dated January 25, 2015, directed registered staff to monitor the resident's condition at least every 15 minutes and record the monitoring on the Emergency Restrain Re-assessment and Monitoring Form. The policy also directed staff to follow the procedure for daily safety device use if the safety device was required after twelve hours (monitoring chart would be completed and resident would be monitored at least every hour and released from the restraint and repositioned at least once every two hours). Registered staff #130 confirmed that the Emergency Restraint Re-assessment and Monitoring Form had not been completed for the 24 hour period. The routine "Restraint Monitoring Chart" had also not been completed for the 24 hour period. Resident #053 had another physician order in August 2015, for the use of a safety device. The home's policy, "Restraint & PASD Procedures in LTC", dated January 25, 2015, also directed staff to complete an "Alternatives to Restraint/PASD Assessment before a restraint was considered. In the resident's clinical health record an Alternatives to Restraint/PASD form was signed as completed 7 days after the restraint was ordered. Registered staff #130 confirmed that the Alternatives to Restraint/PASD Assessment form was the only one completed between for a period of eleven days in August 2015. The Alternatives to Restraint/PASD Assessment form stated the team recommendation was to avoid the use of the safety device. The policy also required registered staff to reassess the resident's condition and evaluate the effectiveness of the safety device at least every eight hours and to document the reassessment on the Medication Administration Record (MAR). Documentation on the Restraint Monitoring Chart for September 2015, identified the restraint was applied on three occasions; however, registered staff did not document or record an assessment of the resident's condition or an evaluation of the effectiveness of the restraint. Registered staff #130 and #142 confirmed that registered staff did not document on the MAR as per the home's policy. The policy also directed staff to complete a 10 Day observation Form when discontinuing a restraint. Registered staff #130 was unable to locate a 10 Day Observation Form completed after the resident's restraint was discontinued on September 2, 2015. [s. 29.(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 with s. 29. (1) Every licensee of a long-term care home, (a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and (b) shall ensure that the policy is complied with, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record relating to each annual evaluation of interdisciplinary programs included a summary of the changes made and the date those changes were implemented.

At the time of the inspection the home had not implemented a formal process for the documentation of the annual evaluation of the required interdisciplinary programs. Several documents provided by the home, as a way of demonstrating the required programs had been evaluated annually, were reviewed at the time of this inspection. Documents provided relating to the home's skin and wound care program, management

of responsive behaviours program and prevention of abuse program did not contain the dates proposed changes to the programs were implemented. [s. 30. (1) 4.]

2. The licensee failed to ensure that any actions taken with respect to a resident under the nursing and personal support services program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #024's plan of care required oral hygiene to be provided twice daily. Documentation on the PSW flow sheets were incomplete in relation to oral hygiene in December 2015 a total of six times during the day shift, and ten times during the evening shift. Documentation on the PSW flow sheets were also incomplete in relation to oral hygiene in January 2016 a total of four times during the day shift and thirteen times during the evening shift. PSW staff providing care (#114 and #137) stated the resident frequently refused oral hygiene; however, documentation was not completed.
The resident's plan of care required showers twice. Documentation on the PSW flow sheets were incomplete for bathing for one identified week in December 2015, no showers were marked provided or refused, and on six occasion in January 2016, no showers were recorded as provided or refused. PSW #114 who routinely provided care to the resident stated that the resident received their showers; however, they forgot to document the showers provided. Registered staff #116 confirmed that all care provided or refused was to be documented on the PSW flow sheets. [s. 30. (2)]

3. The licensee failed to ensure that any actions taken with respect to a resident under the nursing and personal support services program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Registered staff #116 confirmed that resident #018 required oral hygiene twice daily. Documentation on the PSW flow sheets was incomplete in relation to oral hygiene on the day shift in December 2015 a total of six times and on the evening shift in December 2015 a total of nine times. Documentation on the PSW flow sheets was incomplete in relation to oral hygiene on the evening shift in January 2016 a total of twelve times. PSW staff #113 providing care to the resident in the morning stated the resident received the care; however, they forgot to document the care provided. PSW #138 who provided care to the resident in the evening on some of the identified dates stated they were unable to recall if the resident refused care or if care was provided.

Resident #018's plan of care required showers twice weekly. Documentation on the PSW flow sheets were incomplete for the period between an identified date in December 2015, to January 2016. Showers were not documented on any day during that period. PSW #113 who routinely provided care to the resident stated that the resident received their showers; however, they forgot to document the showers provided. Registered staff #116 confirmed that staff were to document the care provided to residents on the PSW flow sheets. [s. 30. (2)]

4. The licensee failed to ensure that any actions taken with respect to a resident under the nursing and personal support program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

On a specified date in January 2016, resident #018 was observed with poor hygiene and grooming just prior to the noon meal and ongoing poor hygiene and grooming throughout the inspection. In an interview, PSW #113, who routinely cared for the resident, stated that the resident appeared to have an infection in their eyes and that it had been reported to Registered staff #110 about three weeks prior. Registered staff #116 confirmed that there was no documentation of an assessment of the resident related to infection. [s. 30. (2)]

5. The licensee failed to ensure that any actions taken with respect to a resident under the nursing and personal support services program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #024's plan of care required oral hygiene to be provided twice daily. Documentation on the PSW flow sheets were incomplete in relation to oral hygiene on the day shift in December 2015 a total of four times and in January 2016 a total of five times. PSW staff providing care (#115) stated the resident frequently refused care; however, documentation was not always completed.

The resident's plan of care required showers twice weekly. Documentation on the PSW flow sheets were incomplete for bathing for a week in December 2015, no showers documented as provided or refused; a second shower was not recorded as provided or refused for a week in January 2016, and a second shower was not recorded as provided or refused for a second identified week in January 2016. PSW #115 who routinely provided care to the resident stated that the resident often refused or an alternate bath

was provided. The PSW confirmed they did not always complete the documentation to reflect if the resident was offered or refused a shower. Registered staff #116 confirmed that all care provided or refused was to be documented on the PSW flow sheets. [s. 30. (2)]

6. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #052 had a fall on an identified date in June 2015. The progress note dated the day of the incident, describing the assessment performed by the RPN #146 indicated that the resident complained of injuries and that medication was administered as per the homes directive, it further stated that there were no physical injuries and that the resident was advised to sleep in bed and call for support whenever they needed to get out of bed. The investigation notes were reviewed and indicated that RPN #146, when interviewed by the Interim DONC, stated that the resident was not able to weight bear and unable to push against palm upon assessment. This assessment was not documented in the progress notes or the Falls Incident Report. The Interim DONC confirmed that the completed assessment by RPN #146 post fall was not documented. [s. 30. (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 with r. 30(1)(4) -
Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented and r. 30(2) - The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident routinely received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

On an identified date in January 2016, just prior to the noon meal, resident #023 was noted to have mouth odour. Flow sheets for the, day shift indicated that the resident refused oral hygiene that morning. Two days later, staff #114 confirmed the resident was not provided oral hygiene that morning. The resident did not have a toothbrush or mouthwash in their room and staff confirmed oral hygiene was not completed that morning. Staff stated the resident was difficult to provide care to and often would not open their mouth. PSW #137 also stated that the resident was resistive or oral hygiene and that most of the time oral care was refused and not provided. Flow sheets for oral hygiene reflected that the resident received oral hygiene 11/56 times (19.6%) over a 28 day period between December 2015, and January 2016. [s. 34. (1) (a)]

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 with r. 34(1)(a) - every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, (a) mouth care in the morning and evening, including the cleaning of dentures, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident who demonstrated responsive behaviours actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Resident #025 was exhibiting responsive behaviours to co-residents in October 2015, and December 2015. There was incomplete documentation on the Dementia Observation Scale (DOS) and the progress notes by the PSWs and the registered staff as it related to the resident's assessments, re-assessments and responses to the interventions to manage their responsive behaviours. [s. 53. (4) (c)]

2. The licensee failed to ensure that for the resident who was demonstrating responsive behaviours, action was taken to meet the needs of the resident including reassessments and documentation of the resident's responses to the interventions.

On an identified date in January 2016, just prior to the lunch meal, the resident #023 was noted to have significant mouth odour. During an interview PSW #114 and #137 who consistently provided care to resident #023 stated that completing oral care was difficult and care was routinely not provided due to the resident's responsive behaviours. The resident did not have oral hygiene implements in their washroom and PSW #114 confirmed that oral care had not been completed that morning. The resident's plan of care identified responsive behaviours related to care and directed staff to provide care with two staff. PSW #114 and #137 stated that care was provided with two staff and they would often re-approach the resident several times; however, oral care was not able to be provided consistently. Ongoing responsive behaviours were documented on the PSW flow sheets almost all day and evening shifts between December 2015 and January 2016 (seven day/evening shifts behaviours not recorded as present). On the PSW flow sheets, the resident was recorded as receiving oral care on 11/56 shifts (19.6%). Registered staff #116 stated that the home's process when residents refused care was to try again on the next shift and if the refusals were ongoing, to refer the resident to the Behavioural Support Ontario (BSO) for re-assessment. Registered staff #116 confirmed they were not aware of the ongoing refusal of oral hygiene and that the resident was not re-assessed in relation to the ongoing refusals for oral hygiene. Staff #116 also confirmed that a referral to BSO for re-assessment did not occur in relation to the refusals. [s. 53. (4) (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 with r. 53(4) - The licensee shall ensure that, for each resident demonstrating responsive behaviours, (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that planned menu items were offered and available at the observed lunch meal.

The planned menu for an identified date in January 2016, required 125 millilitres (mL) of milk to be offered at the lunch meal. Not all residents requiring thickened fluids were offered milk at the observed lunch meal. Ten residents in the dining room required thickened fluids; two of those residents had directions to avoid milk, resident #043 received thickened milk, and the other seven residents were not offered thickened milk at the meal. Dietary Aide #119 serving the meal stated that thickened milk was not offered at the lunch meal as residents received three fluids including the soup so milk was not required. The Dietary Aide stated thickened milk was not routinely offered at the lunch meal. The Nutrition Manager confirmed that the planned menu was to be followed and that thickened milk should have been offered at the lunch meal. The Registered Dietitian confirmed that the planned menu included milk for resident's requiring thickened fluids and that milk should have been offered at the observed meal. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r. 71(4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #14: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

The home's Environmental Services policies and procedures were reviewed and identified that offensive odours would be addressed proactively. Staff #143 and #144 were interviewed and stated they were unsure of the home's procedures for addressing offensive odours in resident rooms. During the inspection the two bathrooms on one identified unit and one bathroom on a separate identified unit had offensive urine odours for a period of seven days in January 2016. Staff member #129 was interviewed and was not aware of the lingering offensive odours in the resident bathrooms through the home's maintenance system, or communicated by the housekeeping aides, therefore no measures were implemented to proactively address incidents of lingering offensive odours in the resident bathrooms. [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 with r. 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, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment and devices were kept in good repair.

Staff #129 confirmed that procedures were not developed and implemented to ensure that air surfaces placed on resident's beds were maintained to optimize their intended function. During a tour of the home with staff #129 to review bed systems audits related to bed safety and the use of bed rails it was noted that resident #046 had a Zephaire air surface on their bed, and resident's #067 and #071 had "other air" surfaces on their beds. All three of these air surfaces were easily compressed using upper body weight to almost the level of the bed frame deck. Staff #129 removed the air filters for all three of these air surface blowers and identified that the filters were completely blocked with dust/lint. Staff #129 indicated that the previous supplier of these air surfaces would regularly attend the home to clean the filters, but since the home no longer used the same supplier the blowers were no longer being maintained and the home had not set up a routine maintenance schedule for the air surface blowers and the cleaning the air filters. [s. 90. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r. 90(2) The licensee shall ensure that procedures are developed and implemented to ensure that, (b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (8) Every licensee shall ensure that every use of a physical device to restrain a resident pursuant to the common law duty referred to in section 36 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (8).
2. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (8).
3. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (8).
4. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (8).
5. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (8).
6. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (8).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was restrained using a physical device that staff apply the physical device in accordance with any manufacturer's instructions.

Resident #030's safety device was not applied in accordance with manufactures directions and the expectations of the home. On an identified date in January 2016, the resident was in the lounge area in a wheelchair that had a side fastening safety device applied. A six inch gap was noted between the resident's body and the safety device. At this time the RPN #142 and PSWs #117 and #118 confirmed that the safety device had been applied too loosely. RPN #142 readjusted the safety device and requested that the physiotherapist review the application of this safety device. RPN #142 identified they were unable to locate manufacturer's directions for the application of the safety device and confirmed that the home's policy and procedure did not provide directions to staff related to the manufacturer's directions for the application of the safety device. RPN #142, and PSWs #117 and 118 confirmed that it was the expectation of the home that the seat belt would be applied leaving a two finger distance between the resident's body and the safety device. [s. 110. (1) 1.]

2. The licensee failed to ensure that when a resident was restrained using a physical device that staff applied the physical device in accordance with any manufacturer's instructions.

Resident #041's front fastening safety device was not applied in accordance with manufactures directions and the expectations of the home. On an identified date in January 2016, the resident was noted to be sitting in a small lounge area in a wheelchair that had a front fastening safety device applied. A four inch gap was noted between the resident's body and the safety device. At this time registered staff #101 confirmed that the safety device had been applied too loosely. Staff #101 readjusted the safety device and requested that the physiotherapist review the application of this safety device. Registered staff #111 indicated they were unable to locate manufacturer's directions for the application of the safety device and confirmed that the home's policy and procedure did not provide directions to staff related to the manufacturer's directions for the application to safety device. Registered staff #111 confirmed that it was the expectation of the home that the safety device would be applied leaving a flat palms distance between the resident's body and the safety device and also confirmed that any safety device that had been applied with a four inch gap between the resident's body and the

safety device would have been applied too loosely. [s. 110. (1) 1.]

3. The licensee has failed to ensure that the documentation included what device was ordered and any instructions relating to the order in relation to a restraining device.

A physician's order was obtained for resident #053 on an identified date in August 2015, for a safety device while seated in chair. The physician's order did not identify what specific restraining device was ordered. Documentation in the progress notes on the identified date also did not identify what device was ordered to restrain the resident, only, "Restraint ordered for safety" and the Medication Administration Record also only identified, "restraint for safety while in w/c [wheelchair]". The order also did not clarify if the resident was to be restrained in all chairs or only a wheelchair. [s. 110. (7) 3.]

4. The licensee failed to ensure that the following were documented: all assessment, reassessment and monitoring, including the resident's response.

Resident #030 was had the use of a safety device while seated in their chair. The home's policy called "Restraint & PASD Procedures in LTC", #04-52, revised January 2015, directed staff to monitor the resident, when the safety device was in place, at least every hour and document on the 'Restraint Monitoring Chart'. The Restraint Monitoring Chart was reviewed to identify if the resident had their restraint in place and that the monitoring was completed hourly; 112 times in December 2015, and 95 times in January 2016, there was no documentation by PSW staff. PSWs #117 and #118 were interviewed and confirmed they were expected to document hourly safety checks to ensure the safety device was intact and the resident was comfortable. The PSWs also identified the resident would be released from the safety device and repositioned at least once every two hours or more frequently if needed, and they would document on the Restraint Monitoring Chart. Staff #116 and #142 were interviewed and confirmed that PSWs were expected to document hourly safety and restraint checks in the Restraint Monitoring Chart as outlined in the home's policy and procedures but failed to do so. [s. 110. (7) 6.]

5. The licensee failed to ensure that every use of a physical device to restrain a resident pursuant to the common law duty referred to in section 36 of the Act was documented and, without limiting the generality of this requirement, the licensee did not ensure that the following was documented: 1. The circumstances precipitating the application of the physical device. 2. The person who made the order, what device was ordered, and any instructions relating to the order. 3. The person who applied the device and the time of application. 4. All assessment, reassessment and monitoring, including the resident's

response. 5. Every release of the device and all repositioning. 6. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

A physician's order for resident #053 was written in August 2015, for a safety device to be applied over a period of 24 hours. The order did not specify what specific safety device was to be applied or any instructions relating to the order. Progress notes in August 2015, stated, "MD ordered to put resident in w/c [wheelchair] for 24 hours". The note also did not identify what device was ordered or any instructions relating to the order. A progress note from August 2015 stated, "resident was assisted back on w/c [wheelchair] for their safety". It was unclear if the device was initiated on that date as registered staff had signed on the Medication Administration Record under "24 hour restraint for safety" on the night shift on an identified date in August 2015, and the day shift on an identified date in August 2015. Documentation did not indicate the time of initial application of the safety device and did not identify the person who applied the device. All assessment, reassessment and monitoring, including the resident's response and every release of the device and all repositioning were also not documented. Registered staff #130 and #142 confirmed that documentation related to the resident's safety device was incomplete and did not meet the legislative requirement. [s. 110. (8)]

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 with r. 110(1)(1), r. 110(7)(3), r. 110(7)(6), and r. 110(8), 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).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

During the tour of the home on January 19, 2016, at 1000 hours, numerous unlabeled soiled personal care items were observed in the tub rooms on the Meadowvale home area: one jar of used unlabeled petroleum jelly, an unlabeled toothbrush (unclear if used or new), two dirty unlabeled nail clippers, a tube of toothpaste, and a dirty unlabeled disposable razor on the shelf above where the slings were stored. New items and soiled items were stored together in the basket/on the cart. At 1421 hours, on January 19, 2016, the items identified above were still on the team care carts/in the basket. Additional items were observed including a soiled unlabeled hair pick, a soiled hair brush belonging to a specific resident, a soiled unlabeled black comb, a soiled electric shaver (dirty and top open in the communal cart), a dirty unlabeled disposable razor, a hair band, jewelery, an unlabeled soiled pink hair brush, an unlabeled stick deodorant, and an unlabeled blue soiled comb. PSW #131 confirmed that those items should have been labeled and stored in the resident's room or discarded. The PSW stated that the nail clippers should go into the box for sterilization after use. Not all staff participated in the infection prevention and control program in relation to the storage and use of personal care items. [s. 229. (4)]

2. The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program.

The home's policy and procedure called "Personal Care Ware", #06-02, revised November 2015, directed staff to ensure that all personal ware for residents was labelled with the residents' name and/or room number, including but not limited to, basin, cup, denture cup, and personal care products. The policy also directed staff to ensure that all personal ware was not placed on the floor.

When touring the Howland, Dundas and Trafalgar units the LTC Inspector identified nail clippers in spa rooms which were not labelled with the residents' name and/or room number, and there was a bedpan on the floor in the spa tub room in the Dundas unit. In addition, on the Dundas unit in room #234, there were unlabelled toothbrushes in the shared washroom and a urinal on the bathroom floor, in room #212 there was a soiled urine measuring container turned upside down on the bathroom floor. PSWs #107, #108 and #109 were interviewed and confirmed that the residents personal care items were expected to be labeled and the urine measuring hat in the resident's bathroom should not be left on the floor. [s. 229. (4)]

3. The licensee failed to ensure that all staff participated in the implementation of the infection control and prevention program.

Staff did not participate in the implementation of the home's infection control and prevention program when they failed to comply with directions contained in the home's policy identified as "Sanitization/Risk Management - Personal Care Ware" located in the Infection Control Manual under Tab 06-02 and dated March 2014. This policy directed that staff were to ensure that all personal ware was labeled with the resident's name and that personal ware was not to be placed on the floor.
a)Staff did not participate in the home's infection control and prevention program when it was noted during a tour of the home on January 19, 2015, that personal ware was stored on the floor. In the Derry home area a slipper bedpan, urine collection hat, and urinal were noted to be stored on the floor in the shower room. It was also noted that a slipper bedpan was stored on the top of the toilet tank in the washroom in room #311 and a wash basin was noted to be stored on the floor in the bathroom in room #329.

b)Staff did not participate in the home's infection control and prevention program when it was noted during a tour of the home on January 19, 2015, that unlabeled large nail clippers, soiled with nail clippings, were stored in a large plastic container in the shower room on the Derry home area. Registered staff #112 confirmed that there were no directions for the cleaning and disinfection of common use nail clippers after they had been use to clip a resident's nails, but staff would be expected to follow a standard cleaning and disinfecting protocol. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r. 229(4) The licensee shall ensure that (4) all staff participate in the implementation of the program, to be implemented voluntarily.

WN #18: 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 failed to ensure that a Personal Assistive Device with the effect of limiting or inhibiting a resident's freedom of movement in which the resident was not able to release themselves from met the requirements prior to the device being included in the resident's plan of care.

Resident #041 was noted on an identified date in January 2016, to be sitting in a small lounge area seated in a wheelchair that had a front fastening "push" open type safety device applied. Registered staff #120 and clinical documentation confirmed that the safety device was being used as a Personal Assistive Service Device (PASD) to assist with positioning. Registered staff #120 and clinical documentation confirmed that alternatives to the use of the front fastening safety device PASD were not considered, or tried where appropriate as is required prior to this intervention being included in resident #041's plan of care. [s. 33. (4) 1.]

WN #19: 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 failed to ensure that the resident received fingernail care, including the cutting of fingernails as frequently as required.

Resident #042 was observed with very long fingernails on an identified date in January 2016. The resident stated they felt their nails were too long and needed to be cut. The home's policy, "Spa, (Shower, Tub Bath, Sponge Bath)", dated February 2014, directed staff to provide nail care (feet and hands) after bathing and stated a registered team member would provide nail care to diabetic residents. Registered staff #116 stated that the resident was diabetic and required registered staff to trim the resident's nails on bath days. Flow sheets, where staff would record when the resident had their nails trimmed, identified the resident had nail care provided once in January 2016, and did not indicate that nail care was offered to the resident again prior to a second identified date in January 2016. Registered staff #116 stated the resident's fingernails grew quite fast and confirmed the resident's nails were long and required cutting on January 21, 2016. [s. 35. (2)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids. O. Reg. 79/10, s. 37 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident received assistance, if required, to use personal aids.

Resident #030 was moderately impaired and had two pairs of eyeglasses in their room. The resident's most recent Resident Assessment Instrument-Minimum Data Set (RAI-MDS) conducted in December 2015, identified that the resident had impaired vision and no visual appliances. The written plan of care identified the resident had vision loss. Staff #101 reviewed the RAI-MDS assessments in 2014, and 2015, which confirmed the resident's vision impairment and no documentation related to visual appliances. Staff #140 was interviewed and confirmed the resident had eye glasses in their room, and the SDM had instructed the staff to put the resident's eye glasses on for meals and then place them back in the eye glass case and put on the top shelf in the resident's room. Staff #116 and #141, both regular care providers to the resident, were not aware the resident wore glasses and did not know about the SDMs instructions regarding the resident's eye glasses. The written plan of care was reviewed and there were no interventions that directed staff to assist the resident to use their eye glasses. [s. 37. (2)]

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

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Resident #054 had a fall on an identified date in November 2014, and sustained an injury. The review of the health records indicated that the fall with an injury was not reported to the Director within one business day after the occurrence. The Critical Incident Report (CI) was submitted to the Director on an identified date in November 2014, a total of six days after the incident occurred. The Interim DONC confirmed that the home should have reported the incident within one business day of its occurrence. [s. 107. (3) 4.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that protected the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy.

During an observation of the medication administration by RPN #132 on January 22, 2016, on the Dundas home area, the LTC Inspector found three eye drop medications in the medication cart with no open dates. The home's policy called "Eye Ointment and Drops - Instillation, dated May 2014, indicated that the procedure in the home was to "ensure all eye drop and ointments indicate the date they were opened and are not used for more than six weeks. If drops or ointment have been opened for one month discard and use a new tube unless otherwise indicated". RPN #132 confirmed that the eye drops should have had open dates on them. RPN #132 immediately discarded the eye drops, opened new ones and added the open dates. The home failed to ensure that the drugs were stored in a medication cart that maintains efficacy of the drug. [s. 129. (1) (a)]

Issued on this 26th day of February, 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

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) :	SAMANTHA DIPIERO (619), DARIA TRZOS (561), KATHLEEN MILLAR (527), MICHELLE WARRENER (107), PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2016_449619_0002
Log No. / Registre no:	001026-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 26, 2016
Licensee / Titulaire de permis :	Schlegel Villages Inc 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF ERIN MEADOWS 2930 Erin Centre Boulevard, MISSISSAUGA, ON, L5M-7M4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ash Agarwal

To Schlegel Villages Inc, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 complete the following:
1. Conduct and document the results of a mattress audit indicating which beds have mattresses that easily slide side to side on the deck of the bed while the bed rails are down or in the transfer position. For those that easily slide side to side, secure the mattresses (either by equipping the bed with mattress keepers or replacing the mattress with a heavier style of mattress). In completing this audit the home is to begin with those beds where one or more bed rails are used by residents assessed as high risk for entrapment. The remaining mattresses with safety concerns shall be addressed by April 25 2016.
2. Conduct and document the results of an audit of the air surfaces being used in the home in relation to possible entrapment risk. Develop and implement a regular preventative maintenance program for all air surfaces in use in the home.
3. Develop and implement an assessment tool for assessing residents for bed rail use and bed rail safety concerns incorporating the guidelines identified in the document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003".
4. Assess all residents who are identified as requiring air surface, in accordance with the manufactures requirements, in order to determine the appropriate surface blower setting and ensure those setting requirements are identified in each resident's plan of care and are easily accessible to staff providing direct care to residents.
5. Bed safety education shall be provided to all staff who provide care by April 25, 2016. The education at a minimum shall include information related to bed entrapment zones 1-4, when to apply bed rails, how staff will be informed as to when to apply bed rails, how to recognize when a bed is unsafe, how and when to report bed safety concerns, how residents are assessed for bed rail use and how to apply any entrapment zone interventions if necessary.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used, the residents were assessed, his or her bed system was evaluated in accordance with prevailing practices practices, and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, in relation to the following: [15(1)(b)]

a)The licensee failed to ensure when bed rails were used, all bed systems were evaluated in accordance with prevailing practices.

During the inspection, 16 bed systems were identified to be equipped with a therapeutic surface that were not measured for entrapment zones 2-4 due to the soft and compressible nature of the mattress. According to prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003", (developed by the US Food and Drug Administration and adopted by Health Canada), air mattresses without side wall reinforcement fail zones 2, 3 and 4 which are associated with gaps in, under, and around the bed rail. Residents who use one or more bed rails and who occupy a bed system with a therapeutic mattress must be clinically assessed for safety and entrapment risks associated with the use of bed rails and interventions implemented to reduce those risks. On an identified date in January 2016, staff #129 and the LTC inspector observed three of the 16 bed systems and the plans of care for the residents using the beds. All three residents were confirmed to use one or more bed rails as a care intervention.

Resident #071's bed system with bed frame labelled #125 identified as an "Other Air" air surface with a full bed rail on the right side and a half bed rail on the left side was reviewed. The air surface was easily compressed with upper body pressure to almost the bed frame deck, creating potential entrapment zones for the resident. Staff #129 checked the blower providing air to this surface and found the filter to be completely clogged with dust/lint which negatively affected the performance of the blower and resulted in the surface malfunctioning.

Resident #067's bed system was equipped with an "Other Air" air surface and one assist bed rail. The air surface was easily depressed with upper body pressure nearly to the bed frame deck, creating potential entrapment zones for the resident. Staff #129 checked the blower providing air to this surface and found the filter to be completely clogged with dust/lint which negatively affected the performance of the blower and resulted in the surface malfunctioning and creating a potential risk for entrapment.

Resident #046's bed system was equipped with a "Zephaire" and two bed rails. The air surface was easily depressed with upper body pressure, nearly to the bed frame deck, creating potential entrapment zones for the resident. Staff #129 checked the blower providing air to this surface and found the filter to be completely clogged with dust/lint which negatively affected the performance of

the blower and resulted in the surface malfunctioning and creating a potential risk for entrapment.

15(1)(a) The licensee failed to ensure that where bed rails were used residents were assessed in accordance with prevailing practices.

According to prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003", (developed by the US Food and Drug Administration and adopted by Health Canada), residents are to be evaluated by an interdisciplinary team over a length of time while in bed, by answering a series of questions to determine if the bed rail is a safe device for resident use. The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would include the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessor in making a decision, with either the resident or by the resident's Substitute Decision Maker (SDM), about the necessity and safety of a bed rail (medical device). The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

Staff #111, #130, #116 and clinical documentation confirmed that at the time of the inspection the home had not developed or implemented an assessment in accordance with the above noted prevailing practices to be used when the use of bed rails were being considered as a care intervention for residents. Staff #111 confirmed that they were unaware of the prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Staff #130 and #116 confirmed that the assessment staff in the home used was the Personal Assistive Devices/Restraint assessment which did not meet the requirements for assessment of a resident when bed rails are used. Fourteen random residents were reviewed, staff #120, #130, #116 and clinical documentation confirmed that

these 14 resident's plans of care directed staff providing care to use bed rails when the resident was in bed. (Residents reviewed included: resident #041, #064, #065, #066, #067, #068, #008, #069,#070, #071, #043, #046, #025 and #072). Staff #120, #130 and #116 confirmed that none of the fourteen residents reviewed where assessed according to prevailing practices prior to implementing the use of bed rails as a care intervention.

c)The licensee failed to ensure steps were not taken to prevent entrapment, taking into consideration all potential entrapment zones.

During stage one of the home's Resident Quality Inspection it was noted by LTC Inspectors that several of the mattresses in use slid easily from side to side on the bed frames. LTC Inspector #527 specially identified that resident #010's mattress was sliding, there were no mattress keepers and the resident's bed was equipped with a quarter bed rail in the rasied position on the left side of the bed. The resident was interviewed and they stated that the bed rail was always up so that when they sat on their bed the mattress would not slide off the frame. The Facility Entrapment Inspection Sheet was reviewed for December 2015, indicated that the resident's bed system had failed for zones 2, 3, and 4.

Confirmation from Staff #129 and results from a bed system audit completed on two identified dates in December 2014, indicated 59 bed systems failed to pass one or more entrapment zones. The reason for failures of the majority of these beds related to the beds not being equipped with mattress keepers resulting in the mattresses sliding from side to side on the bed frame deck. Staff #129 and the results from the bed system audit completed on an identified date in December 2015, indicated that 41 bed systems failed to pass one or more entrapment zones. Staff #129 confirmed that after the mattresses failed the bed system audit, the home did not intervene in any way to make their beds safer and confirmed that no bolsters or mattress keepers were installed. A review of each bed system that failed to pass during the December 2014 audit and the December 2015, audit indicated that 37 of the same beds that failed during the December 2014 audit continued to fail the same zones of entrapment during the December 2015 audit. Staff #129 confirmed that corrective action was not taken to eliminate the risk of bed entrapment for the 37 residents in the identified beds that continued to fail over the course of a year. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 24, 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
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 26th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Samantha Dipiero

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