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

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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 24, 2016	2015_449619_0010	H-0033096-15	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 SANDALWOOD PARK
425 Great Lakes Drive BRAMPTON ON L6R 2W8

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

SAMANTHA DIPIERO (619), DARIA TRZOS (561), KATHLEEN MILLAR (527), MICHELLE WARRENER (107)

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): November 30, 2015, December 1-4, 8-11, 14-18, 21, 2015

The following complaint inspections were completed along with the RQI: 005851-14, 009398-14, 003443-15, 021982-15, 023272-15

The following Critical Incident inspections were completed along with the RQI: 008191-14, 000751-15, 00981-15, 001593-15, 001714-15, 004199-15, 004605-15, 005606-15, 033408-15, 028505-15, 002846-15

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Director of Nursing Care (DOC), Social Worker (SW), Behavioural Support Ontario Nurse (BSO), Administrative coordinator, Administrative Assistant, Kinesiologist, Registered Dietician (RD), Family Council Spokesperson, Resident Council Spokesperson, Manager of Facilities, Activation staff, Registered Staff including Registered Nurses (RN) and Registered Practical Nurses (RPN), and unregistered staff Personal Support Worker (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
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.
- **18 WN(s)**
- **10 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, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A bed entrapment audit was completed on November 12, 2015, by an outside agency. Sixty two of 69 beds tested with rails failed at least one entrapment zone for zones 1-4 and only 17 beds were identified with mattress keepers or rail caps.
New mattresses were ordered December 4, 2015, when concerns over resident safety were brought to the home's attention. Action was not taken to mitigate potential entrapment or safety risks to residents between November 12 and December 4, 2015.

Resident #017 had two rails raised on their bed. Staff confirmed the rails were raised when the resident was in bed. The bed did not contain a foot board and mattress keepers were not in place. The Long Term Care Home (LTC) Inspector noted a large gap between the head board and the mattress and the mattress was sliding down the bed frame (no foot board or mattress keeper was in place at the end of the bed). The Inspector was able to slide the mattress side to side creating a large gap between the bed rail and the mattress. Staff confirmed resident #017 had significant movement while in bed, and required assistance with bed mobility, creating a potential risk for the resident. The bed entrapment risk audit completed November 12, 2015, identified that the bed had no foot board and had an entrapment risk in zones 4 and 7. Action was not taken until December 4, 2015, when it was identified by the LTC Inspector.

Resident #020 had an assist rail in the raised position on their bed. Staff confirmed the rail was raised when the resident was in bed. The mattress was too short to fit within the

mattress keeper on the bed and the Inspector was able to easily slide the mattress side to side and off the bed. The resident was independent with mobility and would often throw themselves onto the bed from a standing position, creating a potential risk to the resident from the mattress sliding around or off the bed and creating a large gap between the rail and the mattress. The bed entrapment risk audit completed November 12, 2015, identified the mattress was too short, had no mattress keepers, and had entrapment risks in zones 2, 3, 4 and 7. Action was not taken immediately to mitigate the risk to the resident until it was identified by the LTC Inspector.

Resident #022 had two rails in the raised position. The resident confirmed they used the rails for positioning and were raised when the resident was in bed. The mattress on the bed was too large and extended over the mattress keeper on the bed, creating the potential for the mattress to move on the frame, creating potential entrapment zone failures. The bed entrapment risk audit completed November 12, 2015, identified an entrapment risk in zones 2 and 3. [s. 15. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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 an identified date in 2015, between 1130 hours and 1215 hours on the Cumberland 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. The registered staff had indicated that this was the current process in the home; previously they had separate bins to throw the empty pouches in but this had been changed. The DOC was interviewed and confirmed that the empty medication pouches should have been separated and placed in a small bin that was provided to each home area and water should have been used to denature them in a way that would remove any 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

On December 15, 2015 at approximately 1200 hours, LTC Inspector observed the medication pass on the Cumberland home area. It was observed that the registered staff

used the assistance of resident #007's family to assist in the provision of care. Staff interviewed identified that the resident was resistant to the care and for that reason family provided assistance. The written plan of care was reviewed and did not include this intervention for the resident. The DOC confirmed that this should have been included in the written plan of care. The home failed to ensure that the plan of care set out the planned care for this resident. [s. 6. (1) (a)]

2. The licensee failed to ensure that the resident was provided the opportunity to participate fully in the development and implementation of their plan of care.

Resident #022 had a Cognitive Performance Scale (CPS) of 1/6 at the last Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment. During interview with the LTC Inspector on December 1, 2015, resident #022 identified they did not feel they were included in decisions about their care. The resident also voiced concerns to the LTC Inspector about their medications affecting their quality of life.

Documentation in the resident's clinical health record indicated the Physician spoke to the resident on December 10, 2015, regarding the concerns with their medications and the Physician wrote an order to decrease the medication. A progress note was written the same day stating that the resident's Substitute Decision Maker (SDM) was called and disagreed with the decrease in medication and the medication change was cancelled. On December 15, 2015 (five days later) registered staff confirmed the cancellation of the medication changes was not communicated or discussed with the resident.

Multiple registered staff interviewed did not have a clear understanding of when the SDM document applied and the need for involvement of the resident in daily care decisions, as applicable.

Information on the resident's six week care conference identified the resident's SDM was invited and attended the meeting; however, documentation did not reflect the resident was invited to attend the meeting. The person who scheduled the meeting stated the resident was invited and chose not to attend; however, there was no documentation to support this. [s. 6. (5)]

3. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-

maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A)The progress notes indicated that resident #052's skin was beginning to breakdown. The progress note indicated that the area identified had deteriorated into stage 2. A review of the progress notes and interview with the Neighbourhood Coordinator indicated that the Power of Attorney (POA) was not notified of the resident's pressure wounds. The health records confirmed that the family was not given an opportunity to participate fully in the development and implementation of the resident's plan of care.

B)The review of the health records indicated that resident #052 received the wrong dose of a medication for pain, The order was obtained from the physician via telephone prior to administration. RPN #155 left a message for the POA with the new order. The progress notes and investigation notes indicated that the treatment was not discussed with the POA prior to administration. The investigation notes and the interview with the Neighbourhood Coordinator confirmed that the POA should have been contacted for consent prior to administering the medication. The home failed to ensure that the POA was given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

4. 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.

On November 30, 2015, resident #020 was observed to have some poorly groomed and untrimmed nails while ambulating in their living area. The staff confirmed that the resident did not have all of their nails trimmed. Staff confirmed that the resident's family trimmed the resident's nails on occasion however, the resident's plan of care states that they were to have nails trimmed on bath days twice weekly. The DOC confirmed that staff did not comply with the residents written plan of care. [s. 6. (7)]

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

Resident #010 had a plan of care that required staff provide a specialized textured entree at meals to maximize intake and tolerance. At the lunch meal on November 30, 2015,

the resident was provided pureed grilled cheese, pureed Waldorf salad, soup and cranberry juice. The entree items were not prepared as required prior to providing them to the resident. The resident did not consume the meal.

Resident #010 had a plan of care that required staff to modify the resident's pudding with milk at snack time. Staff assisting the resident with the afternoon snack on December 9, 2015, stated they used juice to modify the resident's pudding.

The care set out in the plan of care for resident #010 was not provided to the resident as specified in the plan. [s. 6. (7)]

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

On December 3, 8, 10,18, 2015, resident #058 was observed seated in their wheelchair in a room. LTC Inspector observed PSW staff on the dates above conducting observations of the resident while seated behind the nursing station. PSW #107 stated that they "look to see if the resident is okay" but did not physically go and check on or offer assistance at regular intervals. A review of the plan of care last updated in November 2015, stated that the resident was to receive close observation every thirty minutes. The General Manager of the home stated that a close observation would be done in person and not seated from far away to ensure that the resident was safe and that their needs were met and confirmed that the care was not provided as specified in the plan of care. [s. 6. (7)]

7. 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 #047 was determined to be capable of decision making and participating fully in their plan of care, and had a Cognitive Performance Scale (CPS) score of 1/6 and a Mini Mental Status Exam (MMSE) score of 30/30. The written plan of care stated that the resident was capable of determining when and when not to include their substitute decision maker in decision making or informing them of any incidents that occurred within the home as per their preference. In May 2015, following an aggressive responsive behaviour episode, resident #047 was prescribed a medication. The resident received this medication on three occasions. A few days later, the resident was observed by registered staff as being fatigued and having an unsteady gait; in response to these findings the homes physician reduced the resident's medication. An interview with

registered staff #110 confirmed that on three occasions, the residents’ substitute decision maker (SDM) requested that the medication be held and registered staff complied with this request without assessing or consulting the resident. An interview with the home's DOC confirmed that the resident was determined to have the capacity to consent or refuse treatment as they felt appropriate and that the SDM would be included in decisions surrounding the plan of care with the resident's consent. The DOC confirmed that the registered staff failed to consult with resident #047 in regards to withholding the medication and as such did not provide care that was specified in the plan of care. [s. 6. (7)]

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

Resident #032 was sent to the hospital with a specified diagnosis on five occasions over a 19 month period in 2014 and 2015. Registered staff member #123 confirmed that the resident had repeated episodes of the diagnosis which required treatment at hospital and remained an ongoing issue for the resident. Registered staff stated the last episode was only two months after the previous episode. The registered staff were able to identify specific symptoms the resident presented with on each episode and how to identify concerns related to the condition. The resident's plan of care was not revised to include direction for staff related to the resident's ongoing medical condition, including identification of signs and symptoms and action to take when symptoms were identified. Registered staff confirmed the information should have been identified in the resident's plan of care. [s. 6. (10) (b)]

9. 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.

Resident #050 was observed in a tilt wheelchair on December 11, 14, 15 and 16, 2015. The resident was unable to rise from the wheelchair. The resident's clinical record and plan of care were reviewed and identified the resident's health status had deteriorated. It was also identified that there was no documentation related to the resident using a Personal Assistive Services Device (PASD). The staff and the Kinesiologist were interviewed and confirmed that the resident's tilted wheelchair was considered a PASD based on the home's policies and procedures, and that the resident required this type of wheelchair as their health status had declined. The resident's family was interviewed and confirmed the resident's health had deteriorated and when the resident was up, they

required the tilted wheelchair for positioning. The plan of care was not reviewed and revised when the care needs for resident #050 had changed. [s. 6. (10) (b)]

10. 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, care set out in the plan was not effective.

Resident #046 had a continence assessment in June 2015, which identified the resident was usually continent for bowel and bladder. Then, in September 2015 the resident was reassessed for continence, which identified the resident was incontinent of bladder and occasionally incontinent of bowel. The PSW's were interviewed in December 2015 and confirmed the resident was always incontinent of bowel and bladder and wore a purple brief. The staff also identified they checked and changed the resident at least three times per shift and the resident was not toileted. The written plan of care directed PSW's to toilet the resident every two hours and that they wore a pull up; however it was determined that the resident was not toileted by staff and did not wear a pull up. The written plan of care was not reviewed and revised for resident #046 when the care set out in the plan was not effective. [s. 6. (10) (b)]

11. The licensee failed to ensure that when the resident was reassessed and the plan of care was revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

Resident #010 had a goal for weight maintenance within a goal weight range of 42-52 kilograms (kg) identified on their plan of care. The resident was assessed by the RD in relation to a significant weight loss of 6.4% over one month. Alternative approaches were not considered and the plan of care was not revised at that time. The referral was signed as completed by the Registered Dietitian stating, no change. A progress note dated , identified, "increasing the resident's supplement may not be effective"; however, alternative strategies were not considered in revision of the resident's plan of care and in relation to the goal identified for weight maintenance within their goal weight range (resident fell below this range in 2013).

The resident had continued weight loss between May 2015 and November 2015 (21.2% over six months). The Registered Dietitian assessed the resident in October 2015, and identified a significant weight loss over six months (13.8%) and noted the resident was below their goal weight range of 42-52 kg. Food and fluid intake records for

September 2015, identified the resident did not meet their estimated fluid requirement on 22/30 days (73%) and 10/19 (53%) days prior to the assessment in October. The resident's plan of care was not revised in October 2015, in relation to the progressive weight loss, weight less than their target weight range, and suboptimal fluid intake. The Registered Dietitian identified the resident was on comfort measures; however, documentation did not reflect the resident was palliative and did not want additional measures initiated. Registered staff confirmed during interview that the resident was not currently and had not been on palliative status during that time. Nutritional strategies had not been revised since prior to May 2015, despite a 21.2% significant weight loss over six months. [s. 6. (11) (b)]

12. The licensee failed to ensure that when the resident was reassessed and the plan of care was revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care in relation to hydration.

Resident #013 had a plan of care in place that identified an estimated daily fluid requirement of 1185 - 1422 milliliters (mL). The resident was referred to the Registered Dietitian in January 2015, for poor fluid intake over three days with signs of dehydration. The Registered Dietitian reviewed the resident in relation to hydration and stated that the resident was already on interventions to promote hydration and to continue with the current interventions as they were effective. Different approaches to address the poor hydration had not been considered in the revision of the resident's plan of care at that time.

On two specific days in February 2015, the resident experienced constipation and poor fluid intake over three days with signs of dehydration (dry lips). Food and fluid intake records reflected the resident had poor hydration on 11/12 days (average 763 ml/day) during the second half of February. The progress note stated staff were to encourage fluids and to continue monitoring the resident. Documentation during those two weeks did not reflect that alternative approaches were considered to promote hydration.

The resident did not meet their estimated daily fluid intake on 67/77 (87%) of days for about 6 weeks between September and October 2015, with average fluid intakes of 800-900 mL fluids daily and numerous days less than 1000 mL per day. The resident was reviewed by the RD on November 16, 2015, without a revision to the resident's fluid goal or change to the interventions on their plan of care for hydration. The hydration was noted to be less than target but the plan was to continue with the same strategies as the resident did not exhibit signs of dehydration. The resident's plan of care related to hydration had not been

revised in 2015 with the resident not meeting their hydration target on most days. Different approaches were not considered in the revision of the plan of care related to hydration to enable the resident to reach their target fluid intake. [s. 6. (11) (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. 6(1)(a), s. 6(2), s. 6(5), s. 6(7), s. 6(10)(b), and s. 6(11) (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 required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

The home's policy, "Nutrition and Hydration", revised April 2014, stated, "Any resident who has a fluid intake less than their estimated fluid requirements will be reported to the oncoming RPN/RN so that interventions can be initiated. The RPN/RN will assess signs and symptoms of dehydration (Dehydration Risk Assessment Tool)."

Resident #013 did not meet their estimated daily fluid requirement, (identified on the resident's plan of care), for 67/77 days (87%) for about ten weeks between September and November 2015. The resident was not assessed for signs and symptoms of dehydration using the "Dehydration Assessment Tool" during that time. Staff confirmed that the Dehydration Assessment Tool would be located on a paper copy in the resident's chart and confirmed that there were no Dehydration Assessment Tools completed during that time frame. Staff did not follow the home's policy in relation to the assessment of hydration when resident #013 was below their estimated daily fluid requirement.

Resident #010 did not meet their estimated daily fluid requirement, (identified on the resident's plan of care), for 58/91 days (64%) for about ten weeks between September and November 2015, with multiple consecutive days of poor fluid intake below the resident's target. Registered staff confirmed the resident was not assessed for signs and symptoms of dehydration using the "Dehydration Assessment Tool" during that time. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with 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, (b) 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.

On November 30, 2015, at 1130 hours, on the secure home area of Saunders, doors leading to two soiled utility rooms had keypad locks on the doors; however, the doors did not lock and were left unrestricted to residents. PSW staff interviewed stated the locks were no longer in working order.

On November 30, 2015, at 1030 hours, on Cumberland home area, the door to the servery area was left unlocked and ajar. One bottle of powder cleaner with bleach and one bottle of spray cleaner were left accessible to residents in an unlocked cupboard in the servery area. Staff confirmed the area was supposed to be locked when unsupervised to prevent resident access to the area by residents. [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 with 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. 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 the use of a PASD under subsection (3) to assist a resident with a routine activity of living was included in the resident’s plan of care only if the plan of care provided for everything required under subsection (5).

Resident #050 had a change in care needs which required the home to implement a tilted wheelchair for positioning and comfort in November 2015. The staff confirmed the tilted wheelchair was a personal assistance service device (PASD). On review of the residents record it was determined that there was no assessment for the use of a PASD, no PASD approval, no consent for the PASD and the PASD was not included in the resident's plan of care as expected according to the home's policy and procedures; this was confirmed by the home’s DOC. The policies called "Mechanical Lifts", number 04-66A and revised February 2013, and the policy called "Restraint & PASD Procedures", number 04-52 and revised January 25, 2015, was not complied with. [s. 33. (4) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with section 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.
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.
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.
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.
5. The plan of care provides for everything required under subsection (5), to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting the resident.

Resident #050 was transferred using a two man pivot and when they had difficulty weight bearing, a mechanical lift was implemented. The resident was transferred using the mechanical lift on a specified date in 2015. On the identified date the resident sustained a fall during the course of the transfer with the lift. The staff of the home were interviewed and confirmed that the procedure for using the lift was not completed as required resulting in the incident; the level of injury sustained by the resident was unknown as the resident died three weeks later due to unrelated causes. The homes investigative notes were reviewed and identified that the PSWs did not work as they were expected to, or in accordance with the home's policy, procedures, and training for mechanical lifts. The staff did not use safe transferring techniques which resulted in the resident falling. [s. 36.]

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. 36 Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

The Neighbourhood Coordinator and RPN #124 for the Elliott home area confirmed that residents had their height measured once on admission to the home. Annual heights were not consistently available for stage one of this Resident Quality Inspection and staff had difficulty finding the information from admission forms. Some examples from the week of November 30, 2015, (not inclusive of all residents with outdated weight measurements):
Resident #017 did not have a height recorded for 10 years (height provided by staff was dated 2005).
Resident #020 did not have a height recorded for nine years (height provided was dated 2006).
Resident #010 did not have a height recorded for 12 years (height provided was dated 2003).
Resident #014 did not have a height recorded for five years (height provided was dated 2010).
Resident #013 did not have a height recorded for four years (height provided was dated 2011).
Resident #012 did not have a height recorded for two years (height provided was dated 2013).

A "Facility Height" report, printed December 10, 2015, still identified 49 heights not available in the home's computer system and seven weights more than one year old. The home's policy, "Weight & Height Monitoring", revised August 2015, directed staff to measure residents' weight annually. The Neighbourhood Coordinator for the Elliott home area and the DOC confirmed that not all residents had their height measured annually. [s. 68. (2) (e) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r. 68 Every licensee of a long-term care home shall ensure that the programs includes a weight monitoring system to measure and record with respect to each resident, and weight taken on admission and monthly thereafter, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).**

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

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

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

At the observed lunch meal November 30, 2015, a meal of soup, pureed grilled cheese, and pureed Waldorf salad was plated and covered with saran wrap and placed on-top of the covered steam table for resident #010 who was to eat at the end of the meal service. The lunch meal was plated prior to 1250 hours and the meal was served to the resident at 1320 hours. The pureed grilled cheese was probed at 114 degrees Fahrenheit (F) and the pureed soup was probed at 134 degrees F. The home's policy, " Food Temperature Control", dated February 2015, directed staff to serve hot foods at more than 140 degrees F. Staff did not reheat the food prior to serving the food to the resident who was unable to voice their meal preference. Resident #010 had a history of significant weight loss and was at high nutrition risk. [s. 73. (1) 6.]

2. The licensee failed to ensure that the resident was provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Resident #013 had a plan of care that directed staff to provide supervision to limited assistance with eating, and to provide frequent redirection and cueing during meals. During the lunch meal served on November 30, 2015, the resident was observed playing with their food (placing it on the table, mixing it, stacking it) and not eating until 1257 hours. A family member of another resident at the table assisted the resident with eating for a short time at 1245 hours, when they noted the resident not eating. The resident then sat with their food in front of them again, not eating, until staff came to assist the resident at 1257 hours. The resident appeared confused and unclear what to do with their food when questioned by the Inspector. The resident did not receive the level of assistance, cueing and redirection at meals as identified in their plan of care. [s. 73. (1) 9.]

3. The licensee failed to ensure that proper techniques were used to assist residents with eating.

On November 30, 2015, staff assisting residents #017, #041, #042, #043 with eating were mixing their pureed foods together either on the plate or on the spoon prior to feeding the residents. Staff assisting resident #041 mixed their pureed food together on the plate. Staff stated the resident did not like the Waldorf salad so they mixed the pureed grilled cheese (hot item) with the Waldorf salad (cold item) and the resident would eat it. The resident told the Inspector they did not like their food mixed together. Mixing

the resident's food together was not included on their plan of care.

Staff assisting resident #043 stated they were mixing pureed Waldorf salad (cold item) and pureed grilled cheese sandwich (hot item) on the same spoon for the resident but no rationale was given for doing this. Staff confirmed they were not to mix pureed foods together. The resident was unable to voice their preferences to the Inspector and mixing food was not included as part of the resident's plan of care.

Staff assisting resident #042 with eating were placing large amounts of food onto the spoon while feeding the resident. The staff then used the spoon to scrape the resident's mouth as food was on their face or coming out of the resident's mouth. A napkin was not used to wipe the resident's face. The resident was turning their head away from the staff assisting them with eating and the staff member continued to pour the glass of fluids, resulting in thickened fluids running down the resident's face and staff used the edge of the glass to scrape the fluids off the resident's face. Proper techniques were not used for assisting the resident with eating.

Staff assisting resident #043 were using the resident's nosey cup incorrectly when feeding the resident. The opening was placed on the side instead of over the resident's nose to allow the cup to be tipped further back.

The licensee failed to ensure that proper techniques were used to assist residents with eating at the observed snack pass on December 9, 2015. Staff assisting resident #064 with eating appeared to be rushing the resident. The resident had not finished swallowing one bite before the next spoonful was presented to the resident and staff were scraping the resident's mouth with a spoon instead of using a napkin. Proper techniques were not used to assist the resident with eating. [s. 73. (1) 10.]

4. The licensee failed to ensure that the resident, who required assistance with eating or drinking, was only served a meal when someone was available to provide the assistance.

Resident #017 was served their dessert prior to 1255 hours and prior to assistance being available. Staff were assisting another resident at the table and the resident's dessert sat on the table for over 15 minutes without assistance being provided. Another staff came and took the resident out of the dining room without their dessert being offered. Staff confirmed the resident had not been assisted with their dessert prior to being taken out of the dining room. The resident was then brought back into the dining room after

discussion with the Inspector. [s. 73. (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. 73(1)(6), r. 73(1)(9), r. 73(1)(10), and r. 73(2)(b), to be implemented voluntarily.

WN #10: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirement was met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff did not apply the physical device in accordance with any manufacturer's instructions.

Resident #063 was observed in a tilted wheelchair with a seat belt on November 30, 2015, and December 1 and 3, 2015. The Inspector was able to place two hands between the seat belt and the resident's torso. PSW #103 and registered staff #127 identified that they did not know what the manufacturer instructions were for the proper application of the seat belt or where to locate the instructions. PSW #103 also identified that they could not remember what the home's policy and procedure was for applying the seat belt properly. The home was unable to provide a copy of the manufacturer's instructions at the time of the inspection. Registered staff #127 confirmed that they were expected to apply the seat belt according to the manufacturer's instructions and in accordance with the home's policy and procedures. The staff failed to apply the resident's seat belt in accordance with the manufacturer's instructions. [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r. 110(1) Every licensee 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: That staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that a resident taking a combination of drugs was monitored and documented upon in regards to the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

On August 11, 2015, resident #059 was ordered medication to be taken once daily in addition to receiving other medications. After receiving a drug to drug interaction warning via fax from the pharmacy provider a few days later, an order for weekly electrolyte assessment to monitor levels of medication in the resident was completed by the on call physician on the same day. The resident was scheduled to have weekly blood work completed on four consecutive weeks between August and September in 2015; however, this was not completed. Interview with registered staff #122 confirmed that the resident was not placed on the list for blood work three times and only had two out of a possible six blood work labs completed. An interview with the home's DOC confirmed that the staff failed to ensure that the resident, who was taking medication with the potential for harmful drug to drug interactions was monitored appropriately. [s. 134. (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. 134 (a) Every licensee of a long-term care home shall ensure that, (a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system was available at each bed location used by residents.

Residents #010, #017, and #014 did not have a resident to staff communication and response system available at each bedside on November 30, 2015. The residents had a bed alarm system; however, a communication system was not available at the bed side that could be activated when needed when the resident was not in bed. Staff confirmed that call bells were not consistently in place for residents that had bed alarms. [s. 17. (1) (d)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and their substitute decision maker within six weeks of the admission of the resident and at least annually thereafter.

Resident #037 was admitted to the home in November 2013. On review of the resident's records it was determined that the resident did not have an admission care conference within six weeks of admission to the home. It was also determined that the resident had not received an annual care conference thereafter, having no annual care conferences for both the 2014 and 2015 calendar year. It was determined that the home's administrative assistant was responsible for booking annual care conferences and during an interview stated that the February 2014, care conference was canceled due to the home being on outbreak, but was unable to provide any supporting documentation to show that the substitute decision maker (SDM) was notified of the conference or its cancellation. An interview with the home's DOC confirmed the home's policy titled "Care Conferences (Admission & Annual)" #04-18, last revised December 2013, stated that "The annual care conference will be scheduled to occur within six weeks of the residents admission, and annually thereafter as needed". The DOC confirmed that the resident and their SDM did not have the opportunity to fully participate in the development and implementation of the plan of care. [s. 27. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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 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 #050 had a tilted wheelchair implemented and it was confirmed that it was identified as a PASD. The home's policy called "Restraint & PASD Procedures in LTC", #04-52, last revised January 2015, identified that "the personal care assistant (PCA) will release the device and reposition the resident at least every two hours while the device is in use. Repositioning will be recorded on the Repositioning Record". A review of the resident's clinical record and the home's documentation indicated that there was no documentation related to the repositioning of the resident in the PASD. The PSW's/PCA's and registered staff were interviewed and confirmed there was no documentation related to the PASD and there was no repositioning record implemented for the resident. In addition, there was no PASD assessment, consent or or PASD approval documented for the resident. The Kinesiologist and registered staff were interviewed and confirmed there was no a PASD assessment, consent or approval documented for resident #050. [s. 30. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment tool specifically designed for skin and wound assessment.

On November 30, 2015, resident #020 was observed as having a wound. An interview with PSW #134 confirmed that PSWs were responsible for reporting any change in a resident's skin condition to registered staff so that a skin assessment was completed. An interview with registered staff #105 confirmed that they were not aware of the wound. Registered staff #105 stated that when an unwitnessed injury was found an incident report would be completed in addition to a referral to the skin and wound care nurse; registered staff #105 confirmed that this was not completed. On review of the resident's records it was determined that in relation to the wound there were no notations in the resident's chart, no skin and wound assessments were completed, and no incident report was completed. A review of the home's policy titled "Skin/Wound Care" policy #04-78, last revised January 9, 2015, stated that "any redness, bruises, open areas, rashes, scars etc., will be reported to the wound care nurse" and that "if there is a concern it will be documented using the twice weekly skin assessment form". An interview with the DOC confirmed that the staff did not follow the home's policy as it related to the bruise; no assessments or referrals or tracking were completed. The DOC confirmed that the resident did not receive a skin and wound assessment with a clinically appropriate skin and wound assessment tool. [s. 50. (2) (b) (i)]

WN #16: 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 was used exclusively for drugs and drug-related supplies.

On December 15, 2015, at approximately 1145 hours, on the Cumberland home area the LTC Inspector observed the lunch medication pass. The LTC Inspector found a ziplock bag with items that were not narcotic medications in the bottom drawer of the medication cart. The registered staff indicated that these items were stored for safe keeping. The DOC confirmed that the home did not meet the legislative requirement related to drugs being stored in a medication cart that was used exclusively for drugs. [s. 129. (1) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

The investigation notes and progress notes indicated that on an identified date in 2015, resident #052 received an incorrect dose of medication. RPN #134 took a telephone order for medication that morning for pain, and transcribed the order incorrectly. The interview with the DOC, Neighborhood Coordinator and the investigation notes confirmed that RPN #134 administered an incorrect dose of medication causing the resident to be drowsy and unable to participate in their activities of daily living for the remainder of the day. In review of the health records and interview with the DOC and Neighborhood Coordinator, it was confirmed that the home had followed the processes and procedures to ensure that appropriate actions were taken in response to this medication incident. The home failed to ensure that drug was administered to the resident as prescribed. [s. 131. (2)]

WN #18: 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 all staff participated in the implementation of the Infection Prevention and Control program.

During a tour of the home, unlabeled bottles of opened creams (petroleum jelly and Infazinc) were found in the spa rooms in the Cumberland, and Saunders home areas, two soiled unlabeled hair brushes were found in the Saunders spa room, and an unlabeled soiled hair comb and a soiled disposable razor were found placed on top of the mirror in the spa room in the Elliott home area. Staff confirmed that all items used for residents were to be labeled. [s. 229. (4)]

Issued on this 25th 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)
Inspection No. / No de l'inspection :	2015_449619_0010
Log No. / Registre no:	H-0033096-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 24, 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 SANDALWOOD PARK 425 Great Lakes Drive, BRAMPTON, ON, L6R-2W8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Zoie Mohammed

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. Re-assess all bed systems to determine if they passed zones of entrapment 1- 4. Refer to Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards".

2. Implement a system to keep track of all beds in the home, what size of bed rails are used, all the zones that were tested, whether they failed or passed, date of the audit that was completed and by whom.

3. Where bed systems have failed zones of entrapment 1- 4, the home shall mitigate immediately any entrapment risks to residents.

4. Develop a comprehensive bed safety assessment tool using as a guide the US Federal Food and Drug Administration document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".

5. An interdisciplinary assessment of all residents using the bed safety assessment tool shall be completed and the results and recommendations of the assessment shall be documented.

6. The home shall continue to re-assess the bed system and complete a comprehensive bed safety assessment when there is a change in a resident's condition, when a new resident is admitted to the home and when any parts of the bed systems are changed. Accurately document the results of any future bed assessments and continuously maintain the document when changes to the bed system occurs.

7. Update all resident care plans to include whether bed rails are used, how many, which side of the bed and the reason. Include the use of any interventions, such as bed accessories if the bed has not passed all entrapment zones.

8. Educate all staff that provide direct care to residents on bed safety, bed rail use and entrapment zones.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, steps were

taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A bed entrapment audit was completed on November 12, 2015, by an outside agency. Sixty two of 69 beds tested with rails failed at least one entrapment zone for zones 1-4 and only 17 beds were identified with mattress keepers or rail caps.
New mattresses were ordered December 4, 2015, when concerns over resident safety were brought to the home's attention. Action was not taken to mitigate potential entrapment or safety risks to residents between November 12 and December 4, 2015.

Resident #017 had two rails raised on their bed. Staff confirmed the rails were raised when the resident was in bed. The bed did not contain a foot board and mattress keepers were not in place. The inspector noted a large gap between the head board and the mattress and the mattress was sliding down the bed frame (no foot board or mattress keeper in place at the end of the bed). The Inspector was able to slide the mattress side to side creating a large gap between the bed rail and the mattress. Staff confirmed resident #017 had significant movement while in bed, and required assistance with bed mobility, creating a potential risk for the resident. The bed entrapment risk audit completed November 12, 2015, identified the bed had no footboard and had an entrapment risk in zone 4 and 7. Action was not taken until December 4, 2015, when it was identified by the LTC Inspector.

Resident #020 had a rail in the guard position on their bed. Staff confirmed the rail was raised when the resident was in bed. The mattress was too short to fit within the mattress keeper on the bed and the Inspector was able to easily slide the mattress side to side and off the bed. The resident was independent with mobility and would often throw themselves onto the bed from a standing position, creating a potential risk to the resident from the mattress sliding around or off the bed and creating a large gap between the rail and the mattress. The bed entrapment risk audit completed November 12, 2015, identified the mattress was too short, no mattress keepers, and had an entrapment risk in zones 2, 3, 4 and 7. Action was not taken immediately to mitigate the risk to the resident until it was identified by the LTC Inspector.

Resident #022 had a rail in the guard position against the wall and a rail in the transfer position on the other side of the resident's bed. The resident confirmed

they used the rails for positioning and were raised when the resident was in bed. The mattress on the bed was too large and extended over the mattress keeper on the bed, creating the potential for the mattress to move about on the frame, creating potential entrapment zone failures. The bed entrapment risk audit completed November 12, 2015, identified an entrapment risk in zones 2 and 3. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 16, 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 24th 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