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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 22, 2019	2019_549107_0003	006456-18, 002795-19	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

West Oak Village
2370 Third Line OAKVILLE ON L6M 4E2

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

MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 26, March 11, 12, 13, 14, 18, 19, 2019.

The following intakes were completed in this complaint inspection:
Log #006456-18 was related to falls, plan of care, staff training
Log #002795-18 was related to unplanned weight change, toileting schedule, meal service.

The following Critical Incident System intakes related to the same issue (falls) were inspected during this Complaint inspection:
Log #005782-18, CIS 2870-000016-18 related to falls
Log #003289-18, CIS 2870-000009-18 related to falls
Log #010315-18, CIS SAC 19837/2870-000021-18 related to falls.

During the course of the inspection, the inspector(s) spoke with residents, family members, the Administrator, Director of Care (DOC), Associate Director of Care (ADOC)/Staff Educator, Nutrition Manager, District Manager, Registered Dietitian, Environmental Services Manager, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Agency staff working at the home as PSWs, Physiotherapy Assistant, and Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 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	Légende 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. 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 did not ensure that staff used safe transferring and positioning

techniques when assisting resident #001.

Resident #001 had an un-witnessed fall resulting in injuries to the resident.

A. In a written statement PSW #122 stated that they provided care to resident #001, positioned the resident without their fall prevention strategies in place, and then left the room. PSW #122 was unavailable for interview during this inspection.

In a written statement, PSW #136, who found the resident, stated the resident was found without their fall prevention strategies in place. The RPN (#121) who attended to the resident after the fall also confirmed in a written statement and during interview with Inspector #107, that resident #001 was found without their fall prevention strategies in place.

The resident's care plan (the document that staff referred to for direction on resident care needs) included the falls prevention strategies prior to the fall that occurred on the specified date.

As per the Home's investigative notes, and Inspector #107's interviews with PSW #123 and RPN #121, it was confirmed that PSW #122 did not use safe positioning techniques, including implementing the resident's falls prevention strategies, at the time of resident #001's fall.

B. As per the Home's investigative notes, after resident #001's fall, PSW #122 transferred the resident using unsafe transferring techniques and without using any transferring devices. PSW #122 was unavailable for interview during this inspection.

During interview with Inspector #107, Registered Practical Nurse (RPN) #121, who responded to the incident, confirmed the resident was transferred using unsafe techniques after the fall. Prior to the fall the resident required the assistance of staff for transferring.

The Home's policy, "CARE5-010.05-T1, Version 1, Post Fall Clinical Pathway", and "CARE5-010.05 Post Fall Management", which the Administrator confirmed was in place at the time of the incident, directed staff on safe techniques and strategies to use after a resident had fallen.

The licensee did not ensure that staff used safe transferring and positioning techniques when assisting resident #001 resulting in injuries to resident #001. [s. 36.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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. (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 did not ensure that there was a written plan of care for resident #004 that set out clear direction to staff and others who provided direct care to the resident in relation to diet order.

Resident #004 went to hospital after a fall. The resident had an assessment while in hospital and the discharge summary stated that a specific diet was recommended for resident #004.

When the resident was re-admitted to the home, clear direction was not provided in relation to the dietary recommendations suggested in hospital. Transfer documentation sent from the hospital and documentation on the "24 hour unit profile tracking tool" were vague and non-specific related to the resident's required diet. A re-admission diet order was not entered into Point Click Care as confirmed by the Registered Dietitian (#108). Progress notes were also unclear regarding what was required or being provided to the resident upon re-admission from hospital.

The home's Registered Dietitian saw the resident and stated that staff were giving the resident a specific diet and to continue with it. The diet being provided by staff was not consistent with the hospital recommendations. The resident was re-assessed by an allied health profession who recommended to continue with the diet recommended by the hospital. During interview with Inspector #107, RPN #109 stated they remembered the resident receiving a specialized diet upon re-admission but could not be certain the specific interventions provided to the resident.

During interview with the Administrator (#100), Nutrition Manager (#103), and Registered Dietitian (#108), they stated they were unable to verify what diet was provided to resident #004 between re-admission to the home and when the resident was assessed by the Registered Dietitian. [s. 6. (1) (c)]

2. The licensee did not ensure that the care set out in the plan of care related to skin integrity was provided to resident #001 as specified in their plan.

Resident #001 was at risk for skin impairment and had an area on their skin that had deteriorated.

On a specified date, two progress note entries directed staff to implement the identified strategies for the prevention of skin impairment.

Almost one month later, the Wound Care Champion wrote a follow up progress note related to healing progression of the skin impairment. The note indicted the area had increased in size with new areas of impairment. New strategies were identified in addition to the current strategies.

Twelve days later the resident's Substitute Decision Maker (SDM) voiced concerns to the home that the new strategies had not been implemented. According to the resident's

electronic health record for the date that the SDM voiced concerns, the strategies were not in place at the time of the SDM's visit to the home. The strategies were also not in place on two addition dates reviewed. Documentation did not support that there was any specific reason the interventions were not in place.

According to the home's complaint log, the resident's SDM voiced further concerns that the strategies were not in place and that the resident's skin impairment was worsening. According to the resident's electronic health record, for the time period of the voiced concerns, the strategies were not in place. Documentation in the resident's progress notes did not identify rationale for why the strategies to promote skin integrity were not in place.

During interview with the Administrator #100 about the concerns voiced by the SDM, the Administrator confirmed that the strategies to promote skin integrity were required and were not in place when the SDM came to see resident #001 on the specified date.

Five days later the Wound Care Champion wrote a follow up progress note indicating the resident's skin impairment had increased in size.

The resident's care plan included the strategies to promote skin integrity during a specified time. Progress notes on six occasions over a four day period identified the strategies had not been implemented according to the plan of care. During interview with Inspector #107, RPN #120 and RPN #121, who wrote the progress notes, the staff could not recall if the resident had the required strategies in place, however, confirmed that the notes did not reflect the strategies were implemented consistently as per direction on the resident's plan of care. A progress note by the Wound Care Champion five days later indicated the resident's skin impairment had progressed.

The licensee did not ensure that the care set out in the plan of care related to skin integrity was provided to resident #001 as specified in their plan. [s. 6. (7)]

3. The licensee did not ensure that the care set out in the plan of care was provided to resident #002 as specified in their plan related to nutrition.

A. Resident #002 had a plan of care that directed staff not to serve a specific food at meals. At the observed lunch meal, the resident was provided with a meal that included the restricted item. The resident was not eating well at the meal and had not eaten much of the item. The person who was feeding the meal to the resident stated that they were

not sure what the meal was when asked by Inspector #107. Inspector #107 then asked the PSW (#118) who served the resident and the Dietary Aide (#128) who portioned the meal to confirm what the resident received and the resident was given the restricted item. The dietary serving list also directed staff not to serve the item to resident #002. The resident was not always able to communicate their preferences to staff and had not chosen the item themselves that day.

B. Resident #002 had a plan of care that required a specific diet. At an observed supper meal, PSW #111 provided an item to resident #002 that was not consistent with the resident's required diet. The person assisting the resident with eating noticed the item was not consistent with the resident's dietary requirements and asked the staff to alter the item before it was provided to the resident.

C. At an observed lunch meal, the resident was provided with an item that was not consistent with their required diet order. RPN #125 confirmed that the item was different than the resident's other items on the table. When the person assisting the resident with eating asked for the item to be altered, RPN #125 stated the item was fine and no alteration was required. [s. 6. (7)]

4. The licensee did not ensure that the care set out in the plan of care was provided to resident #008 as specified in their plan related to continence.

The care plan (the document that outlined the care to be provided to the resident) for resident #008 identified the resident's level of continence and directed staff to see the incontinence list for current continence care products.

On a specified date, resident #008's Substitute Decision Maker (SDM) voiced concerns that PSW staff were unaware of what the resident's needs were in relation to continence. The staff had not followed the resident's plan of care related to continence, resulting in the resident becoming soiled.

Inspector #107 interviewed PSW staff (#114), who was caring for the resident on the identified date. Staff #114 confirmed they had access to the resident's care plan; however, had not reviewed the plan prior to providing care to the resident. PSW #115, who was working with PSW #114, also confirmed during interview, that they had not reviewed the needs of resident #008 with PSW #114 prior to PSW #114 providing care to resident #008. [s. 6. (7)]

5. The licensee did not ensure that the care set out in the plan of care was provided to resident #006 as specified in their plan related to nutrition at an observed supper meal.

The plan of care for resident #006 directed staff to provide a specific diet at meals and snacks. At the observed supper meal, PSW #111 provided an item to resident #006 that was not consistent with their required diet order and the resident began to cough. The RPN (#127) then repositioned the resident and altered the resident's meal. The resident was able to finish the meal after they were re-positioned and the menu item was altered. [s. 6. (7)]

6. The licensee did not ensure that the plan of care for resident #001 was reviewed and revised when the resident's care needs changed in relation to skin and wound care management strategies.

On a specified date, the Wound Care Champion wrote a follow up progress note related to healing progression of an area of skin impairment. The note indicted the area had increased in size with new areas of impairment. The Wound Care Champion identified new strategies related to skin and would care management.

The resident's plan of care was not updated to include the revised strategies identified by the Wound Care Champion until a complaint was made by the resident's Substitute Decision Maker indicating the new strategies had not been implemented.

The Associate Director of Care (ADOC) reviewed the information with Inspector #107 and confirmed that the plan of care was not updated at the time that the resident's care needs changed. [s. 6. (10) (b)]

7. A. The licensee did not ensure that the plan of care for resident #002 was reviewed and revised when the resident's care needs changed in relation to transfers and mobility.

Inspector #107 reviewed the "Bed Mobility" and "Transfers" sections of resident #002's current care plan (the document that provided direction to staff providing care) and the care plan directed staff to provide specific strategies due to declining health status. The care plan also included specific direction requested by the resident's Substitute Decision Maker (SDM), related to transferring.

During this inspection, Inspector #107 routinely observed staff providing care that was

not consistent with the direction for staff identified on the resident's care plan. Registered Practical Nurse (RPN) #125 confirmed the resident's condition had improved and the direction on the resident's care plan related to "Bed Mobility" and "Transfers" had not been updated when the resident's condition improved.

During an Annual Care Conference for resident #002, held with the resident's Substitute Decision Makers, it was identified that the resident's condition had improved and specific strategies related to "Mobility" and "Transfers" were identified in the Care Conference notes. The resident's care plan had not been updated to include this information after the meeting, which was two months prior.

During interview with Inspector #107, RPN #125 confirmed that the "bed mobility" and "transfers" section of the care plan was not updated when resident had an improvement in their condition.

B. The licensee did not ensure that the plan of care for resident #002 was reviewed and revised when the resident's care needs changed in relation to toileting.

According to interviews with PSWs #105 and #111, and RPN #109, resident #002 required a toileting schedule with specific direction related to the toileting routine. The resident's care plan was reviewed by Inspector #107 and did not include specific direction for staff related to a toileting routine for the resident.

During interview with Inspector #107, RPN #125 confirmed that the specific information related to the resident's toileting routine was not included in the resident's current care plan. The RPN stated that the specific direction for staff had been removed from the care plan when the resident had a previous decline in condition and the care plan had not been revised to include the information when the resident's condition improved again. The RPN confirmed that the resident currently required a specific toileting routine.

The resident's substitute decision maker voiced concerns related to the resident's toileting routine. Direction on the resident's care plan had not been updated to ensure that all staff providing care to the resident were aware of the resident's care needs. [s. 6. (10) (b)]

8. The licensee did not ensure that resident #004 had their plan of care reviewed and revised when the resident's care needs changed in relation to feeding and positioning strategies.

Resident #004 went to hospital after a fall. The resident had an assessment while in hospital and the discharge summary included specific feeding and positioning strategies/precautions. The resident's plan of care upon re-admission did not include nine out of 17 of the specific swallowing and positioning strategies identified. [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 with 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,
(b) the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: 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 Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy or system, the policy or system was complied with.

A. In accordance with O. Reg. 79/10, s. 48(1)1 and in reference to O.Reg. 79/10, s. 49

the licensee was required to have a falls prevention and management program that included monitoring of residents and post fall assessment.

The licensee did not ensure that the policies related to fall prevention and management were complied with by staff providing care to resident #001. Specifically, staff did not comply with the Home's policy, "CARE5-010.05-T1, Version 1, Post Fall Clinical Pathway", and "CARE5-010.05 Post Fall Management", which the Administrator confirmed was in place at the time of the fall. The policies provided direction for staff on what to do after a resident had fallen.

The home's policy, "CARE5-010.06", including the "Neurological Flowsheet LTC-E-70-05", which the Administrator confirmed was also in place at the time of the incident, were also not followed by staff providing care to the resident.

Resident #001 had an un-witnessed fall resulting in injuries to the resident. As per the Home's investigative notes, and Inspector #107's interviews with PSW #123, and RPN #121 who responded to the incident, PSW #122 did not follow the home's Post Fall Clinical Pathway and Post Fall Management polices. PSW #122 was not available for interview during this inspection.

The Inspector was also unable to locate any evidence that the Neurological Flowsheet was completed for resident #001 after the fall. In discussion with the Administrator and Assistant Director of Care, they were unable to locate any evidence that the Neurological Flowsheet was completed for this resident, as required by the home's policy.

B. In accordance with O. Reg. 79/10, s. 48(1)3 and in reference to O.Reg. 79/10, s. 51(2)(a) the licensee was required to have a continence care and bowel management program that included assessment of residents who were incontinent.

The licensee did not ensure that the policies related to continence care and bowel management were complied with by staff providing care to resident #002.

Specifically, staff failed to comply with the licensee's policy, "CARE2-010-01 Continence Care – Change of Continence". The policy directed staff to initiate a three day continence diary and to complete the Continence Assessment on Point Click Care (PCC) which included evaluation of the three day Continence diary whenever there was a change in a resident's continence level. If the Nurse chose not to complete a continence assessment it would be recorded in a progress note and on the Continence Assessment

form in PCC.

Resident #002 had a decline in their bladder continence over a three month period and a decline of bowels over a two month period, as identified on the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) assessments.

During interview, the RAI-MDS Coordinator #124 confirmed that when there were changes in a resident's continence that were identified through the RAI-MDS assessment, staff were required to complete a three day voiding record and a standardized Continence Assessment in Point Click Care (PCC).

Registered Practical Nurse (#125) also confirmed that Registered staff were required to complete a three day voiding record and a Continence assessment on PCC when there were any RAI-MDS assessment changes to a resident's continence level. The RPN confirmed that resident #102 had a decline in both their bladder and bowel continence and that a continence assessment had not been completed at the time of the change for resident #002. [s. 8. (1) (a),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) 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 #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the planned menu items were offered and available at an observed lunch and supper meal.

A. At an observed lunch meal, the licensee did not follow the planned menu and not all items were offered and available to residents.

The planned menu required bread to be offered to residents requiring a specific menu. The bread was available, however, was not offered to residents at the meal, resulting in reduced nutritional value of the meal. Dietary Aide #128 told Inspector #107 that they had forgotten to serve it.

The planned menu, including the menu for a specific diet, required milk to be offered to residents. Residents requiring a specific menu were not offered milk at the lunch meal, resulting in reduced nutritional value of the meal. Dietary Aide #128 stated that some residents did not like milk and that residents requiring the specific diet only received milk at the breakfast meal if they asked for it. During interview with Inspector #107, Nutrition Manager (#103) stated that milk was available for the specific menu and the Manager was not sure why residents were not consistently offered milk as per the planned menu.

A review of the serving list in the dining room (used to communicate resident preferences or dietary needs to staff serving the meal) indicated that only two residents (residents #010 and #011) in the dining room had a noted dislike to milk. Residents #012, #013, #006, #002, who required the specific menu, were not offered milk at the observed lunch meal. Resident #002 was also not offered milk at the observed supper meal. During interview with Inspector #107, the caregiver for resident #002 indicated the resident never received milk with their meals. Resident #002 was at nutritional risk and was receiving additional supplements; resident #012 was also receiving a nutritional supplement; and resident #006 was at nutritional risk. Residents #006 and #012 were not interviewable when questioned by Inspector #107.

B. At an observed supper meal, the licensee did not ensure that the planned menu items were offered and available.

The planned therapeutic extension menu required a specific item for a specified menu. A different item was prepared and served to residents requiring the specialized menu. The substitution was not communicated to residents receiving the meal. During interview with Inspector #107, Nutrition Manager (#103) confirmed that the planned menu was not followed by staff preparing the meal. The Nutrition Manager stated that when the

required item was on the menu the Cooks substituted a different menu item. The Nutrition Manager confirmed there was no supporting documentation to indicate residents did not like the original menu item and confirmed that staff preparing meals were not following the planned menu.

At an observed supper meal, Dietary Aide #129, portioning the meal, did not follow the planned menu portion size for numerous items being served to residents, resulting in altered nutritional value of the meal.

The planned menu required the following portion size, followed by the actual portion offered to residents:
Vegetables - #8 scoop required (4 oz) - #10 scoop served (3 oz)
Minced vegetables - #10 scoop required (3 oz) - # 8 scoop served (4 oz)
Pureed sandwich - #8 scoop required (4 oz scoop) - #10 scoop served (3 oz)
Pureed dessert - #10 scoop required (3 oz) - #16 scoop served (2 oz)
Fruit - #8 scoop required (4 oz) - #10 scoop served (3 oz)
Pureed fruit - #10 scoop required (3 oz) - #16 scoop served (2 oz)

Dietary Aide #129 confirmed they did not use the planned portion size for the items. Portions served to residents were routinely less than the planned menu resulting in reduced nutritional intake.

During interview with Inspector #107, Personal Support Worker #130 stated that the portions served to residents were small so they felt they needed to give resident #007 more food when they were assisting them.

Therapeutic extension menus did not provide adequate direction and/or the portions identified did not reflect the actual items served to residents at a supper meal. Portion size for a texture modified menu item was unclear. The therapeutic extension menu required one portion but scoops were being used by staff portioning the meal. Staff serving the item used a #12 scoop. Portion size for a different menu item required for a lunch meal also stated a 1 x 1 centimeter portion was required, however, staff serving the item had a #16 scoop in the pan. During interview with Inspector #107, Nutrition Manager #103 and District Manager of Food Services #104 confirmed that the portion size listed on the therapeutic extension menus did not provide clear direction to staff portioning meals. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with O.Reg.79/10, s.71(4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that staff used proper techniques to assist residents #006 and #007 with eating, including safe positioning of residents who required assistance at an observed lunch and supper meal.

A. The plan of care for resident #006 included specific direction for staff related to positioning the resident at meals and snacks. At the observed supper meal, resident #006 was not positioned according to the specific positioning directions identified in the resident's plan of care. The resident was being assisted with eating by staff and began to cough when they were being fed. The RPN (#127) came over and adjusted the resident's position. During interview with Inspector #107, the RPN stated that staff only positioned the resident in the required position if the resident was choking.

At an observed lunch meal, resident #006 was again observed in a position that was not consistent with the positioning direction identified on their plan of care. The resident had an assistive device in place but it had moved and was not in place anymore. PSW #119 began feeding the resident when they were not positioned according to the directions on the plan of care and the resident started coughing. The PSW then re-positioned the resident. After re-positioning the resident, PSW #119 told Inspector #107 that the resident was not positioned correctly and it seemed to help when the resident was positioned correctly as the resident was at risk for choking.

B. At an observed supper meal, resident #007 was observed in an unsafe position while being fed by PSW #130. The PSW stated that they were concerned about the resident's poor positioning during meals and had been voicing their concerns to Registered staff. Registered staff #127 confirmed that PSW #130 had voiced concerns about the resident's positioning at meals the week prior. Both PSW #130 and RPN #127 stated that the resident was unable to be positioned according to directions on the resident's plan of care.

The resident's care plan directed staff to use specific positioning strategies during meals. The plan of care also directed staff to use a specific intervention to assist with the positioning of the resident. RPN #127 stated that the positioning device was ineffective.

During interview with Inspector #107, Administrator (#100) and ADOC (#102) were not aware that residents #006 and #007 were being positioned in an unsafe way during meal service. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with O.Reg. 79/10, s. 73(1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance, 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 did not ensure that all staff at the home had received training as required

by this section.

The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before they received training in the areas mentioned below: the long-term care home's policy to minimize the restraining of residents, and policies of the licensee that were relevant to the person's responsibilities.

The LTCHA, 2007, definition of staff includes a person who worked at the home, pursuant to a contract or agreement between the licensee and an employment agency or other third party.

The Associate Director of Care (ADOC)/Staff Educator #102 outlined the hiring process for staff to Inspector #107. The ADOC/Staff Educator (#102) confirmed that staff did not receive additional training above what was discussed. The ADOC/Staff Educator (#102) confirmed that a review of the home's policies relevant to each position was not included in the orientation provided to certain staff.

Inspector #107 reviewed the training records for three staff members (#134, #135, #136) providing care at the home. The training provided did not include the above information.

Inspector #107 reviewed the education booklet with the Administrator (#100) and the Administrator confirmed that the required information was not included in the package provided to certain staff.

Personal Support Worker (PSW) staff #122 was providing care to resident #001 on the shift that the resident had an un-witnessed fall resulting in injuries to the resident. As per the Home's investigative notes, and Inspector #107's interview with PSW #123 and RPN #121, PSW #122 did not follow the home's policies related to fall prevention and management, provision of care, and for caring for a resident after a fall. PSW staff #122 was not available for interview during this inspection.

Inspector #107 reviewed the training package that was signed by PSW #122 prior to hire. The employee had signed a document that indicated some falls reduction training was provided, however, it was unclear what information was included. The Inspector was unable to obtain the actual training provided to the staff member to confirm if they received training on the home's falls prevention and management policies and procedures. The Administrator #100 was also unable to confirm what was included in

the education package signed by the employee. The information identified in PSW #122's file was not included in the current training booklets provided to staff. [s. 76. (2)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that drugs were administered to resident #003 in accordance with the directions for use specified by the prescriber.

Resident #003 had a bowel protocol in place, including specific directions for staff to follow.

Inspector #107 reviewed resident #003's clinical health record related to frequency of bowel movements over a specified period between when the resident returned from hospital and when the resident was sent back to hospital.

The resident had the first documented bowel movement at least 6 days post return from hospital and again three days later. The resident's Medication Administration Record (MAR) was reviewed and the bowel protocol steps were not administered to resident #003 in accordance with the directions for use specified over the specified period.

The Administrator (#100) and RPN #125 reviewed the records with Inspector #107 and verified that the bowel protocol was not provided as ordered by the resident's Physician. [s. 131. (2)]

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 11th day of June, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2019_549107_0003
Log No. / No de registre :	006456-18, 002795-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 22, 2019
Licensee / Titulaire de permis :	AXR Operating (National) LP, by its general partners c/o Revera Long Term Care Inc., 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	West Oak Village 2370 Third Line, OAKVILLE, ON, L6M-4E2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Saad Akhter

To AXR Operating (National) LP, by its general partners, 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. 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.

Order / Ordre :

The licensee must be compliant with r. 36 of the LTCHA.

Specifically the licensee must:
a) Ensure that when any resident has fallen the home's policies and procedures related to falls management are followed by staff.
b) Ensure that all staff have been educated on the home's policies related to procedures when residents fall, including but not limited to the home's Post Fall Clinical Pathway, Post Fall Management, and any other applicable policies related to fall prevention and management.
c) Conduct an audit, at a schedule of the home's choosing, to ensure that staff use safe transferring and position devices and techniques when assisting residents.
d) Keep a documented record of the audit.

Grounds / Motifs :

1. The licensee did not ensure that staff used safe transferring and positioning techniques when assisting resident #001.

Resident #001 had an un-witnessed fall resulting in injuries to the resident.

A. In a written statement PSW #122 stated that they provided care to resident #001, positioned the resident without their fall prevention strategies in place, and then left the room. PSW #122 was unavailable for interview during this inspection.

In a written statement, PSW #136, who found the resident, stated the resident was found without their fall prevention strategies in place. The RPN (#121) who

attended to the resident after the fall also confirmed in a written statement and during interview with Inspector #107, that resident #001 was found without their fall prevention strategies in place.

The resident's care plan (the document that staff referred to for direction on resident care needs) included the falls prevention strategies prior to the fall that occurred on the specified date.

As per the Home's investigative notes, and Inspector #107's interviews with PSW #123 and RPN #121, it was confirmed that PSW #122 did not use safe positioning techniques, including implementing the resident's falls prevention strategies, at the time of resident #001's fall.

B. As per the Home's investigative notes, after resident #001's fall, PSW #122 transferred the resident using unsafe transferring techniques and without using any transferring devices. PSW #122 was unavailable for interview during this inspection.

During interview with Inspector #107, Registered Practical Nurse (RPN) #121, who responded to the incident, confirmed the resident was transferred using unsafe techniques after the fall. Prior to the fall the resident required the assistance of staff for transferring.

The Home's policy, "CARE5-010.05-T1, Version 1, Post Fall Clinical Pathway", and "CARE5-010.05 Post Fall Management", which the Administrator confirmed was in place at the time of the incident, directed staff on safe techniques and strategies to use after a resident had fallen.

The licensee did not ensure that staff used safe transferring and positioning techniques when assisting resident #001 resulting in injuries to resident #001. [s. 36.]

The severity of this issue was determined to be a level three as there was actual harm to a resident. The scope of the issue was a level one as non-compliance was found in one of three (33%) of the affected population that was inspected. The compliance history was a level three as they had on-going non-compliance

with this section of the LTCHA that included:
Voluntary plan of correction (VPC) r. 36 issued February 9, 2017 (2016_543561_0028)

(107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2019

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MICHELLE WARRENER

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