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 le Loi de 2007 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jul 25, 2016;	2016_191107_0007 (A1)	008295-16	Resident Quality Inspection

Licensee/Titulaire de permis

WEST PARK HEALTHCARE CENTRE
82 BUTTONWOOD AVENUE TORONTO ON M6M 2J5

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

WEST PARK LONG TERM CARE CENTRE
82 BUTTONWOOD AVENUE TORONTO ON M6M 2J5

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

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 le Loi de 2007 les foyers de soins de longue durée

MICHELLE WARRENER (107) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Amendments have been made to r. 90(1)(b) as requested. The dates for submission of compliance plans have also been extended to July 29, 2016.

Issued on this 25 day of July 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 25, 2016;	2016_191107_0007 (A1)	008295-16	Resident Quality Inspection

Licensee/Titulaire de permis

WEST PARK HEALTHCARE CENTRE
82 BUTTONWOOD AVENUE TORONTO ON M6M 2J5

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

WEST PARK LONG TERM CARE CENTRE
82 BUTTONWOOD AVENUE TORONTO ON M6M 2J5

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

MICHELLE WARRENER (107) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): April 15, 18, 19, 20, 21, 25, 26, 27, 28, May 3, 4, 5, 9, 10, 11, 12, 13, 16, 2016

The following complaint inspections were completed concurrently with the Resident Quality Inspection:

001407-14 - medication administration, complaints process, plan of care

000747-15 - staff to resident abuse

014651-15 - nursing care

018710-15 - responsive behaviours, resident bill of rights

019282-15 - staff to resident abuse

025058-15 - staffing, continence, weight changes, responsive behaviours,

005549-16 - palliative care, skin and wound care, transferring/positioning, nursing care, medication administration, plan of care, infection prevention and control, staffing

010704-16 - staff to resident abuse

The following Critical Incident System Inspections were completed concurrently with the Resident Quality Inspection:

004787-15 - resident to resident abuse

009170-15 - resident to resident abuse

002028-16 - continence, duty to protect

006197-16 - controlled substance missing

012496-16 - turning/repositioning, skin and wound care, duty to protect

During the course of the inspection, the inspector(s) spoke with residents, family members, Executive Director, Acting Director of Care, Assistant Director of Care, Support Services Manager, Nursing Quality Clerk, Social Worker, Registered Dietitian, RAI Coordinators, Dietary Manager, Programs Manager, Maintenance Supervisor, front line nursing and dietary staff, registered nursing staff, President of the Residents' Council, President of the Family Council, and the Physiotherapist

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

27 WN(s)
15 VPC(s)
4 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone and did not ensure that residents were not neglected by the licensee or staff.

Resident #046 had a history of inappropriate behaviours since admission to the home. Resident #046 abused a co-resident on a specified date after admission. The home did not report the abuse to the Director and they did not investigate and/or take appropriate actions as a result of the incident. Subsequently, resident #046 abused resident #047, and on another specified date, resident #046 sexually abused resident #067. The ED and Nursing Consultant were interviewed on May 5, 2016 and confirmed the abuse incidents occurred. The ED confirmed that the first incident met the home's definition of sexual behaviours and should have been reported to the Director. The ED confirmed that there were no assessments, no monitoring, and no updates to the written plan of care and no evaluation of the responsive behaviour interventions to ensure they were effective for the second incident. The licensee failed to protect residents from abuse by resident #046. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. Procedures and schedules were not in place for preventive maintenance related to the home's furnishings (beds).

The licensee did not have a procedure or preventive schedule in place to ensure that the beds in the home were monitored regularly and maintained in good condition. During the inspection, five beds were observed to have assist rails in the transfer or assist position that appeared to have bowed outwards and were significantly loose, creating a gap between the rail and the mattress. The bolts and associated hardware were observed to be very loose. As a result, the home completed an audit of all bed rails in the home. One hundred and fifty three beds in the home were identified to have loose rails and 21 beds were missing mattress keepers either at the head or foot of the bed. According to the Support Services Manager, no procedure was developed which included the bed manufacturer's instructions for care and maintenance of the beds in the home. When the instructions were reviewed, the manufacturer required that the beds be inspected yearly and that any loose bolts or parts be replaced or tightened. The licensee's maintenance program for the beds relied on health care staff to report disrepair which was not preventive in nature. When the maintenance logs were reviewed from January to May 2016, several bed rails were identified as either broken or loose and were remediated; however, those identified in the rooms above were not included and had not been reported by staff.
Procedures and schedules were not in place for preventive maintenance of the home's beds to ensure the safety of residents using the beds. [s. 90. (1) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

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 this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the plan, policy, protocol, procedure, strategy or system, was complied with.

A) The policy, "Cleaning and disinfecting equipment IC-03-01-07", revised September 2015, directed staff to clean and disinfect resident care equipment in accordance with the manufacturer's directions and recommendations. Registered staff and front line nursing staff were responsible for cleaning, disinfecting and storing resident care equipment in between resident use.

PSW #151 was interviewed and stated that washbasins were to be cleaned, labelled and stored on the hook. Several unwashed and unlabelled washbasins were observed on the home tour on April 18, 2016. An unlabelled and unclean

urine hat was also observed in a specified room. Similarly on May 12th, an unwashed unlabelled washbasin and labelled and clean washbasin were stored together. PSW #151 confirmed that the expectation was to wash and label each washbasin and store them separately.

The Assistant Director of Care and Infection Control Co-ordinator was interviewed and confirmed that it was the staff responsibility for cleaning and disinfecting residents' care equipment and staff were trained on the policy. Staff were also expected to clean and disinfect all equipment listed on the policy that included urinals and basins, and to label single resident-use equipment. (645)

B) The policy, "Emergency Starter Box Policy 2-4", dated January 2014, directed staff to write the resident's name on the medication label and then peel off the label when a medication was used from the emergency starter box (ESB). The peeled off label was to be placed on the ESB Drug Record Book page and faxed immediately to the pharmacy.

The nurse who removed the narcotics from the ESB on February 5, 2016, failed to document on the narcotic count sheet the required information and failed to place the peeled off label from the ESB medication card on the Drug Record Book page as directed by the policy. On May 3, 2016, at 0955 hours, the Assistant Director of Care confirmed both steps had not been completed as per policy 2-4. (640)

C) The policy, "Cleaning Frequency HL-05-03-01" and Appendix 2, directed staff to carbolize resident beds, including the deck and legs of the bed every 30-90 days.

During interview, housekeeper #116 confirmed there was no predetermined schedule for carbolizing or deep cleaning the resident mattresses and beds. ESM #122 confirmed there was no schedule for deep cleaning or carbolizing resident beds. (640)

D) The policy, "Isolation Room Cleaning HL-05-04-02", directed staff to bag cleaning cloths and mop heads and send to laundry after cleaning each isolation room.

Housekeeper #116 confirmed that the mop head was cleaned on the home area using hot water and Virox. ESM #122 confirmed mop heads were cleaned on the

home area in a washing machine. (640)

E) The home's policy, "Care of residents with Diabetes Mellitus CLIN-05-07-01", last reviewed December 2002, did not include directions for staff related to the management of hypoglycemia. A document in the "Nursing Services - Clinical Procedures" referenced a "Clinical Procedures Notice" and "Lippincott Manual of Nursing Practice 9th edition Index of Clinical Procedures". The notice stated, "This manual contains clinical policies and procedures. For clinical situations not covered by these documents, or for further procedural guidance, consult the company's preferred reference manual for resident care - The Lippincott Manual of Nursing Practice (9th edition)".

Direction provided in the Lippincott Manual of Nursing Practice in relation to the treatment of hypoglycemia directed staff to treat hypoglycemia promptly using the 15 gram (g) / 15 minute rule with 15 g of rapidly absorbed carbohydrates (half cup juice, 1 cup skim milk, three glucose tablets, four sugar cubes, five to six pieces of hard candy may be taken orally). Repeat blood glucose; if less than 70 (milligrams per decilitre (mg/dL), repeat the treatment. If more than 70 mg/dL and more than three hours since last dose or immediate-acting insulin, no further treatment required. If more than 70 mg/dL and less than three hours since last dose of immediate acting insulin, follow with a snack of 75 to 100 calories. If using a split mix or REG/NPH insulin and more than 30 minutes before the next planned meal/snack, have snack now (nutrition bar specifically designed for diabetes). Glucagon 1 milligram (mg) is given if the patient cannot ingest a sugar treatment. Intravenous bolus of 50 mL of 50 percent dextrose solution can be given if the patient fails to respond to glucagon within 15 minutes.
Direction provided for staff in this manual reflected lab reference values using American and not Canadian reference ranges.

Registered staff #125, 126, 127, were interviewed about the method of treatment for hypoglycemia and staff were not consistent in their approach. When asked, the registered staff were unable to locate direction for the treatment of hypoglycemia. Staff were not aware to consult the Lippincott Manual and a copy of the Lippincott Manual was not available in the two nursing areas observed by Inspector #645 on April 28, 2016.

Resident #197 had low blood sugar documented on two identified dates. Staff used different methods for treating the low blood glucose or no treatment and different time frames for re-testing (hourly versus every 15 minutes) when the

resident's blood sugar remained low . When the resident was resistive to drinking the juice offered, documentation did not reflect an alternative approach was tried and not all low blood sugars recorded had a corresponding treatment or follow up. The low blood sugar occurred in the middle of the night; however, documentation did not reflect a snack was provided to the resident to prevent the resident's blood sugars from falling after initial treatment.

Staff were not aware of and did not follow the home's policy for the management of this resident's hypoglycemia while at the home. (107)

F) The home's policy, "Weight Change Program RESI-05-02-07", version November 2013, directed staff to weigh residents monthly and record the weight on the Weight Change Program Tracking Sheet either on paper or electronically. The home's process was to enter weights into the Point Click Care electronic system. For monthly monitoring, every resident was to be weighed on the first bath day within the first seven days of each month. Staff were to compare the weight to the previous month's weight and any weight with a 2.5 kilogram (kg) difference from the previous month required a re-weigh. The re-weighs were to be recorded by the tenth day of each month either on paper or electronically.

Not all residents had their weights monitored monthly. Weights were missing from the weight monitoring records and were not available for review during stage one of this inspection. A family member voiced concerns about the weights not always being completed on time or as per the home's policy. The Registered Dietitian confirmed that not all of the weights were being recorded monthly as per the home's policy and that re-weighs were not consistently being taken as per the home's policy.

Resident #199 was missing a documented weight for August 2015.
Resident #108 was missing a documented weight for January 2016 and October, 2015.
Resident #057 was missing a documented weight for October 2015.
Resident #037was missing a documented weight for October 2015.
Resident #094 was missing a documented weight for October 2015.
Resident #109 was missing a documented weight for January 2016 and October, 2015
Resident #166 was missing a documented weight for April, March, January 2016, and August 2015.
Resident #101 was missing a documented weight for October 2015.

Resident #087 was missing a documented weight for January 2016
Resident #084 was missing all documented weights since 2014. (107)

G) The home's policy, "Food and Fluid Intake Monitoring RESI-05-02-05", version September 2014, directed staff to document resident food and fluid intake after meals and snacks and to review the intake records daily on nights. The policy directed staff to complete a hydration assessment on the Point Click Care system when a resident consumed less than their minimum fluid target levels for three consecutive days. If the hydration assessment indicated signs and symptoms of dehydration, immediately implement strategies to increase fluid intake based on the needs and preferences of the resident. The policy also directed staff to continue to review the fluid records daily and if the resident's intake remained below minimum target despite strategies to increase fluid intake, complete an additional hydration assessment and to refer to the Registered Dietitian as necessary. The policy also directed staff to refer to the Registered Dietitian if the resident consumed 50% or less from all meals for three or more days or refused supplements or nutrition interventions for three consecutive days.

Resident #178 was routinely meeting their food and fluid intake requirements and then had a decrease in their hydration. Daily food and fluid intake records reflected the resident did not meet their minimum hydration target on 10 days over an 11 day period. A hydration assessment was completed on the fourth day, indicating no signs and symptoms of dehydration. An additional dehydration assessment was not completed when the poor hydration continued. A progress note indicated the resident went to hospital with dehydration three days after this 11 day period. There were no follow up notes related to the resident's poor hydration between the first hydration assessment and when the resident was sent to hospital.

Upon return from hospital the resident continued to have poor food and fluid intake. A hydration assessment was not completed as per the home's policy four times in the month after the resident returned from hospital, and three times in the subsequent month. The Registered Dietitian was not notified of the ongoing poor hydration and were not aware of the poor hydration until they completed the resident's Annual review. A referral to the Registered Dietitian was initiated just prior to the resident being sent to hospital a second time (two months after the first hospitalization).

The resident also experienced poor food intake of 50% or less for three meals or more on: seven days prior to the first hospitalization, and most of the subsequent

two months.

The Registered Dietitian confirmed that staff did not consistently follow the home's hydration policy. (107) [s. 8. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents #022 and #191, who were dependent on staff for repositioning, were repositioned every two hours or more frequently as required and as clinically indicated.

A) Resident #022 had an open area on their skin, which subsequently progressed to a worsened pressure area the next month. The pressure ulcer was acquired in the home and the resident was previously identified as high risk for altered skin integrity. The resident was identified as needing turning and repositioning every two hours and as needed. PSWs #150 and #151 were interviewed and identified that they were expected to turn and reposition the resident every two hours, and

document on the turning and repositioning sheet in the PSW flow sheet binder. The Wound and Skin Lead, staff #126 and registered staff #114 confirmed that resident #022 was assessed and required turning and repositioning every two hours. The registered staff also confirmed that the PSWs were required to turn and reposition the resident every two hours and document the intervention on the flow sheet. The clinical record and plan of care were reviewed and it was identified that the turning and repositioning intervention was not implemented until eight days after the original open area was identified, and the home was unable to provide any documentation to support that turning and repositioning was performed. Resident #022 was not repositioned every two hours as required and as clinically indicated. (527)

B) Resident #191 had multiple significant pressure areas and was at risk for further skin breakdown and required full assistance by staff for turning and repositioning. Documentation on the "Turning / Repositioning Sheet" for two months, reflected that the resident was not consistently being repositioned by staff while in bed.

Documentation reflected the resident was not repositioned between 2300 hours and 0900-1200 hours on all days over two months, with the exception of four days. Documentation was blank/incomplete for day shift on 20 days over a two and a half month period. The resident's pressure areas deteriorated during this time. PSW staff #162 and #163 confirmed that the resident was not being repositioned every two hours on two of the specified dates that they were working. During interview, the resident also confirmed that they were not routinely repositioned during the night shift over a two month period. PSW staff #163 stated to the Acting Director of Care (DOC) that the resident often refused to be repositioned; however, this information was not communicated to the registered staff for re-assessment. (107) [s. 50. (2) (d)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care Specifically failed to comply with the following:

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 care set out in the plan of care was provided to resident #121 as specified in their plan.

Resident #121 did not receive medication their medication as per instructions documented in the current care plan, confirmed by RPN #143. Resident #121's family member confirmed that staff were administering the resident's medication the same way for the past six months. Registered Practical Nurse (RPN) #143 confirmed they were not following the instructions documented in the resident's current care plan. The resident did not receive care as set out in their plan of care. [s. 6. (7)]

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

Resident #033's plan of care directed staff to provide the resident with assistance to and from program(s) of their choice, and identified specific programs the resident enjoyed.

At the Interdisciplinary Annual Care Conference the Substitute Decision Maker (SDM) of the resident identified the resident would benefit from specific activities

and identified specific things the resident did not prefer. These activities were not implemented as confirmed by the Program Manager #145 on May 10, 2016, at 1440. Of 99 days in total, over a three and a half month period, resident #033 participated in one activity.

The licensee failed to ensure the resident was reassessed and the plan of care reviewed and revised at any other time when the resident's care needs changed or care set out in the plan of care was no longer necessary. [s. 6. (10) (b)]

3. The licensee failed to ensure that resident #046 was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the care set out in the plan was not effective.

As a result of the sexual abuse behaviours of resident #046, the plan of care for resident #046 was not reviewed and revised when the care set out in the plan was not effective at preventing or minimizing the resident's abusive and responsive behaviours. The clinical record was reviewed and the LTC Inspector was unable to identify that the plan of care for resident #046 was reviewed and revised as a result of the two incidents. Staff #103 was interviewed and was unable to identify when the resident's plan of care was reviewed and revised as a result of the two incidents of abuse and responsive behaviours exhibited by resident #046 over a two month period. The ED and staff #144 confirmed that the resident's plan of care was not reviewed and revised when the interventions for responsive behaviours were not effective. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with section 6(7), s. 6(10)(b) and s. 6(10)(c), to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opened to the outdoors could not be opened more than 15 centimetres.

On Friday April 15, 2016, at approximately 1020 hours, during the initial observation of the home, two windows in an identified dining room were in the fully open position. Inspector #640 checked both windows and both were easily opened to the fully open position. The dining room was not being supervised. At approximately 1445 hours, Inspector #640 met with the Executive Director and the Support Services Manager (SSM). Both confirmed the windows were open and that the staff opened them on a regular basis. Inspector #640 observed the SSM, under supervision of the Executive Director, open the window, reach in and release the window stop, and open the window fully. Both stated this was what the staff did on a daily basis during nice weather and that bypassing the safety stop was acceptable.

On April 18, 2016, at 0910 hours, upon entry to the third floor, the Inspector noted that the right window in an identified dining room was open beyond 15 centimetres with no supervision of the area.

The licensee did not ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres. [s. 16.]

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 ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, 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 without in any way restricting the generality of the duty provided for in section 19, that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

A) Resident #046 had a history of inappropriate behaviours and incidents of abuse of resident #047 and #067 in March over a three month period. On a specified date there was an incident which resident #046 was seen with inappropriate abusive behaviours towards another resident. This incident was not reported to the Director. The home's policy, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", number RC-02-01-02, and revised April 2016, identified that anyone who suspected or witnessed abuse was required to contact the Ministry of Health and Long Term Care (Director). The Executive Director confirmed that the home did not report the abuse incident that occurred, and that the incident should have been reported to the Director as outlined in their policy and procedures.

B) An incident occurred where resident #049 alleged that resident #070 abused them. This incident was not immediately investigated and reported to the Director. The home's policy, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", number RC-02-01-02, and revised April 2016, identified that anyone who suspected or witnessed abuse was required to immediately investigate and to contact the Ministry of Health and Long Term Care (Director). The Executive Director confirmed that the home did not immediately investigate and report the abuse incident that occurred, and that the incident should have been investigated and reported to the Director as outlined in their policy and procedures. (107) [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The home failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knew of, or that was reported to the licensee (a) was immediately investigated, (b) appropriate action was taken in response to the incident, and (c) any requirements that were provided for in the regulations for investigation and responding as required under clauses (a) and (b) were complied with.

A) Resident #046 had a history of inappropriate behaviours towards other residents. On February 14, 2015, there was an incident, where resident #046 had inappropriate abusive behaviours towards resident #067. Resident #067 was cognitively impaired. The clinical record was reviewed and identified the alleged abuse by resident #046 to resident #067. The home's critical incident log was reviewed and there was no documentation that the abuse was investigated, appropriate action was taken in response to the incident, and any requirements that were provided for in the regulations for investigation and responding were complied with. The home was unable to provide any documentation related to the critical incident of abuse, there were no investigative notes, and there were no actions taken in response to the incident. The ED was interviewed on May 5, 2016, and identified that initially the home did not believe the incident was abuse, and did not immediately investigate or take appropriate action in response to the incident; however after the ED reviewed the home's definition of inappropriate behaviours, the ED confirmed the incident did meet the home's definition of abuse and should have been reported to the Director. (527)

B) Documentation in resident #070's progress notes identified an incident that was reported to staff, where resident #049 alleged that resident #070 abused them. Documentation reflected that action was not taken in response to the allegations until two days later, including revision to resident #070's plan of care, and an investigation was not immediately initiated. The Executive Director confirmed on May 27, 2016, that an investigation into the alleged abuse of resident #049 was not immediately initiated and that action was not taken in response to the incident until two days later. (107) [s. 23. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations; (b) appropriate action is taken in response to every such incident; and (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) Changes to resident #006's plan of care related to waking and care times had been discussed with the resident and numerous options were provided to the resident; however, documentation did not include the assessments, reassessments and the resident's responses to the proposed interventions. During interview, the Executive Director and Acting DOC were able to identify multiple meetings and interventions discussed to meet the resident's needs; however, documentation did not reflect that information.

B) Documentation on the, "Turning / Repositioning Sheets" for a two and a half month period was blank/incomplete for resident #191. Staff failed to document any turning and repositioning on the day shift on 20 days during that time. The resident had significant pressure related areas on their skin and had a deterioration of their skin integrity during that time.

C) Documentation on the flow sheets for resident #052 was not always completed as required by the home's policies and procedures. Documentation related to the provision of oral hygiene was incomplete on four shifts over a two month period. The resident was observed with clean teeth and PSW #158 who routinely cared for the resident confirmed the resident routinely received and enjoyed oral hygiene, however; the documentation was sometimes incomplete.

Documentation on the flow sheets for resident #052 related to bathing was incomplete for on week in a one month period reviewed. The resident was recorded as having only one shower that week. Staff were unable to confirm if a second shower was provided to the resident that week. Documentation was incomplete and did not reflect if a shower was offered to the resident or if the resident refused.

D) Documentation for bathing was incomplete (blank) for resident #183 for two identified weeks the weeks. The resident's plan of care required a bath or shower twice weekly. Staff #160 confirmed that the resident refused bathing but it was not documented. The staff member confirmed that all bathing refusals were to be documented on the flow sheets. Flow sheets were missing entries for seven potential bathing days over a three month period. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident of the home was restrained, by the use of barriers, locks or other devices, from leaving a room or any part of the home.

A) Resident #075 was observed to be in an area with a barrier in place that prevented the resident from leaving the area. RPN #114 and PSW #104 confirmed this was common practice to stop the resident from responsive behaviours. The Executive Director (ED) and Assistant Director of Care #121 confirmed the barrier was to be used for resident #075 to prevent the responsive behaviour. (640)

B) Resident #077 was observed to be in an area with a barrier in place that prevented the resident from leaving the area. RPN #114 and PSW #104 confirmed this was common practice to stop the responsive behaviours. The ED and ADOC #121 confirmed that the physical restraint was to be used for resident #077 to prevent the responsive behavior.

The licensee failed to ensure that no resident of the home was restrained, by the use of a barrier, locks or other devices, from leaving a room or any part of the home. [s. 30. (1) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that no resident of the home is restrained by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

Resident #187 was assessed as frequently incontinent of bladder and the resident wore briefs. The resident was also cognitively impaired and required extensive assistance of staff to transfer to the toilet, to pivot, and to provide all aspects of care. During the same month, the resident's Substitute Decision Maker (SDM) arrived on the unit to find the resident not toileted as per the plan of care on two occasions (within five days). On the second date, when the resident's SDM arrived on the unit, they found their father in distress and upset. The resident's plan of care was reviewed and identified that the resident had a scheduled toileting plan and was to be toileted after breakfast. PSW #152 confirmed the resident was on a toileting scheduling and was to be toileted after breakfast. The SDM confirmed the toileting schedule and the need for staff to transfer on and off the toilet for safety, and that the resident was not to be left alone on the toilet. The Executive Director (ED) confirmed that PSW #154 did not provide continence care to resident #187, as part of their plan of care, to promote and manage bladder continence. [s. 51. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

Resident #046 exhibited inappropriate behaviours, when they abused three residents. The resident was identified as exhibiting responsive behaviours. The home's policy, "Responsive Behaviours", number 09-05-01, and revised September 2010, identified that an Aggressive Behaviour Scale (ABS) score of six plus was considered as very severe risk. The policy also directed staff to conduct a more in-depth assessment, such as the Dementia Observation Scale (DOS) form to record behavioural observations when they were observed and to be added to the resident's file. Resident #046 exhibited inappropriate behaviours identified in a two month period, and after reviewing the clinical record there was no DOS documentation to assess the resident's behaviours, which prevented the staff in determining any patterns of behaviours, what type of activity triggered the behaviours, and therefore, the staff were unable to identify and implement the interventions to deal with the behaviours. Staff #103, #144 and the ED confirmed that there was no DOS assessments conducted for the resident in the two months that the incidents occurred and as a result any identification of the triggers and interventions to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 54. (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 ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all planned menu items were offered at the observed lunch meal April 15, 2016.

The planned menu included milk with meals and staff were to offer the milk to residents. At the observed lunch meal in two identified home areas, only two residents were offered milk. Residents who required thickened fluids and those that were unable to voice their preferences were not offered milk. Dietary Aide #101 confirmed that not all residents were offered milk in both dining areas.

Residents (#066, 061, 075) had a plan of care that specifically required milk to be provided at meals and the residents did not receive it. The residents had not refused milk at that meal and no specific reason was provided for not offering those residents milk.

A variety of beverages was planned and available for the regular texture menus. Three residents (#050, 052, 041) in one home area and three residents (#072, 063, 066) in another home area that required thickened consistency fluids were offered only one glass of thickened juice. Residents not requiring thickened fluids were offered juice, water and coffee or tea (two residents also received milk). The Registered Dietitian confirmed that residents receiving thickened consistency beverages were to be offered the same fluids as were offered to residents who did not require thickened beverages.

At the lunch meal May 3, 2016, on an identified home area, resident #001 was only provided with one fluid (juice). Staff stated that the resident usually received more fluids but wasn't sure why they only received one fluid at the meal. The resident had not requested only one fluid and was receiving their fluids in an specialized cup. [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 ensuring that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food was served using methods that preserved taste, appearance and food quality.

At the observed lunch meal April 15, 2016, PSW #104 was observed mixing two residents' (#040 and #077) pureed foods together. The residents had not requested that the food items be mixed together and did not have a plan of care that required their foods to be mixed together. The PSW stated there was no particular reason for mixing the residents' food together.

At the breakfast meal April 21, 2016, PSW staff assisting resident #174 with eating was stirring the resident's pureed foods together. The resident had not asked for the food to be stirred together and they did not have a plan of care requiring staff to mix their food together.

The Registered Dietitian confirmed that pureed foods were not to be mixed together unless it was indicated in the resident's plan of care or requested by the resident. [s. 72. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #15: 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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

At the observed lunch meal April 15, 2016, all menu courses (beverages, soup, entree, dessert) were served together on a tray for two residents (#052, 041). The residents were not interviewable and had not asked for all of their items to be served together. The residents did not have a plan of care that required all menu items to be served together. The Dietary Manager confirmed that meals were to be offered course by course unless otherwise specified in a resident's plan of care. Dietary Aide #101 confirmed that the meals should have been served course by course.

Resident #075 had their soup and entree placed on the table together. The resident had not asked for their entree while they were consuming their soup and the resident had a plan of care that required staff to serve one category of food at a time until the completion of meals.

At the observed lunch meal May 3, 2016, desserts were placed on the table prior to residents finishing their entrees. Dessert was placed on the table for resident #123 at 1253 hours and the resident had not yet started their entree. Dessert was also placed on the table for resident #135 at 1307 hours when they were still eating their entree. Resident #121 had all of their meal courses served together. The resident's plan of care directed staff to provide items course by course. The residents had not asked for their dessert to be served early and did not have a plan of care to have all items served together.

At the lunch meal May 12, 2016, on an identified home area, all residents had their dessert on the table while they were still eating their entrees. The dessert was chocolate ice cream or mango. The ice cream was melted in the bowls. PSW #157 stated that staff were too busy and that was why all the desserts were placed on the tables with the entrees that day. [s. 73. (1) 8.]

2. The licensee failed to ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

At the observed lunch meal May 3, 2016, not all residents received assistive devices and the required level of assistance with eating for independence.

Resident #123 had a plan of care that directed staff to provide the resident with an assistive device for their fluids. The resident was provided regular beverage cups and did not drink independently at the meal. Dietary Aide #140 and PSW #134

confirmed the resident should have received the assistive devices at the meal.

Residents #123, 130, 135, had a plan of care that required extensive assistance with eating. The residents sat for long periods of time without assistance and not eating. Staff were traveling around the dining room between the three residents giving a mouthful here and there while the staff was standing or leaning against a chair.

Resident #135 had staff assistance with two spoonfuls of soup (the resident was not eating between the two mouthfuls provided by staff) and then the soup was removed from the table unconsumed without encouragement to finish. The resident was able to consume the finger foods independently; however, was not able to eat without assistance for the other menu items.

Resident #123 had one mouthful of entree provided by staff and staff did not return to the resident for 16 minutes, provided another spoonful then left the resident again to assist other residents and did not return again for another 15 minutes. The resident did not consume their meal. Staff did not return to assist with dessert and fluids until 1320 hours.

Resident #130 ate when they were provided verbal and physical encouragement, however; the resident did not continue to consume their meal. Staff did not return to the resident between 1255 and 1320 hours. The resident had stopped eating at 1255 hours. [s. 73. (1) 9.]

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 ensuring that course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee did not ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

On May 16, 2016, at approximately 1420 hours, the door to the housekeeping room was left open, unsupervised, and accessible to residents on a secure home area. Tissue had been stuffed in the door to keep it ajar and to prevent the door from closing and locking. The room was a storage area and contained numerous bottles of hazardous chemicals that were accessible on the wall or in an unlocked cupboard that had the doors open, including three bottles of Vert-2-Go Neutral Cleaner (toxic symbol); two bottles of Everyday Disinfectant (label stated very toxic); one bottle of Swish King Lotion Cleanser (toxic); five bottles of Virox 5 RTU cleaner (hazardous). Housekeeper #156 stated they had forgotten their key and had put tissue in the door to prevent it from closing and locking. [s. 91.]

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 ensuring that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances were stored in a double locked stationary cupboard in a locked area or in a separate locked area within the locked medication cart.

On May 3, 2016, at approximately 0945 hours, five tablets of Hydromorphine 1 mg on a dispensing card, were observed on the small round table in the Director of Care's office. The medications were not stored in a double locked stationary cupboard in a locked area as verified by the Assistant Director of Care. [s. 129. (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 ensuring that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

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

On April 18, 2016, several unclean wash basins were observed on top of the toilet tank lids in four shared ensuite rooms. Urine measuring hats were stored on the tank lid of the toilet in a shared ensuite and were unlabelled. On May 12, 2016, the same urine hat was still there. In an identified room, two unlabelled denture cups, unlabelled, unclean washbasins were observed. In the same room four unlabelled tooth brushes and one labelled toothbrush were stored in one holder. One tooth brush that belonged to resident #003 was labelled but was stored with the other four tooth brushes that are unlabelled. On May 12, 2016, the same four unlabelled tooth brushes were in the same position as observed April 18, 2016. On April 19, 2016, a urine catheter drainage bag was draped over the handrail of the ensuite washroom in an identified room, which was a shared room.

On May 12, 2015, resident #017 was interviewed and stated that the labelled tooth brush belonged to them; however, they thought it was one of their old tooth brushes. On April 18, 2015, PSW #100 was interviewed and confirmed that the wash basins were expected to be stored on a hook on the wall and the urine measuring hats should be either in the toilet labelled or taken to the soiled utility room.

On May 12, 2015, PSW #151 was interviewed and confirmed that the tooth brushes should be labelled and stored separately. PSW #151 also stated wash basins and the unlabelled urine hat were to be hooked on the wall and the unlabelled urine measuring hat should not be stored on the tank lid.

A family member was interviewed on May 5, 2016, and identified that dirty urine cups were left in the washroom and voiced a concern regarding infection control practices in the home.

A record review of the minutes from the Residents' Council meetings on June 15, 2015, revealed that residents raised concerns about staff bringing a co-residents' washbasins to them to use for daily care and the wash basins did not belong to them. [s. 229. (4)]

Additional Required Actions:

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

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was created and maintained for each resident of the home.

Resident #199 had a significant weight loss of 10.6% over one month. Food and fluid intake records for the month prior to the weight loss were not available for review by the Registered Dietitian (identified in a progress note) and remained unavailable for review in the resident's chart during the RQI inspection in April 2016. The resident had not been absent from the home for the entire month and staff were unable to locate the documents. The licensee failed to ensure that the written record for resident #199 was maintained with all monitoring records included. [s. 231. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that a written record is created and maintained for each resident of the home, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident's bedroom occupied by more than one resident had sufficient privacy curtains to provide privacy.

Resident #052 did not have sufficient privacy curtains to provide privacy to the resident. On April 18, 2016, it was observed that the resident's privacy curtain in a shared bedroom did not go all the way to the floor. The curtain was about two to three feet above the floor. The resident had a plan of care that required their bed to be in the lowest position while sleeping and the resident would be fully visible from the doorway or by the other resident sharing the room during sleeping and during care. DOC #129 confirmed that the curtain would not provide sufficient privacy for the resident. [s. 13.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum interdisciplinary assessment of the following with respect to the resident: Sleep patterns and preferences.

A) The plan of care for resident #108 was not based on the resident's sleep patterns and wake preference. During interview on May 5, 2016, at 1050 hours, resident #108 confirmed their preferred wake time was 1000 hours. PSW #118 and RPN #119 both identified during interview that resident #108 preferred to wake at 1000 hours each day. The resident's plan of care stated the resident preferred to get up at 0600 hours. The resident's plan of care was not based on the resident's preferred wake time of 1000 hours. (640)

B) The plan of care for resident #033 was not based on the resident's sleep patterns and preferences. On April 18, 2016, the resident's SDM confirmed the resident did not prefer to get up early. On May 12, 2016, the resident confirmed a preference of not being wakened early and specifically stated that 0900 hours would be their preferred time. The admission assessment from two years prior documented the preferred wake time of 0700 hours. The current care plan stated the preferred wake time was 0700 hours. Acting Director of Care #129 confirmed the preferred wake time was later in the morning and the resident preferred to be left in bed if sleeping or drowsy in the morning. The plan of care was not based on the resident's preferred wake time of 0900 hours. (640) [s. 26. (3) 21.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that behavioural triggers were identified for resident #033. Triggers related to responsive behaviours were not identified in the current care plan. On May 9, 2016, Registered Nurse (RN)#126 confirmed the triggers were not identified on the plan of care. The licensee failed to ensure that for resident #033 demonstrating responsive behaviours, the behavioural triggers were identified. [s. 53. (4) (a)]

2. The licensee failed to ensure that for resident #183, who was demonstrating responsive behaviours, that actions were taken to meet the needs of the resident, including reassessments interventions and documentation of the resident's responses to the interventions.

Resident #183 was refusing an activity of daily living over a three month period. Staff member #159 voiced concerns to the Inspector about the resident's care refusal. According to the Acting DOC, staff had not communicated the persistent care refusals to the ADOC. Strategies identified on the resident's plan of care related to refusal of care were not evaluated or revised during that time and there was no documentation of the resident's response to the interventions identified on the plan of care. Staff #160 stated that the care plan strategies were not effective and the resident was not consistently being offered all of the strategies identified as they were ineffective. Progress notes on two dates in one month, identified concerns with refusal of care; however, the resident's plan of care was not revised and documentation did not include the resident's responses to the interventions identified on the plan of care. The resident continued to refuse care without a multidisciplinary re-assessment with revision to interventions identified on the plan of care. [s. 53. (4) (c)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, procedures were implemented for, (a) cleaning of the home including, (ii) common areas including furnishings.

The licensee had a procedure for cleaning of common areas, which included furnishings; however, the procedure was not implemented. The procedure, "Cleaning Frequency # HL-05-03-01", directed housekeeping staff to clean the common areas daily and complete a deep cleaning quarterly. On April 18, 2016, and May 4, 2016, at 1046 hours, the sofa and chair in an identified lounge were visibly soiled with brown debris, smelled of urine and had food debris, wrappers, tissues and two medication tablets under the seat cushions. Furnishings in six of the eight common areas were observed to be unclean, confirming the home did not implement their procedure. [s. 87. (2) (a)]

WN #24: 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 (SDM), if any, and any other person specified by the resident was, notified within 12 hours upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse.

Resident #047 and #067 were abused on two dates by resident #046. The clinical record for both residents was reviewed and there was no documentation that the SDMs for both residents were notified of the abuse within 12 hours of the home becoming aware of the incidents. Staff #103 was interviewed and was unable to verify that the SDM for residents #047 and #067 were notified of the abuse. The ED and staff #144 were interviewed and confirmed that there was no notification of the abuse of both residents to their SDM on both identfied dates. [s. 97. (1) (b)]

WN #25: 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:
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. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a response to the person who made a complaint was completed to include what the licensee did to resolve the complaint.

A complaint was lodged with the home by a family member. The concern was related to the and identified home area frequently being short-staffed, the care of a resident, and inappropriate behaviour of staff. A response to the complainant was not completed nor dated. The ED confirmed on May 10, 2016, at 1445 hours, the complainant had not been informed of the results and actions taken to address the lodged complaint. [s. 101. (1) 3.]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a Registered Dietitian, who was a member of the interdisciplinary team, participated in the annual evaluation of the effectiveness of the medication management system in the home.
A review of the "Quality Program Evaluation - Medication Annual", dated December 18, 2015, did not include the home's Registered Dietitian. [s. 116. (1)]

WN #27: 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. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure a quarterly review was undertaken of all medication incidents that occurred in the home since the time of the last review in order to reduce and prevent medication incidents.

A review of the home's "Quality Program Evaluation – Medication" minutes, dated December 18, 2015, reflected that the section titled "Medication Errors of all types", was documented as "N/A". The Executive Director confirmed that medication errors and incidents were not documented, tracked or reviewed for trends. (640) [s. 135. (3) (a)]

Issued on this 25 day of July 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MICHELLE WARRENER (107) - (A1)

Inspection No. / No de l'inspection : 2016_191107_0007 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 008295-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jul 25, 2016;(A1)

Licensee / Titulaire de permis : WEST PARK HEALTHCARE CENTRE
82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5

LTC Home / Foyer de SLD : WEST PARK LONG TERM CARE CENTRE
82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Sandy Hall

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To WEST PARK HEALTHCARE CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents, are protected from abuse by anyone and to ensure that all residents are not neglected by the licensee or staff.

The plan shall include, but not limited to the following:

1. Mandatory re-education for all staff on the home`s Abuse and Neglect policy, to include the Residents' Bill of Rights and Mandatory Reporting.

2. Education for all relevant staff related to the Responsive Behaviour Program, including monitoring residents with responsive behaviours, identifying behavioural triggers, developing and implementing strategies and interventions, and minimizing and mitigating altercations between residents.

3. Evaluate the education in #1 and #2 to ensure it is effective in providing quality and safe care to all residents, and implement quality management systems for monitoring / auditing compliance with the home's Abuse and Neglect, and Responsive Behaviour policies and procedures.

The plan is to be submitted on or before July 29, 2016, to Long Term Care Homes Inspector, Kathy Millar by email at: kathy.millar@ontario.ca
The plan shall be complied with by September 30, 2016.

Grounds / Motifs :

1. Severity: 2 (Minimal harm or potential for actual harm)
Scope: 2 (Pattern)
Compliance History: 4 (Ongoing non-compliance with a VPC or CO)

The licensee failed to protect residents from abuse by anyone and did not ensure that residents were not neglected by the licensee or staff.

Resident #046 had a history of inappropriate behaviours since admission to the home. Resident #046 abused a co-resident on a specified date after admission. The home did not report the abuse to the Director and they did not investigate and/or take appropriate actions as a result of the incident. Subsequently, resident #046 abused resident #047, and on another specific date, resident #046 sexually abused resident #067. The ED and Nursing Consultant were interviewed on May 5, 2016 and confirmed the abuse incidents occurred. The ED confirmed that the first incident met the home's definition of sexual behaviours and should have been reported to the Director. The ED confirmed that there were no assessments, no monitoring, and no updates to the written plan of care and no evaluation of the responsive behaviour interventions to ensure they were effective for the second incident. The licensee failed to protect residents from abuse by resident #046. (527)

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

Sep 30, 2016

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee shall ensure that there are schedules and procedures in place for routine, preventive and remedial maintenance of the home's beds.

The licensee shall ensure that:

1. All beds shall be inspected and the results documented at a minimum of once per year or more often in accordance with manufacturer's recommendations related to the care and maintenance of the beds.
2. Develop a written procedure that describes at a minimum who will inspect the beds, how often, how the inspection will be documented, course of action to be taken when disrepair identified and the expectations of all nursing and housekeeping staff with respect to monitoring bed systems. The written procedure shall be communicated to all maintenance, nursing and housekeeping staff.
3. Develop quality management activities, including auditing, to ensure that bed rails remain safe between the annual inspections and processes are in place for reporting and identifying loose bed rails.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

(A1)
1. Severity: 2 (Minimal harm or potential for actual harm)
Scope: 3 (Widespread)
Compliance History: 2 (Previous non-compliance, unrelated)

Procedures and schedules were not in place for preventive maintenance related to the home's furnishings (beds).

The licensee did not have a procedure or preventive schedule in place to ensure that the beds in the home were monitored regularly and maintained in good condition. During the inspection, five beds were observed to have assist rails in the transfer or assist position that appeared to have bowed outwards and were significantly loose, creating a gap between the rail and the mattress. The bolts and associated hardware were observed to be very loose. As a result, the home completed an audit of all bed rails in the home. One hundred and fifty three beds in the home were identified to have loose rails and 21 beds were missing mattress keepers either at the head or foot of the bed. According to the Support Services Manager, no procedure was developed which included the bed manufacturer's instructions for care and maintenance of the beds in the home. When the instructions were reviewed, the manufacturer required that the beds be inspected yearly and that any loose bolts or parts be replaced or tightened. The licensee's maintenance program for the beds relied on health care staff to report disrepair which was not preventive in nature. When the maintenance logs were reviewed from January to May 2016, several bed rails were identified as either broken or loose and were remediated; however, those identified in the rooms above were not included and had not been reported by staff.
Procedures and schedules were not in place for preventive maintenance of the home's beds to ensure the safety of residents using the beds. (107)

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

Oct 31, 2016

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that the home's policies and procedures are available to staff, that staff are aware of the policies and procedures at the home, and that staff are following the policies of the home in relation to: cleaning and disinfecting equipment, cleaning frequency, isolation room cleaning, medication administration, care of residents with Diabetes Mellitus, including hypoglycemia management, weight monitoring, food and fluid intake monitoring and referral to the Registered Dietitian.

The plan shall include, but is not limited to:
1. A review of the home's policies and procedures to ensure there is adequate direction for staff and that the above mentioned policies are available and accessible to staff providing care
2. Education for staff related to the policies and procedures identified above
3. Quality management activities, including auditing, to ensure that staff are following the identified policies.

The plan shall be submitted to Long Term Care Inspector Michelle Warrener by July 29, 2016, via e-mail to: Michelle.Warrener@ontario.ca. The plan shall be complied with by October 31, 2016.

Grounds / Motifs :

1. Severity: 3 (Actual Harm / Risk)
Scope: 2 (Pattern)
Compliance History: 4 (Ongoing non-compliance with a VPC or CO)

The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the plan, policy, protocol, procedure, strategy or system, was complied with.

A) The policy, “Cleaning and disinfecting equipment IC-03-01-07", revised September 2015, directed staff to clean and disinfect resident care equipment in accordance with the manufacturer’s directions and recommendations. Registered staff and front line nursing staff were responsible for cleaning, disinfecting and storing resident care equipment in between resident use.

PSW #151 was interviewed and stated that washbasins were to be cleaned, labelled and stored on the hook. Several unwashed and unlabelled washbasins were observed on the home tour on April 18, 2016. An unlabelled and unclean urine hat was also observed in a specified room. Similarly on May 12th, an unwashed unlabelled washbasin and labelled and clean washbasin were stored together. PSW #151 confirmed that the expectation was to wash and label each washbasin and store them separately.

The Assistant Director of Care and Infection Control Co-ordinator was interviewed and confirmed that it was the staff responsibility for cleaning and disinfecting residents' care equipment and staff were trained on the policy. Staff were also expected to clean and disinfect all equipment listed on the policy that included urinals and basins, and to label single resident-use equipment. (645)

B) The policy, "Emergency Starter Box Policy 2-4", dated January 2014, directed staff to write the resident's name on the medication label and then peel off the label when a medication was used from the emergency starter box (ESB). The peeled off label was to be placed on the ESB Drug Record Book page and faxed immediately to the pharmacy.

The nurse who removed the narcotics from the ESB on February 5, 2016, failed to document on the narcotic count sheet the required information and failed to place the peeled off label from the ESB medication card on the Drug Record Book page as directed by the policy. On May 3, 2016, at 0955 hours, the Assistant Director of Care confirmed both steps had not been completed as per policy 2-4. (640)

C) The policy, "Cleaning Frequency HL-05-03-01" and Appendix 2, directed staff to carbolize resident beds, including the deck and legs of the bed every 30-90 days.

During interview, housekeeper #116 confirmed there was no predetermined schedule for carbolizing or deep cleaning the resident mattresses and beds. ESM #122 confirmed there was no schedule for deep cleaning or carbolizing resident beds. (640)

D) The policy, "Isolation Room Cleaning HL-05-04-02", directed staff to bag cleaning cloths and mop heads and send to laundry after cleaning each isolation room.

Housekeeper #116 confirmed that the mop head was cleaned on the home area using hot water and Virox. ESM #122 confirmed mop heads were cleaned on the home area in a washing machine. (640)

E) The home's policy, "Care of residents with Diabetes Mellitus CLIN-05-07-01", last reviewed December 2002, did not include directions for staff related to the management of hypoglycemia. A document in the "Nursing Services - Clinical Procedures" referenced a "Clinical Procedures Notice" and "Lippincott Manual of Nursing Practice 9th edition Index of Clinical Procedures". The notice stated, "This manual contains clinical policies and procedures. For clinical situations not covered by these documents, or for further procedural guidance, consult the company's preferred reference manual for resident care - The Lippincott Manual of Nursing Practice (9th edition)".

Direction provided in the Lippincott Manual of Nursing Practice in relation to the treatment of hypoglycemia directed staff to treat hypoglycemia promptly using the 15 gram (g) / 15 minute rule with 15 g of rapidly absorbed carbohydrates (half cup juice, 1 cup skim milk, three glucose tablets, four sugar cubes, five to six pieces of hard candy may be taken orally). Repeat blood glucose; if less than 70 (milligrams per decilitre (mg/dL), repeat the treatment. If more than 70 mg/dL and more than three hours since last dose or immediate-acting insulin, no further treatment required. If more than 70 mg/dL and less than three hours since last dose of immediate acting insulin, follow with a snack of 75 to 100 calories. If using a split mix or REG/NPH insulin and more than 30 minutes before the next planned meal/snack, have snack now (nutrition bar specifically designed for diabetes). Glucagon 1 milligram (mg) is given if the patient cannot ingest a sugar treatment. Intravenous bolus of 50 mL of 50 percent dextrose solution can be given if the patient fails to respond to glucagon within 15 minutes.
Direction provided for staff in this manual reflected lab reference values using American and not Canadian reference ranges.

Registered staff #125, 126, 127, were interviewed about the method of treatment for hypoglycemia and staff were not consistent in their approach. When asked, the registered staff were unable to locate direction for the treatment of hypoglycemia. Staff were not aware to consult the Lippincott Manual and a copy of the Lippincott Manual was not available in the two nursing areas observed by Inspector #645 on April 28, 2016.

Resident #197 had low blood sugar documented on two identified dates. Staff used different methods for treating the low blood glucose or no treatment and different time frames for re-testing (hourly versus every 15 minutes) when the resident's blood sugar remained low . When the resident was resistive to drinking the juice offered, documentation did not reflect an alternative approach was tried and not all low blood sugars recorded had a corresponding treatment or follow up. The low blood sugar occurred in the middle of the night; however, documentation did not reflect a snack was provided to the resident to prevent the resident's blood sugars from falling after initial treatment.

Staff were not aware of and did not follow the home's policy for the management of this resident's hypoglycemia while at the home. (107)

F) The home's policy, "Weight Change Program RESI-05-02-07", version November 2013, directed staff to weigh residents monthly and record the weight on the Weight Change Program Tracking Sheet either on paper or electronically. The home's process was to enter weights into the Point Click Care electronic system. For monthly monitoring, every resident was to be weighed on the first bath day within the first seven days of each month. Staff were to compare the weight to the previous month's weight and any weight with a 2.5 kilogram (kg) difference from the previous month required a re-weigh. The re-weighs were to be recorded by the tenth day of each month either on paper or electronically.

Not all residents had their weights monitored monthly. Weights were missing from the weight monitoring records and were not available for review during stage one of this inspection. A family member voiced concerns about the weights not always being completed on time or as per the home's policy. The Registered Dietitian confirmed that not all of the weights were being recorded monthly as per the home's policy and that re-weighs were not consistently being taken as per the home's policy.

Resident #199 was missing a documented weight for August 2015.
Resident #108 was missing a documented weight for January 2016 and October, 2015.
Resident #057 was missing a documented weight for October 2015.
Resident #037was missing a documented weight for October 2015.
Resident #094 was missing a documented weight for October 2015.
Resident #109 was missing a documented weight for January 2016 and October, 2015

Resident #166 was missing a documented weight for April, March, January 2016, and August 2015.
Resident #101 was missing a documented weight for October 2015.
Resident #087 was missing a documented weight for January 2016
Resident #084 was missing all documented weights since 2014. (107)

G) The home's policy, "Food and Fluid Intake Monitoring RESI-05-02-05", version September 2014, directed staff to document resident food and fluid intake after meals and snacks and to review the intake records daily on nights. The policy directed staff to complete a hydration assessment on the Point Click Care system when a resident consumed less than their minimum fluid target levels for three consecutive days. If the hydration assessment indicated signs and symptoms of dehydration, immediately implement strategies to increase fluid intake based on the needs and preferences of the resident. The policy also directed staff to continue to review the fluid records daily and if the resident's intake remained below minimum target despite strategies to increase fluid intake, complete an additional hydration assessment and to refer to the Registered Dietitian as necessary. The policy also directed staff to refer to the Registered Dietitian if the resident consumed 50% or less from all meals for three or more days or refused supplements or nutrition interventions for three consecutive days.

Resident #178 was routinely meeting their food and fluid intake requirements and then had a decrease in their hydration. Daily food and fluid intake records reflected the resident did not meet their minimum hydration target on 10 days over an 11 day period. A hydration assessment was completed on the fourth day, indicating no signs and symptoms of dehydration. An additional dehydration assessment was not completed when the poor hydration continued. A progress note indicated the resident went to hospital with dehydration three days after this 11 day period. There were no follow up notes related to the resident's poor hydration between the first hydration assessment and when the resident was sent to hospital.

Upon return from hospital the resident continued to have poor food and fluid intake. A hydration assessment was not completed as per the home's policy four times in the month after the resident returned from hospital, and three times in the subsequent month. The Registered Dietitian was not notified of the ongoing poor hydration and were not aware of the poor hydration until they completed the resident's Annual review. A referral to the Registered Dietitian was initiated just prior to the resident being sent to hospital a second time (two months after the first hospitalization).

The resident also experienced poor food intake of 50% or less for three meals or more on: seven days prior to the first hospitalization, and most of the subsequent two months.

The Registered Dietitian confirmed that staff did not consistently follow the home's hydration policy. (107) (645)

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

Oct 31, 2016

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that all residents who are dependent on staff for repositioning are repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

The plan shall include, but is not limited to:
1. Education for staff related to the home's policy and procedures on turning and repositioning residents for high risk residents.
2. Education for staff on reporting and communication when residents have responsive behaviours or refuse turning and repositioning when it is clinically indicated
3. Quality management activities, including auditing of documentation, to ensure that staff are following the home's policy and procedure and that turning and repositioning is provided as outlined in residents' plans of care.

The plan shall be submitted by July 29, 2016, to Long Term Care Inspector Michelle Warrener via email to: Michelle.Warrener@ontario.ca. The plan shall be complied with by October 31, 2016.

Grounds / Motifs :

1. Severity: 3 (Actual Harm / Risk)
Scope: 2 (Pattern)
Compliance History: 2 (Previous non-compliance, unrelated)

The licensee failed to ensure that residents #022 and #191, who were dependent on staff for repositioning, were repositioned every two hours or more frequently as required and as clinically indicated.

A) Resident #022 had an open area on their skin, which subsequently progressed to a worsened pressure area the next month. The pressure ulcer was acquired in the home and the resident was previously identified as high risk for altered skin integrity. The resident was identified as needing turning and repositioning every two hours and as needed. PSWs #150 and #151 were interviewed and identified that they were expected to turn and reposition the resident every two hours, and document on the turning and repositioning sheet in the PSW flow sheet binder. The Wound and Skin Lead, staff #126 and registered staff #114 confirmed that resident #022 was

assessed and required turning and repositioning every two hours. The registered staff also confirmed that the PSWs were required to turn and reposition the resident every two hours and document the intervention on the flow sheet. The clinical record and plan of care were reviewed and it was identified that the turning and repositioning intervention was not implemented until eight days after the original open area was identified, and the home was unable to provide any documentation to support that turning and repositioning was performed. Resident #022 was not repositioned every two hours as required and as clinically indicated. (527)

B) Resident #191 had multiple significant pressure areas and was at risk for further skin breakdown and required full assistance by staff for turning and repositioning. Documentation on the "Turning / Repositioning Sheet" for two months, reflected that the resident was not consistently being repositioned by staff while in bed.

Documentation reflected the resident was not repositioned between 2300 hours and 0900-1200 hours on all days over two months, with the exception of four days. Documentation was blank/incomplete for day shift on 20 days over a two and a half month period. The resident's pressure areas deteriorated during this time. PSW staff #162 and #163 confirmed that the resident was not being repositioned every two hours on two of the specified dates that they were working. During interview, the resident also confirmed that they were not routinely repositioned during the night shift over a two month period. PSW staff #163 stated to the Acting Director of Care (DOC) that the resident often refused to be repositioned; however, this information was not communicated to the registered staff for re-assessment. (107) (107)

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

Oct 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25 day of July 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MICHELLE WARRENER - (A1)

Service Area Office /
Bureau régional de services : Toronto