Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 16, 2018	2018_546585_0013	007616-18	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 Tansley Woods
4100 Upper Middle Road BURLINGTON ON L7M 4W8

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

LEAH CURLE (585), LESLEY EDWARDS (506), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): April 18, 19, 20, 23, 24, 25, 26, 27, 30 May 1 and 2, 2018.

During the course of this inspection, the following additional inspections and inquiries were conducted:

Follow-up inspection log #028422-17 on compliance order (CO) #001 regarding Long-Term Care Homes Act (LTCHA) s.19. (1) duty to protect (issued in inspection report #2017_587129_0012 / 023882-17).

Complaint inspection log #025858-17 related to skin and wound care and continence care and bowel management.

Critical Incidents (CI) inspections:
CI log #004819-18/ CI # 2854-000003-18 related to resident to resident abuse.
CI log #005483-18 /CI # 2854-000006-18 related to resident to resident abuse.
CI log #006783-18/ CI # 2854-000007-18 related to transferring and positioning.

CI Inquiry log #008143-18 / CI #2854-000008-18 related to alleged staff to resident abuse.

Inspector Josee Snelgrove (674) was on-site training and shadowing during course of the inspection.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager (AGM), Director of Nursing Care (DONC), Interim Assistant Director of Nursing Care (ADNC), the Kinesiologist, Registered Dietitian (RD), Neighbourhood Coordinators (NC), Director of Environmental Services, Housekeeping staff, Resident Assessment Instrument / Quality Improvement (RAI/QI) Coordinators, the Food Services Manager (FSM), Dietary staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Aides (PCA), Residents and Residents' Family Members.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to:
meeting minutes, policy and procedures, investigative notes, menus and recipes, training information and clinical health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

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

- **15 WN(s)**
- **10 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_587129_0012	506

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

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

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (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 the plan of care set out clear directions to staff and others who provided direct care to the resident.

Resident #001's written plan of care was reviewed. Under the bowel focus, the plan indicated they were continent of bowel; however, also noted they were incontinent of

bowel. Registered staff #101 reviewed the written plan of care related to bowel continence and confirmed in an interview that it did not set out clear directions to staff and others who provided direct care to the resident regarding the resident's level of bowel continence [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A) Resident #001's plan of care was reviewed. The bladder and bowel function areas of the plan indicated the type of continence product they used. The home's continence management record (Tena Binder) including the Resident Profile Worksheet was reviewed and noted they used continence products that differed from what was noted in their plan of care.

Personal Care Aide (PCA) #125 was interviewed and reported the resident used specified continence products. PCA #125, #126 and registered staff #101 confirmed resident #001's plan of care was not based on the assessment of the resident and their needs and preferences related to continence.

B) Resident #002's clinical record was reviewed, including their Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment from December 2017. The assessment indicated they had a specified communication issue. The Resident Assessment Protocols (RAPS) were reviewed and noted that the above was an actual problem for the resident.

The resident was interviewed and the specified communication issue noted above was observed; however, their plan of care was reviewed and it did not include a care focus related to communication.

Registered staff #101 reviewed the resident's record and confirmed the communication problem as noted in the assessment and RAPS and that the information was not included in the resident's plan of care. Resident #002's plan of care was not based on the assessment of the resident and their needs and preferences related to communication.

C) Resident #008's clinical record was reviewed, including their RAI-MDS assessment from February 2018. The assessment indicated they had a specified communication issue. The RAPS were reviewed and noted that the above was an actual problem for the resident.

The resident was interviewed and the specified communication issue noted above was observed; however, their plan of care was reviewed and did not include a care focus related to communication.

Registered staff #101 reviewed the resident's record and confirmed the resident's communication problem as noted in the assessment and RAPS and that the information was not included in the resident's plan of care. Resident #008's plan of care was not based on the assessment of the resident and the resident's needs and preferences related to communication. [s. 6. (2)]

3. The licensee failed to ensure that 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 and are consistent with and complemented each other.

A) Resident #004’s RAI-MDS assessment completed in January 2018 was reviewed and noted they experienced specified levels of bladder and bowel incontinence. A Continence Evaluation also completed in January 2018 noted they were continent of bowel and bladder. In March 2018, their quarterly MDS assessment noted their continence level had not changed.

PCA #113 and #114 were interviewed and both reported the resident experienced a specified level of bladder incontinence. Review of a look-back report from during a specified period in April 2018, noted the resident experienced episodes of bowel incontinence. Registered Nurse (RN) #108 was interviewed and confirmed the resident's MDS assessments and Continence Evaluation were not consistent with or complemented each other.

B) Resident #001's clinical record was reviewed including their RAI-MDS assessment from December 2017 and it was noted that the resident experienced a specified level of bladder incontinence. This represented a change from their previous RAI-MDS assessment completed in September 2017.

The resident's continence assessment completed a specified date in December 2017 was reviewed and it was noted that the resident did not have any change in their continence since the last assessment. A request was made for the home to provide a copy of resident's prior continence assessment and registered staff #132 and #108

reported one was not available. Registered staff #101 confirmed the staff did not collaborate with each other in their assessment of resident #001's bladder continence so that their assessments were consistent with and complemented each other. [s. 6. (4) (a)]

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.

A) Resident #004's plan of care was reviewed and noted they were at risk for falls. Their written plan of care directed staff to provide assistance with transfers and noted the resident had a personal assistance services device (PASD). On a specified date in March 2018, an Alternatives To PASD/Restraint Assessment was completed and stated what the PASD was used for and recommended when the device was to be applied.

Post-fall assessments were reviewed and identified the resident experienced multiple falls in during a specified period in 2018 and noted falls were related to transferring without assistance and/or that their PASD was not applied as per the plan of care.

On an identified date in April 2018, the resident was observed and their PASD was not applied. PCA #109 was interviewed and reported the resident required assistance with transfers and used the PASD. PCA #109 confirmed the device was not applied. RN #110 was interviewed and stated the PASD was used for safety. RN #108 was interviewed and confirmed the resident required assistance with transfers and had a PASD. RN #108 confirmed the resident had experienced falls as a result of transferring without assistance and had been found with their PASD not applied. The Director of Nursing Care (DONC) was interviewed and confirmed the resident's written plan of care and Alternatives To PASD/Restraint Assessment stated that the device was to be applied.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan in relation to transferring and PASDs.

B) Resident #009 was identified as being at risk for falls. A review of the clinical record and documentation in the plan of care indicated that they were to have a multiple devices in place as fall intervention strategies. On a specified date in April 2018, the resident experienced a fall. As per the Falls Incident Report, it was documented that the specified devices were not in place at the time of the fall. The DONC was interviewed and confirmed that the care was not provided as specified in the plan as the resident. [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Resident #004's plan of care identified they were at risk of falls. During a specified period in 2018, the resident experienced multiple falls. On an identified date in March 2018, after experiencing a fall, staff documented one strategy as an intervention implemented to reduce the risk of another fall. Approximately one week later, after experiencing another fall, staff documented another new fall intervention strategy; however, at the time of the inspection; their plan of care did not include the two specified interventions.

RN #108 was interviewed and confirmed the two specified interventions were recommended, neither were in the included in the revised plan of care, and only one strategy had been implemented. The DONC was interviewed and confirmed when the resident was reassessed after experiencing falls, the plan of care should have been reviewed and revised to include the two interventions. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that the care set out in the plan of care is provided to the resident as specified in the plan and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with 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 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.

In accordance with O. Reg. 79/10, s. 48(1) 3, the licensee is required to ensure there is a continence and bowel management program developed and implemented. In accordance with O. Reg. s. 30(1), the licensee is required to ensure that each of the required programs under section 48 of this regulation have written policies, procedures and protocols.

The licensee's specified care policy, "Nursing- Care Manual, tab 04-26", last revised in December 2017, directed the nurse to complete and document in the progress notes a weekly assessment during device changes and included direction on what to inspect and document on when conducting the assessment.

A review of resident #008, #011 and #015's clinical records confirmed that the home was not documenting weekly assessments as per their policy. Interview with the DONC confirmed that the staff were not following the home's identified policy as part of the continence care and bowel management program.

The above noted non-compliance was identified during complaint inspection log #025858 -17. [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 and ensure 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 #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided with food and fluids that were safe, adequate in quantity, nutritious and varied.

Food Services Manager (FSM) #133 was interviewed and reported the home used a cornstarch-based thickener to thicken beverages, and beverages were expected to be prepared according to a document, titled "Tips for Thickening Liquids", which directed liquids be prepared using the following direction: stir measured liquid briskly with fork or wire whisk and gradually add measured thickener, stir immediately for 10 seconds, allow three to five minutes for liquid to reach desired consistency.

A) On an identified date in April 2018, a meal service was observed. Resident #037 was served fluid that appeared inconsistently thickened. An unlabelled container of thickener was observed in the dining room. No measuring spoon was present nor were instructions available on how to thicken beverages.

PCA #137 was interviewed and reported PCA's prepared thickened beverages at meal

service. PCA #137 stated they did not measure how much thickener they used when preparing thickened beverages. PCA #105 was later observed adding unmeasured amounts of thickener to resident #007's beverage. PCA #105 was interviewed and stated they estimated how much thickener to add when preparing thickened beverages.

Registered Dietitian (RD) #102 was interviewed and confirmed resident #007's beverage was not thickened appropriately as required in the resident's plan of care.

B) On an identified date in April 2018, a meal service was observed. Registered Practical Nurse (RPN) #131 was observed preparing thickened beverages for resident #005 and #037. RPN #131 was adding thickener into cups, adding fluid, stirring briefly and then serving the beverages immediately to the residents.

RPN #131 was interviewed and reported how they prepared thickened beverages. RPN #131 confirmed they did not allow the beverage to sit for three to five minutes and confirmed resident #005 and 007's beverages was not prepared to the consistency as required in their plan of care.

RD #102 was interviewed and reported information had not been accessible in the dining room for non-dietary staff on how to appropriately thicken beverages during meal service. RD #102 confirmed resident #005 and resident #037 required thickened beverages related to previously identified risk and history.

C) On an identified date in April 2018, a meal service was observed. Puree salmon was on the planned menu and served to residents. The puree salmon did not appear to hold its shape and noted to pool on plates when served. Dietary staff #130 confirmed puree salmon was pouring off the serving spoon. Dietary staff #129 was interviewed and confirmed they prepared puree salmon to nectar thick consistency. Dietary staff #129 confirmed the recipe for puree salmon stated to prepare until a pudding-like consistency is reached. FSM #133 was interviewed and confirmed puree salmon was to be prepared to a pudding thick consistency; not nectar thick. [s. 11. (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 and without restricting the generality of subsection (1), ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied, to be implemented voluntarily.

WN #4: 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 resident #012 was transferred using safe transferring and positioning techniques.

On an identified date in 2018, Critical Incident System (CIS) report #2854-000007-18 was submitted to the Director. According to the report, resident #012 sustained a superficial injury while being transferred by PCA #122 and #128.

Resident #012's clinical record was reviewed and confirmed they sustained an injury during the transfer and a review of the investigative notes provided by the DONC confirmed the incident of improper transferring. The DONC was interviewed and confirmed the resident was not transferred using safe transferring and positioning techniques.

The above noted non-compliance was identified during CIS inspection log #006783-18/ CIS #2854-000007-18. [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 and ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: 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 residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On a specified date in March 2018, resident #006 was identified with an area of altered skin integrity. A review of the clinical record did not include a reassessment of the area of altered skin integrity on a weekly basis. On an identified date later that month, an assessment was completed that indicated that the resident did not have any impaired skin integrity areas; however, the clinical record showed the resident was still receiving treatment for the identified area. Interview with RPN #121 confirmed the expectation was that areas of altered skin integrity were to be assessed and documented weekly and confirmed that the skin assessment had not been completed since the area of altered skin integrity was identified on a specified date in March 2018 and not again until a specified date in April 2018. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff received annual training in the areas of continence care and bowel management; skin and wound management and falls prevention and management.

A) In accordance O. Reg. 79/10, s. 221(1) 3 and 219 (3) the home is required to provide all staff who provide direct care to residents with annual training in the area of continence care and bowel management.

Documents provided and confirmed by the DONC indicated that not all staff who provided direct care to residents in 2017, received training in the area of continence care and bowel management. Training records provided at the time of this inspection confirmed that of the 124 staff in the home who provided direct care to residents in 2017, 113 (91%) of those staff had not received the required training in the 2017 calendar year.

B) In accordance O. Reg. 79/10, s. 221(1) 2 and 219 (3) the home is required to provide all staff who provide direct care to residents with annual training in the area of skin and wound management.

Documents provided and confirmed by the DONC indicated that not all staff who provided direct care to residents in 2017, received training in the area of skin and wound management. Training records provided at the time of this inspection confirmed that of the 124 staff in the home who provided direct care to residents in 2017, 114 (92%) of those staff had not received the required training in the 2017 calendar year.

C) In accordance O. Reg. 79/10, s. 221(1) 4 and 219 (1) the home is required to provide all staff who provide direct care to residents with annual training in the area of falls prevention and management.

Documents provided and confirmed by the DONC indicated that not all staff who provided direct care to residents in 2017 received training in the area of falls prevention and management. Training records provided at the time of this inspection confirmed that of the 124 staff in the home who provided direct care to residents in 2017, 117 (94%) of those staff had not received the required training in the 2017 calendar year. [s. 76. (2) 11.]

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 and ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 11. Any other areas provided for in the regulations, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that had resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

According to the home's CIS report #2854-000003-18, on an identified date in 2018, staff became aware of an incident of resident to resident abuse between resident #031 and resident #034.

Progress notes were reviewed and it was noted that the resident's SDM was not notified immediately regarding the incident. Interview with RN #141 confirmed they did not attempt to contact the resident's SDM at the time of the incident. The DONC confirmed in an interview that the home did not notify the resident's SDM immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse of resident #034 that caused distress to the resident.

The above noted non-compliance was identified during CIS inspection log #004819-18 / CIS #2854-000003-18. [s. 97. (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 and ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

WN #8: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A) The home's Medication Incident Report from an identified date in January 2018 was reviewed and noted that resident #022 was administered the wrong medication. There was no harm to the resident. The physician, the resident and the family were notified.

B) The home's Medication Incident Report from an identified date in January 2018 was reviewed and noted that resident #023 was given an identified medication that was discontinued. The resident was not harmed and the nurse practitioner was notified.

C) The home's Medication Incident Report from an identified date in March 2018 was reviewed and noted that resident #024 was given an identified medication that had been discontinued. The medication was not removed for destruction when the order was discontinued. The report indicated there was no harm to the resident. The physician, the resident were notified. The resident indicated there was no need to inform the family.

The home failed to ensure that no drug was administered to resident #022, #023, and #024 unless the drug was prescribed for the resident. [s. 131. (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 and ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #9: 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 home's infection prevention and control program related to labelling of personal care items.

i) On an identified date in April 2018, on a specified neighbourhood, one used and unlabelled hair comb, hair brush and a used container of zinc were found in a spa room.
ii) On an identified date in April 2018, on a specified neighbourhood, three used and unlabelled hair brushes, and a used and unlabelled container of zinc were found in the spa and shower rooms.
iii) On an identified date in April 2018, on a specified neighbourhood, one used and unlabelled hair comb and hair brush were found in the spa and shower rooms.

PCA #106 was interviewed and reported the home's expectation was that all personal items be labelled. The DONC was interviewed and confirmed the home's expectation was that all personal items be labelled. [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 and ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee failed to ensure that residents were not charged for goods and services that the licensee was required to provide to residents under any agreement between the

licensee and the Ministry or between the licensee and a local health integration network.

i) Resident #004’s clinical record was reviewed regarding falls prevention and management. After experiencing a fall on an identified date in 2018, staff documented they had suggested to the family to purchase hip protectors. Family member #144 was interviewed and reported they were provided information on how to pay for hip protectors and had not purchased them. RN #108 confirmed in an interview that hip protectors had not been trialed for resident #004.

ii) Resident #009's clinical record was reviewed and their plan of care identified they used hip protectors as a fall intervention strategy. PCA #136 was interviewed and reported the resident wore hip protectors. Family member #145 was interviewed and reported they purchased hip protectors for the resident as the home recommended them. Family member #145 reported the home provided information on where they could purchase hip protectors and did not offer hip protectors to use as a trial.

iii) Resident #038's clinical record was reviewed and their plan of care identified they used hip protectors as a fall intervention strategy. PCA #136 was interviewed and reported the resident wore hip protectors. Family member #146 was interviewed and reported resident #038 had worn hip protectors as recommended by the home. Family member #146 reported the home offered hip protectors as a trial; however, informed them if they wanted hip protectors long-term they could purchase them, which they did.

The DONC was interviewed and confirmed the home’s falls policy, "Fall Prevention and Management Program [LTC], Policy Number 04-33", last reviewed on August 1, 2017, stated, "for residents who have a risk for falls, falls prevention equipment may be considered by the team and will be identified in the plan of care. Examples include, but are not limited to the following: d. hip protectors."

The DONC reported the home had some hip protectors available for use to trial as a post-fall intervention and if found to be effective, the home's practice was that residents and/or families purchase them. The DONC reported the home’s process for the use of hip protectors was to provide information to residents and/or families on where to they could purchase them and had been the home's practice for the last two years. The Assistant General Manager also confirmed in an interview that the process had been in place for several years.

The licensee failed to ensure that residents were not charged for goods and services that

the licensee was required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. [s. 245. 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 and ensure that the following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act: 1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from, i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability and ii. the Minister under section 90 of the Act, to be implemented voluntarily.

WN #11: 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 their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The licensee's policy, "Prevention of Abuse and Neglect - Policy Number 04-06" revised November 20, 2016, indicated that any person who has reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and information upon which it was based to their immediate supervisor or any member of the leadership team, including abuse of a resident by anyone or neglect of a resident by staff that resulted in harm or risk of harm to the resident. The Prevention of Abuse and Neglect policy referenced "Mandatory Reporting - Policy 04-23", that stated the manager/charge nurse will immediately contact the general manager (GM) with the details or on-call manager if the GM is not available. In the event that the issue being reported is received outside the hours of 8 a.m. and 5 p.m. from Monday to Friday, the GM or their designate will notify the MOHLTC using the after-hours pager in addition to initiating the MCIS report.

Staff did not comply with the above noted direction on an identified date in 2018, when staff became aware of an incident of resident to resident abuse between resident #034 and #031. As per the CIS report, the Director was notified over 14 hours after staff became aware of the incident.

RN #141 was interviewed and reported they did not reach the designated manager for long-term care at the time of the incident. The DONC was interviewed and confirmed the home did not comply with their written policy to promote zero tolerance of abuse and neglect of residents.

The above noted non-compliance was identified during CIS inspection log #004819-18 / CIS #2854-000003-18. [s. 20. (1)]

WN #12: 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 the following was 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: 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. 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.

The Long-Term Care Homes Act (LTCHA) 2007, Chapter 8, requires all long-term care homes to have a Nursing and Personal Support Services program.

The home was requested to produce the 2017 annual evaluation of the Nursing and Personal Support Services program. The evaluation was not produced. The DONC confirmed that in 2017 the Nursing and Personal Support Services was not evaluated and there was no record available.

The home's Nursing and Personal Support Services Program was not evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices in 2017. [s. 30. (1) 3.]

2. The licensee failed 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.

Clinical record review for resident #011 identified that staff were not signing off on the resident's treatment administration record (TAR) when the resident was to receive their specified care intervention as ordered. It was identified that there was no documentation on the TAR or in the resident's progress notes to show that the care was provided during an identified period between November and December 2017. Interview with the DONC confirmed that staff were to document on the TAR when care was provided as ordered.

The above noted non-compliance was identified during complaint inspection log #025858 -17. [s. 30. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system must, at a minimum, provided for preparation of all menu items according to the planned menu.

On an identified date in April 2018, the planned menu included puree California salad, puree romaine and onion salad, and minced chilled peach slices for lunch. An observation of meal service was conducted. One puree salad was available at meal service as confirmed by dietary staff #104. Dietary staff #104 confirmed the puree salad available and served to residents appeared blended together as some of the salad appeared yellow and some appeared darker green. Minced fruit served to residents appeared to be a mix of peach and another fruit. PCA #105 confirmed the fruit did not appear to be just peaches.

FSM #133 was interviewed and confirmed the planned lunch menu for the identified date in April 2018 included puree California salad, puree romaine and onion salad, and minced chilled peach slices. FSM #133 confirmed all menu items should have been prepared according to the planned menu. [s. 72. (2) (d)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

The home's "Process for Resident/Family Concerns" last reviewed November 2017, directed staff that an Incident Report Form was to be completed if a family member or resident expresses a complaint or a concern to a team member.

On two occasions in August 2017, the staff became aware of complaints regarding the care of resident #011. The DONC was interviewed and confirmed it was the home's expectation that incident report form be completed when a resident or family member expressed a concern or a complaint. The DONC confirmed that the licensee failed to ensure the complaint process was followed.

The above noted non-compliance was identified during complaint inspection log #025858 -17. [s. 101. (1) 1.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The home's Medication Incident Report from an identified date in January 2018 was reviewed noted that resident #023 was given an identified medication in error. The Nurse Practitioner was notified; however the resident, family and/or substitute-decision maker and Medical Director were not notified. The DONC was interviewed and confirmed the above information.

The home failed to ensure that a medication incident involving resident #023 was reported to the resident, the resident's SDM and the Medical Director. [s. 135. (1) (b)]

Issued on this 16th day of May, 2018

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

Original report signed by the inspector.