Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 1, 2016	2016_344586_0007	007231-16	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

WESTSIDE
1145 Albion Road Rexdale ON M9V 4J7

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

JESSICA PALADINO (586), BERNADETTE SUSNIK (120), NATASHA JONES (591), THERESA MCMILLAN (526)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 1, 4, 5, 6, 7, 8, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28, 29 and May 3, 2016.

The following Critical Incident inspections (CIS) were completed simultaneously during this RQI:
003661-14 (Prevention of Abuse)
004682-14 (Prevention of Abuse)

008186-14 (Prevention of Abuse)
008880-14 (Prevention of Abuse)
010164-14 (Prevention of Abuse)
003284-14 (Falls Prevention)
009077-14 (Falls Prevention)
009172-14 (Falls Prevention)
008071-14 (Prevention of Abuse)
011843-15 (Falls Prevention)
013005-15 (Prevention of Abuse)
015841-15 (Prevention of Abuse)
016332-15 (Prevention of Abuse)
016668-15 (Prevention of Abuse)
025524-15 (Prevention of Abuse)
026777-15 (Prevention of Abuse)
028546-15 (Prevention of Abuse)
032601-15 (Prevention of Abuse)
034737-15 (Transferring and Positioning; Prevention of Abuse)
000456-15 (Prevention of Abuse)
011602-16 (Prevention of Abuse)
009811-16 (Prevention of Abuse)
011071-16 (Prevention of Abuse)

The following Complaint Inspections were completed during this RQI:
004347-14 (Prevention of Abuse)
007851-14 (Accommodation Services – Maintenance)
004554-15 (Prevention of Abuse)
017632-15 (Infection Prevention and Control)
021025-15 (Prevent of Abuse; Reporting and Complaints)
023075-15 (Prevention of Abuse)

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Programs Manager, Food Service Manager (FSM), Environmental Services Manager (ESM), Resident Services Coordinator (RSC), Staff Educator, Scheduler, Physiotherapist (PT), Pharmacist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), dietary staff, recreation staff, housekeeping and maintenance staff, Family and Resident Council representatives, residents and family members.

During the course of the inspection, inspectors reviewed resident health records, investigative notes, complaints logs and files, maintenance logs and audits, infection control surveillance documentation and outbreak files, staff files, menus and dietary sheets, staff education records, program evaluations, policies and procedures; toured the home; and observed dining services, residents and care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **25 WN(s)**
- **13 VPC(s)**
- **6 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, where bed rails were used that the residents' bed system was evaluated and that residents were assessed in accordance with prevailing practices, to minimize risk to the resident.

A) The licensee commissioned a company to test resident bed systems on April 16, 2015, for entrapment zones 1-4. The results provided by the DOC identified that 42 beds failed one or more entrapment zones 2, 3 or 4 and that another bed system audit was pending for late April 2016. According to the bed system audit results and the DOC, all of the failed beds had some remedial modifications completed shortly after the audit but no dates were made available of when the remedial work was completed. Some of the 42 identified beds received new mattress stops, had bed rails tightened, received new mattresses or had bed rails removed or replaced since April 2015. However, as the home did not have their own bed system entrapment measuring tool, verification was not conducted to verify that the changes that were made were effective in eliminating any of the identified entrapment zones. The status of the 42 resident bed systems that previously failed an entrapment zone was therefore unknown at the time of inspection.

B) According to prevailing practices tilted "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and endorsed by Health Canada), residents were to be evaluated while sleeping in bed over a period of time by an interdisciplinary team to determine if the bed rail was a safe alternative for the resident after trialling other options (as listed in the guidelines). According to the guidelines, questions would need to be developed and answered related to but not

limited to the resident's falls history, medication use, toileting habits, sleeping patterns, behaviours, environmental factors and other relevant information that would guide the assessor to make a decision, with either the resident or Substitute Decision Maker (SDM), about the necessity for a bed rail. The information would be documented on a form (either electronically or on paper) as to why one or more bed rails were required, what type of rail was required, when the rails were to be applied, how many and on what sides. The interdisciplinary team members involved in the assessment for each resident would include but not be limited to a registered staff member, PT and PSW; all individuals who would be involved in caring for the resident.

The DOC provided a copy of the assessment tool that was used to evaluate residents who used a rail titled "Side Rail and Alternative Equipment Decision Tree". When reviewed, it was noted to be missing signatures from an interdisciplinary team and a component related to identifying whether the resident was offered any alternatives to bed rails, whether the alternative was successful or not, how long the alternative was used for and whether an evaluation of safety risks was completed including but not limited to entrapment risks when a bed rail was applied. The assessment tool was geared towards resident bed mobility and repositioning and transfers in or out of bed. The assessment tool was therefore not developed fully in accordance with prevailing practices as identified in the guideline.

At the time of inspection, five residents were observed lying in bed, each with one or more rails elevated. In order to determine why residents required a bed rail, the most recent plan of care for each resident was reviewed. The plans for the six residents reviewed included the reason for bed rail use, but the statements were very generic. The statements were either "bed rails up on either R/L or both sides and used to facilitate bed mobility" or "assist rail use to facilitate bed mobility and repositioning".

According to the home's "Side Rail Alternative Equipment Decision Tree" form, the assessing staff members were to apply additional precautions to mitigate entrapment risks for residents residing on therapeutic air surfaces and who used a bed rail due to the additional risks posed by such surfaces. The form identified a cautionary statement stating that therapeutic air surfaces could not be assessed for entrapment and therefore it may pose additional risk to the resident when using side rails.

*Resident #073 was observed to be in bed lying on a therapeutic air surface with both of their quarter rails elevated by inspector #120 between 1030 and 1130 hours. The resident's bed system was assessed on April 16, 2015 and determined to have ½ rails on

at the time with a therapeutic surface that failed zones 2 and 3. The bed was either changed or different rails were applied. The entrapment status of the bed at time of inspection was unknown. The resident's plan of care identified that the resident was to have "either the left or right bed rail up when in bed to facilitate bed mobility". The assessment tool could not be located in the resident's chart.

*Resident #032 was observed to be in bed lying on a therapeutic air surface with both of their ¾ length rails elevated or raised by inspector #120 between 1030 and 1130 hours. The resident's bed system was assessed on April 16, 2015, but at the time was identified to have a flat foam mattress on the bed frame. A different mattress was therefore applied and not re-tested. The entrapment status of the bed was unknown at time of inspection. The resident's plan of care identified that "assist rail to be used for bed mobility and repositioning". The assessment tool was partially completed on February 22, 2016, requiring the resident to have a hi-low bed and side rails. No additional precautions were identified on the tool to mitigate possible entrapment risk.

*Resident #074 was observed by inspector #653 to be lying on a therapeutic air mattress with both rotating assist rails elevated between 1330 and 1400 hours. The resident's care giver was asked why the rails were elevated while in bed and the PSW reported that it was to prevent falls. The resident's plan of care dated March 23, 2016, identified the resident as a low risk for falls and did not have any direction for staff to apply the rails to prevent falls. The plan identified that the resident was to have "assist rail use to facilitate bed mobility and repositioning". The assessment tool was partially completed on February 17, 2016, requiring the resident to have a hi-low bed and side rails. No additional precautions were identified on the tool to mitigate possible entrapment risk.

*Resident #071 was observed to be lying in bed on a conventional foam mattress by inspector #120 with both of their assist rails in the guard position (positioned centrally alongside of the bed). The resident's plan of care required that "bed rails up on either R/L or both sides and used to facilitate bed mobility". A completed assessment tool could not be located in the resident's chart. The resident was admitted in January 2016.

*Resident #076 was admitted to the home on April 12, 2016. The resident was observed to be lying in bed on a conventional foam mattress by inspector #653 with two bed rails in use between 1330 and 1400 hours. As of May 3, 2016, no information was provided in their care plan regarding the application or use of any bed rails. No completed assessment tool could be located in the resident's chart.

During a tour of the resident rooms on all floors after the lunch period on April 13, 14 and 15, 2016, when most residents were out of their rooms, approximately 50% of the beds had one or more bed rails elevated. When the DOC was asked why, some reasons given related to staff habits or resident preference. As not all of the bed entrapment status was known at time of inspection, residents returning to these beds either alone or assisted, would have been placed at risk of zone 2, 3 or 4 entrapment unless interventions were specified in the plan of care and those interventions applied. [s. 15. (1) (a)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (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 there was a written plan of care for each resident that set out the planned care for the resident.

Interview with PSW #016, the ADOC, the DOC, and review of the home's internal investigation notes confirmed that resident #052 was often restless at night, and confirmed the reasoning for this; therefore, would initiate a specific intervention to aid in reducing their agitation. Review of the resident's documented plan of care did not include any information regarding the resident's sleep and rest patterns, any identification of their restlessness in the evenings, or any interventions to mitigate this. This was confirmed by the DOC. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and

others who provide direct care to the resident.

A) According to their health record, resident #038 had a progressive health condition that limited their mobility. According to their most recent Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment resident #038 required specified assistance for transferring, toileting, and bed mobility. During interview, they stated that they did not like to use a particular lift as they felt that it hampered their independence, and stated what their preference was for transferring.

During interview, PSW staff #117 stated that the resident's plan of care called for use of the particular lift and that they insisted on transferring the resident using that lift; PSW staff #052 stated that they transferred the resident without use of the lift as it promoted their independence and the resident preferred it and seemed able to manage this type of transfer. During interview the home's PT stated that according to their assessment, the resident was most safe being transferred with the use of the lift; they stated that they were not aware that the resident had alternative preference.

Review of the document the home referred to as resident #038's documented plan of care included several specific interventions for transferring, toileting, and bathing the resident.

PSW staff #117and #052, the ADOC and the PT confirmed that the resident's plan of care did not provide clear directions to staff regarding resident #038's transferring needs, that the plan of care did not respect the resident's preferences and also increased their safety risk during transfer. (526).

B) Observation of resident #035 on an identified date in April 2016, on two occasions, confirmed the resident was sleeping in bed with no bed rails in use. Interview with registered staff #126 and PSW #130 confirmed the resident did not use bed rails on their bed. In an interview with the DOC, she stated she spoke with night staff members and some said the resident used bed rails, while others said they did not. The DOC confirmed that the resident required the use of one half rail while in bed, and that it was the expectation of the staff to put the rail up on the bed when the resident was in bed, even if they got into bed themselves. Review of the resident's documented plan of care stated "bed rails used to facilitate bed mobility". The DOC confirmed the plan of care did not include information on the resident's specific needs related to bed rails, including the number, type, and size, and confirmed the plan of care did not provide clear direction to staff. [s. 6. (1) (c)]

3. The licensee failed to ensure that the staff and others involved in the different aspects of care of resident #020 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Interviews with PSWs #129, #120 and #80, and registered staff #062, and record review confirmed that resident #020 demonstrated responsive behaviours toward staff on a regular basis. On an identified date in January 2016, resident #020 had an altercation with PSW #120. Due to the incident, the DOC updated the resident's documented plan of care from one-person assistance for a particular type of care to two-person assistance"; however, their kardex, which front line staff use to direct care, still indicated that the resident required one-person assistance. During interviews with PSWs #129, #120 and #80, and registered staff #062, all staff indicated the resident required only one-person assistance. The DOC confirmed she and the front line staff did not collaborate in the resident's plan of care. [s. 6. (4) (b)]

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

A) The document the home referred to as resident #038's care plan indicated the resident exhibited certain responsive behaviours. Review of the resident's health record indicated that they did not have a cognitive impairment and no entries in progress notes between January 2015 and April 2016 indicated that the resident had demonstrated inappropriate behaviours.

Resident #038's RAI MDS Assessments indicated that the resident had not exhibited inappropriate behaviours during these assessments. During interviews, PSW's #052 and #117, and the DOC stated that the resident had not exhibited responsive behaviours for over a year. The DOC confirmed that resident #038's plan of care had not been updated when their care needs changed in relation to responsive behaviours.

B) Resident #038 did not have cognitive impairment and was their own decision maker regarding their care. During interview, they told the LTC Inspector that some evening staff assist them to bed much earlier than their preferred bed time; sometimes two hours earlier.

Review of the document the home referred to as resident #038's care plan directed staff to assist the resident to bed at two different times, one much earlier in the evening than the other.

During interview, PSW #007 confirmed the resident liked to go to bed at the later time. Registered staff #105 stated that interventions in the care plan that the resident liked to go to bed earlier were from when the resident was initially admitted and confirmed that the resident's plan of care had not been updated and may be unclear to staff not familiar to resident #038's bedtime preferences.

C) Resident #040's RAI MDS indicated that they had impaired vision but did not use visual appliances. During interview, PSW #089 and RN #104 stated that the resident did not use glasses. During interviews, PSWs #086 and #120 stated that the resident had glasses but they were not sure when or why they would wear them. Review of the document the home referred to as resident #040's care plan did not include any information about their limited vision or their use of glasses.

Resident #040 confirmed that they used glasses on occasion but were not wearing them at the time of the observation. Two days later, the resident was observed wearing their glasses and their family member reported to the LTC Inspector that they notified the home one month ago that the resident needed to wear their glasses all the time; prior to then they required glasses for reading.

During interview, the ADOC stated that the family had brought in glasses but staff had not updated the RAI MDS assessment or plan of care to direct staff on resident #040's use of glasses to correct their vision.

D) According to resident #054's health record and the home's risk management documentation, they fell 15 times in 2014. They were diagnosed with an injury after a fall. Prior to this time, they had been ambulating independently using a walker. They were assessed by the PT and it was determined that they would benefit from the use of a wheelchair due to risk for falls and their inability to ambulate safely using the walker after their injury. They began using a wheelchair and according to progress notes and interview with the PT, the wheelchair was periodically tilted for the resident's comfort.

Review of the document the home referred to as the resident's care plan as of their discharge indicated that they continued to use a walker for ambulation and not a wheelchair, did not indicate how the tilt should be applied to the wheelchair, and did not

include a plan of care regarding change in needs associated with their injury. The RAI Coordinator and PT confirmed that resident #054's plan of care had not been reviewed and revised when their care needs changed after sustaining a fracture.

E) Interviews and record review confirmed resident #020 often refused care. POC documentation from early 2016 to present demonstrated that the resident refused 19 out of 30 offers for a specific type of care. Interviews with PSWs #129 and #080, and registered staff #062, confirmed that the resident almost always refused this, but would at times accept an alternative method of care. Review of the resident's documented plan of care and kardex, which front line staff use to direct care, did not include any information regarding the resident's refusal or acceptance of an alternative. No information was included about successful interventions or techniques staff use to aid in the resident`s acceptance. This was confirmed by the DOC.

F) Interviews and record review confirmed that resident #020 exhibited responsive behaviours toward staff on a regular basis. Interviews with PSWs #129 and #080, and registered staff #062, confirmed that one of the there was one specific method that was most effective for calming the resident down. A physician's progress note confirmed this method. Review of the resident's documented plan of care and kardex, which front line staff use to direct care, did not include any information on this intervention to manage the resident's responsive behaviours.

G) During Stage 1 of the RQI, Inspector #526 noted resident #035 to have a strong frank urine odour upon observation. Over a three day period, resident #035 had three documented reports to their clinical record indicating the resident was experiencing restlessness, anxiety, and confusion. There were two documented reports of the resident experiencing typical symptoms of a urinary tract infection (UTI). Registered staff #110 confirmed the resident had a history of UTI's, with the last occurrence the month prior; this included a progress note, indicating the resident was demonstrating a usual symptom they expressed when they had a UTI. The physician was not informed of the resident's status until three days later when the inspector brought the information to registered staff #110 and the DOC's attention, whereby the physician ordered a urine specimen as the resident's symptoms progressed and they experience further symptoms. The DOC confirmed the physician should have been notified sooner, and that the home did not review and revise the resident's plan of care when the resident's care needs changed.

H) On an identified date in 2015, resident #059 was discovered by their family member

lying in bed with the bed in an unsafe position. Interview with PSW #003, who put the resident to bed, confirmed PSW #003, who put the resident to bed, indicated that they put the bed remote underneath the resident's pillow to prevent them from playing with it. Internal investigation notes determined the resident was "likely randomly pressing remote control buttons thereby changing the position of headboard & footboard without intention". Interview with PSW #003 confirmed the resident was known to play with the bed remote prior to the incident. In the home's investigation notes the PSW stated "[they] will press buttons without knowing what [they] are doing". Review of the resident's documented plan of care in place at the time of the incident did not include any information regarding the resident's behaviour of playing with the bed remote, including any interventions to assist in preventing potential negative outcomes. The plan of care was not updated when the resident's care needs changed. This was confirmed by the ADOC. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) Resident #040 had a health condition that limited their movement. The document the home referred to as their care plan directed staff to provide care with two staff persons at all times due to resident's behaviour specific needs.

Review of the home's CIS submission and the home's internal investigative notes indicated that on an identified date in 2015, PSW #071 pulled resident #040's arm and

inflicted pain while providing care with one person. According to these notes, the resident motioned that the staff was hurting them and when the staff person did not stop pulling. During interview with the LTC Inspector, resident #040 confirmed that the PSW had hurt them by pulling on their arm during care.

PSW #071 was not available for interview. During interview with the DOC, they confirmed the above details and stated that the PSW #071 had inflicted physical abuse upon resident #040. (526).

B) A review of the home's internal investigation notes indicated that resident #050 reported to the staff educator that when PSW #082 gave them a shower on an identified date in 2014, they were rough with them. The resident was interviewed and stated that the PSW hit them and was rough with them in the shower. Interview with the DOC confirmed that resident #050 was not protected from abuse. (591).

C) A review of the home's internal investigation notes indicated registered staff #109 witnessed PSW #027 tell the resident to go back to their room as they were coughing a lot. The resident was on isolation for respiratory symptoms. When the resident did not move, the PSW yelled at them and was physically aggressive toward them. The resident was interviewed and stated that the PSW hit them and took away their drink. An interview with registered staff #109 revealed she had witnessed the incident as described above and reported immediately to the charge nurse. The DOC confirmed that resident #050 was not protected from abuse. (591).

D) On an identified date in 2015, resident #049 observed PSW #030 yell at resident #066. Resident #049 reported that the PSW always raised their voiced and yelled at residents. In an interview with the LTC Inspector, resident #049 confirmed the incident, stating that the PSW was yelling at resident #066 and speaking in a rude tone, and that they felt upset by the occurrence. Interview with PSW #030 confirmed they spoke loudly and this upset the resident. The home's internal investigation notes and interview with the DOC confirmed that the PSW spoke loudly to residents, and confirmed that resident #066 felt upset. Residents #049 and #066 were not protected from verbal abuse. (586).

E) In an interview, resident #038 told the LTC Inspector that in 2015, a PSW staff approached them and asked them why they complained about the care that they had provided. The resident said that they felt afraid and intimidated by the staff person's questions and approach. Review of the home's investigative notes indicated the following:

i. PSW #301 had negotiated with resident #038 that they would "be allowed" to have certain items if the resident did not complain about them;
ii. On an identified date in June 2015, RPN #096 had been questioned by a LTC Inspector regarding resident #038's allegations against PSW #300;
iii. On an identified date in June 2015, PSW #300 was observed by RPN #096 to approach resident #038 and told them that they were spoken to about something the resident had complained about; they asked the resident why they complained;
iv. During interview, the resident said that they felt intimidated by PSW #301; and
v. During interview, PSW #301 confirmed that they approached the resident because they did not want the resident to complain about them.

During interview with LTC Inspector, resident #038 stated that they felt afraid to complain about care in the home since they felt intimidated and afraid when PSW staff #301 approached them about their complaint about care. During interview, RPN #096 stated that PSW's remarks toward resident #038 were intimidating and threatening. The PSW who made the remarks was not available for interview as they had been terminated. These details were confirmed by the DOC who also confirmed that PSW #301's remarks to resident #038 were abusive since they were threatening and intimidating to the resident. (526).

F) Review of the home's internal investigation notes indicated the home's ADOC forwarded a complaint letter written by resident #048 to the Director. The letter from an identified date in 2015 was addressed to the DOC regarding an incident where it was alleged that resident #079 entered their room while they were asleep and physically assaulted them. PSW #033 responded to the call for help, witnessed the altercation and escorted resident #079 out of the room.

Resident #048 confirmed the details of the CIS during interview. The resident stated that the incident left them fearful. The resident stated that they reported the incident to the DOC who responded by acknowledging the incident and outlining the steps and specific interventions that would be taken to prevent the incident from happening again. The resident stated the interventions were not sufficient for their security.

Review of progress notes indicated registered staff #054 noted the incident and completed an assessment of resident #048 but found no injury. Review of interview notes of PSW #033 confirmed the incident details.

Interview with the DOC confirmed the details of the incident, the steps taken to protect the resident, and that the home did not regard the incident as "abuse" because the resident was not injured. The DOC confirmed resident #048 was not protected from abuse. (591).

G) During interview RN #104 confirmed that resident #037 was cognitively intact in 2014, and that they were more confused during this inspection. They stated that in 2014, the resident could accurately communicate their concerns.

According to a CIS submission on August 15, 2014, resident #037 complained that a PSW had been physically and verbally abusive. Review of the home's investigative notes confirmed these allegations, listing specific instances.

During interview, RPN #096 verified the above complaints that resident #037 had told them regarding PSW #300's treatment of them. RPN #096 and RN #104 confirmed that the resident was an accurate historian in 2014. PSW #300 was not available in the home for interview.

During interview an identified date in April 2016, resident #037 exhibited an anxious look on their face when they stated that a staff person had made verbally abusive comments to them. Their family member told the LTC Inspector that PSW #300's comments that were made in 2014 continued to upset the resident up to the time of this inspection. During interview, the DOC confirmed that PSW #300's actions against resident #037 constituted verbal and physical abuse. (526).

H) In April 2016, resident #068 voiced concern to housekeeping staff #250 about another resident and the housekeeper encouraged the resident to report their concern. PSW #061 then approached the resident and questioned them in an intimidating tone about whom and what they were going to report. This was witnessed by housekeeping staff #250 and activity staff #197. The resident indicated they felt intimidated and afraid. Review of the home's internal investigation notes and interview with the DOC confirmed the PSW asked the resident questions in a very intimidating manner, and confirmed the resident felt intimidated. The DOC confirmed resident #068 was not protected from verbal abuse. (586).

I) On September 11, 2015, resident #056 reported that they were provided care by PSW #057 and #025 even though they said they did not want the care, and said the staff roughly handled them during the procedure. The resident also stated that the two

PSW's, along with registered staff #013, were also verbally abusive to them and spoke in a language other than English while in the resident's room which the resident could not understand. Resident #056 was not available for interview with the LTC Inspector; however, review of the home's internal investigation notes and interview with the DOC confirmed the occurrence, and confirmed PSW's #057 and #025 and registered staff #013 physically and verbally abused resident #056. (586).

J) On an identified date in 2016, PSW's #088 and #194 witnessed PSW #097 yell at resident #067 and push them down into a chair. PSW #097 denied this; however, this occurrence was confirmed through video surveillance that was reviewed by the DOC. Review of the home's internal investigation notes and interview with the DOC confirmed the resident was physically and verbally abused by PSW #097. The DOC confirmed resident #067 was not protected from abuse. (586).

K) Resident #064's written plan of care indicated that resident had a specific bathing preference due to privacy concerns, and was able to complete most of their care on their own but needed some assistance for certain aspects.

According to interview with the resident, on an identified date in April 2016, PSW #064 assisted them to shower. The resident reported that the staff person was rough with them during care to the point of pain, and that the staff would not let the resident independently complete parts of their own care according to their plan of care, even though they asked repeatedly. The resident stated that they felt abused and said they were in tears after the occurrence. They reported the incident to RPN #105 and to the DOC.

During interview, PSW #007 confirmed that they were working on the day of the incident as described above. They confirmed the resident's care preferences and needs as per their plan of care. They stated that it seemed that PSW #053 rushed resident #064's care and that this resulted in the resident crying.

During interview, RPN #105 stated that PSW #053 should have asked another PSW to assist them when resident #064 indicated that they were upset or distressed. During interview, the DOC stated that PSW #053 told them that they were not familiar with resident #064's plan of care. During interview, PSW #053 told the LTC Inspector that they did not have time to review the resident's plan of care. They stated that they hurried the resident through the care and did not check with the resident about preferences.

The DOC confirmed that PSW #053 had inflicted abuse on resident #064 since they used

physical force that caused pain to the resident; the staff did not follow the resident's plan of care, did not ask the resident about their preferences, and did not seek assistance from a staff member who was more familiar with the resident's needs. (526). [s. 19. (1)]

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. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee failed to ensure that the lighting requirements set out in the lighting table were maintained.

The home was built prior to 2009 and therefore the section of the lighting table that applied was titled "In all other areas of the home". A handheld non-digital light meter was used (Sekonic Handi Lumi) to measure the lux levels in one ward bedroom, one semi-private room and one private room, several resident ensuite washrooms, corridors on all three floors, dining rooms and lounge. The meter was held a standard 30 inches above the floor and held parallel to the floor. Window coverings were drawn in the resident bedrooms tested and lights were turned on five minutes prior to measuring. Areas that could not be tested due to natural light infiltration were dining rooms and common areas. Outdoor conditions were semi-bright during the measuring procedure. The minimum required lux for all resident areas excluding corridors is 215.28 lux (bedrooms, washrooms, lounges, dining rooms, showers, tub rooms). The minimum required lux for all corridors is a continuous and consistent lux of 215.28 lux.

A) Resident Bedrooms

A private bedroom (#207) was measured on April 13, 2016 and was similarly equipped with the same light fixtures as all of the other private rooms. Each room had a wall mounted over bed light fixture consisting of two fluorescent tubes (top and bottom) and a recessed pot light with a compact fluorescent light bulb at the entrance to the room. None of the bedrooms were equipped with bedroom ceiling light fixtures. The entrance into the bedroom was 90-100 lux under the pot light. The centre of the room was 60 lux with the over bed light on. The lux under the over bed light was 245.

A semi-private room (#405) was measured on April 21, 2016 and was similarly equipped with the same light fixtures as all of the other semi-private rooms. Each room had a wall mounted over bed light fixture consisting of two fluorescent tubes (top and bottom) and a recessed pot light at the entrance of the room. None of the rooms were equipped with ceiling light fixtures. The entrance into the bedroom was 20 lux due to a burnt out bulb. The centre of the room or near the foot end of the beds was 90 lux and the lux between beds was 200 lux.

A four-bed ward room (#440) was measured on April 21, 2016 and was similarly equipped with the same light fixtures as all of the other four-bed ward rooms. Each room had a wall mounted over bed light fixture consisting of two fluorescent tubes (top and bottom) and a recessed pot light at the entrance of the room. The centre of the room was 90 lux, the area under the entry pot light was 100 lux, the side of bed #1, #2 and #3 was 180-190 lux, the foot of bed #1 and bed #3 was 75 lux and the over bed lights were

approximately 350 lux. The area that included the wardrobes was near the entry to the room and was 100 lux.

The minimum required lux level for resident bedrooms in areas where activities of daily living take place such as sitting, dressing, walking is 215.28 lux. The minimum required lux level under the over bed light is 376.73

B) Corridors

The homes three resident occupied corridors were measured on April 21, 2016 and each had unique lighting configurations. The corridors on the south wing beyond the fire doors were adequate on all floors. The east and west wings were not adequate. The entrance to each of the three corridors, including the south wing were not adequate as they were equipped with three pot lights for a 12 foot long section of corridor.

* Elevator area on floors 2, 3 and 4

Each floor was equipped similarly with three wall lights on the same side as the elevators, large windows opposite the elevators and fluorescent tube lighting running along the window wall and across the top of the windows. The tubes were housed behind a wood valence and louvered lens. The area was 12 foot wide by 40 feet long. No ceiling lights were provided. The fourth floor was measured as it had thick curtains that were drawn across the windows. The lux was 150-190 lux along path of travel from the nurse's station and around the corner towards the dining room doors. The area in front of the dining room doors had three pot lights which were 150 lux.

*West Corridor

The west wing had recessed fluorescent tube lights on either side of the corridor on all resident occupied floors. Due to a number of burnt out lights, the lux was 110-150 lux. In areas fully lit, the lux was 190-200 lux.

* South Corridor

The entrance to the south corridor had a low ceiling with two pot lights on all three floors. The distance between the entrance of the corridor and the fire doors and resident rooms beyond was approximately 12-14 feet. The lux for the pot lights on each floor ranged from 60 to 125 lux.

* East Corridor

The east wing on all floors was similarly equipped with recessed fluorescent tube lights on either side of the corridor ceiling. At the time of inspection, the fourth floor east corridor had 5 bulbs burnt out and the lux was very low in some areas, especially at the beginning of the corridor which was 50 lux. Otherwise, where all of the bulbs were lit, the lux met minimum requirements.

C) Main floor

The home's main floor dining room and main foyer lounge area was equipped with over 10 chandelier light fixtures with six bulbs each. Due to the excessive natural light infiltration, the levels could not be measured. A small section with tables #16 and #17 was measured as it was not impacted by natural light. This area had a lower ceiling height with pot lights instead of chandelier light fixtures. The lux was 100-195. The lounge in front of reception was equipped with the same chandelier light fixtures as the dining room. They produced approximately 155 lux of light. The lounge area on the main floor behind the reception area was equipped with 8 pot lights spaced out on the ceiling, in decorative sectioned areas and 11 pot lights around the perimeter of the room. The area not as affected by natural light was measured and was 90 lux by the fish tank and 150 lux by the television. This area was furthest from the windows. The main corridor leading past the elevators to the activity room could not be measured but was suspected of not being adequate due to the number and type of fixtures provided. The LTC Inspector discussed with the ESM that the lighting levels would need to be independently verified when outdoor conditions were dark.

D) Lounges

Due to the fact that most lounges were missing window coverings, many could not be verified for lighting levels. One section of the west lounge on the fourth floor was measured and blinds pulled. The room was equipped with two ceiling lights with two fluorescent tubes each. One was burnt out in each fixture. The lux was 350 under the lights and the lux dropped to 110 four feet away from the lights. The minimum required lux for lounge space is 215.28 lux throughout (excluding corners).

E) Bathing areas/resident washrooms

Resident washroom #234 had a lux of 93 lux over the toilet.
3E Shower- 130 lux under opaque lens in the shower.
Resident washroom #308 had a lux of 220 at the vanity but it dropped to 50 lux at the toilet.
Fourth floor tub room - five pot light fixtures noted without bulbs thereby reducing the lust to 150 at the and the lux in the shower was 120. [s. 18.]

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

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

On an identified date in April 2016, during inspection of a medication cart in the medication room, a pouch labelled for resident #077 was found in the resident's drawer.

During an interview with registered staff #109, who was responsible for the medication administration of this resident, stated the resident refused to take their medication when offered and she did not have time to document the refusal. The staff stated that the resident frequently refused to take their medication, and confirmed that she had not reported this behaviour to the charge nurse or physician.

A review of the residents #077's MAR's (Medication Administration Records) for the past 6 months indicated there were no documented incidences of refusal of medication. A review of the resident's most recent written plan of care including revisions dated March 21, 2016, did not include information related to refusal of medication, nor did it include information to indicate the resident had any resistive or other behaviour.

Interviews with registered staff #033 and #091 confirmed they had medicated the resident in the past and recently; however, the resident had never refused to take their medication, nor was the resident known to have resistive behaviour related to medication. Staff #091 stated that she had medicated the resident that week and all of last week and they did not refuse their medication.

An interview with the ADOC revealed it is the home's expectation that medication is administered within one hour before and after the prescribed time in the MAR, documentation of administration should occur immediately after administration, and all medication incidences should be reported immediately to the ADOC. The ADOC stated that medications should be removed from the pouch, taken to the resident and if refused, discarded and the refusal documented immediately in the resident's MAR. The ADOC and DOC confirmed that registered staff #109 did not administer medication to resident #077 as per the physician's orders. [s. 131. (7)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) According to their health record and the home's risk management system, resident #054 fell 15 times in 2014. One of these falls resulted in injury. They were sent to hospital and diagnosed with an injury. Progress note entries indicated that they were experiencing pain and were not assessed for pain using a clinically appropriate instrument specifically designed for this purpose upon return from hospital or when initial interventions were ineffective until the resident's next fall which was 14 days later.

During interview, the RAI Coordinator confirmed that resident #054's pain should have been assessed using a clinically relevant pain assessment instrument, upon return from hospital and when initial interventions for pain management had not been effective. (526).

B) Between 2013 and 2014, resident #060 had 47 falls in the home. Interview with the DOC confirmed that it was the expectation of the home that when a resident falls, staff were to complete a pain assessment if pain was expressed by the resident as a result of the fall. According to the resident #060's health record and the home's risk management system, the resident was experiencing pain after falling on three instances, and the DOC confirmed no pain assessments were completed. [s. 52. (2)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents' right to be afforded privacy in treatment and in caring for his or her personal needs was not fully respected and promoted.

A) At the time of inspection, a number of four-bed and two-bed resident rooms (#231, #304, #342, #434, #437, #438) were observed to have a fabric curtain as a substitute for

a bathroom door. The fabric curtain was not able to provide 100% visual privacy or acoustic privacy. According to the ESM, the sliding pocket doors were removed years prior to allow residents to have independent access to the bathroom using their wheelchairs. According to a full-time PSW working with residents in bedroom #342, two out of the four residents used a wheelchair. The residents with wheelchairs could not use the washroom independently and required a transfer using a floor lift. Therefore there was no reason why the pocket door for this washroom could not have been re-installed. No consideration was given to re-designing the bathroom door so that a solid barrier could still be provided. The licensee did not take any actions to promote or uphold residents' right to privacy. (120).

B) Resident #064 did not have cognitive impairment according to their health record, and had a diagnosis of anxiety. The resident's documented plan of care indicated that the resident requested to do a certain part of their cause on their own due to privacy. During resident interview, they reported to LTC Inspectors that on an identified date in April 2016, staff person #053 accompanied them into the spa room where another resident was found waiting for their shower. The resident said that the staff person began providing care to them quickly while the other resident was in the spa room and that they felt that their privacy was violated. During interview, PSW #053 confirmed that the other resident was in the spa room while resident #064 began their care and that they rushed the process since another resident was present.

During interview, PSW staff #007 stated that on an identified date in April 2016, they had brought a resident to the spa room and returned to the resident's room to retrieve an item. Upon return to the spa room, they found the door open and the curtain in front of the shower open and stated that they could see resident #064 being showered from where their resident had been sitting. PSW #007 confirmed that resident #064's right to be afforded privacy during care had not been fully respected since they could be viewed while having their shower. During interview, the DOC confirmed this as well. [s. 3. (1) 8.]

2. The licensee failed to ensure that the resident's right to participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters was respected and promoted.

Resident #038 did not have cognitive impairment according to their health record, and was their own decision maker. During interview, they complained to LTC Inspector that a

particular staff member called their family member to ask for consent for the resident. They stated that they were their own decision maker and that they had told the staff that staff did not have to call their family members for consent; that staff having to ask their children for consent made them upset. The staff told the resident that it was the home’s policy to call all family members for consent.

Review of the home's "Recreation Services Community Outings" (number LTC-I-30, last revised December 2015) directed staff that "Consent will be obtained from the Resident/SDM/Family for the resident to participate in outings. This consent will be documented in the resident's chart”.

According to resident #038’s progress notes, recreation staff called their family members on four dates in 2016, to ask them for consent for the resident.

During interview, recreation staff #192 stated that it was the home’s policy to call all family members of residents for particular reasons regardless of whether the resident was their own decision maker or not. They stated that they informed residents that they would be calling their family members rather than asking for permission. The staff confirmed that resident #038 was their own decision maker, and that their permission should have been sought rather than informing them that their family member would be notified. Recreation staff #192 and the Programs Manager confirmed that they should not have asked resident #038’s family member to consent for the resident when the resident was their own decision maker as this did not respect and promote their right to make decisions about any aspect of their care. [s. 3. (1) 11. iii.]

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 to ensure every resident's right to be afforded privacy in treatment and in caring for his or her personal needs, and their right to participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, is fully respected and promoted., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

A tour was conducted of the home on April 1 and 13-21, 2016, by various inspectors. The following was observed:

A) On April 13, 2016, the second floor utility room door was found unlocked despite the availability of a key hanging next to the door. The room contained numerous buckets labelled "bio hazardous waste". One bucket was easy to open and contents seen inside. The risk to residents included access to unknown bio hazardous contents.

B) On April 13, 2016, the laundry chute room on the second floor did not have a functioning door handle and was not lockable. On April 21, 2016, the handle had been removed and no handle was available to lock the chute room. The risk to residents included the potential of residents falling into the chute.

C) On April 13, 2016, the second floor shower room was left unlocked, despite the

availability of a key hanging next to the door. Inside the room was a bottle of liquid disinfectant which, if ingested, can cause serious harm.

D) Loose and lifting carpet was noted in the second floor lounge (near room #221) which presented a trip hazard on April 13, 2016.

E) Very loose toilet seats were noted in #403 and #302 on April 13, 2016. The seat in #403 was tightened by April 18, 2016, but not the seat in #302. Toilet seats were loose in #402, 408 and 409 on the April 18, 2016. Residents using the toilets would have been at risk of falling off the toilet.

F) On April 18, 2016, the gate surrounding the enclosed outdoor courtyard used by residents was left unlocked all day. Residents were observed in the courtyard throughout the day and very easily could have left the property without being detected.

G) A resident was observed to have a specific furniture item located between their bed and their co-resident's bed. According to the resident, they had acquired the item in December 2015. The resident's bed was against the wall with the item beside one end of the bed. The co-resident's bed was positioned with the head of the bed against the wall. Therefore the co-resident had the large item positioned next to their bed and half way down the length of their bed. The location and size of the item was observed to be in a precarious location for resident and worker safety. The RSC, ESS and a representative of the health and safety committee were aware of the potential safety risks but did not take any actions. According to the RSC, all residents and families were informed about the rules relating to the size of those items and the acceptable size of furniture permitted in each type of bedroom in the home, for safety reasons. According to the above noted staff interviewed, they reported that they did not want to violate the resident's right to have the item. Discussion was held that safety would always prevail over residents' rights. In this case, the resident did agree to have the items set relocated against the wall and their bed repositioned.

H) The licensee submitted plans to replace an aging cylinder on one of their three elevators on October 27, 2014. In the plan, the scope of work included some "minor welding" and identified that "it would not be that noticeable". Three to four sections of stainless steel casing would be joined by welding and that dust would be contained within the construction site. The plan did not identify how dust would be contained within the construction site (within the elevator shaft) or how fumes and odours would be controlled during the welding, drilling or grinding processes. The plan identified that the ED, ESM

and contractors would be "in charge of ensuring that safety was maintained" during the project.

On November 3, 2014, between 1030 and 1100 hours, dense smoke was observed by a family member on the ground floor after witnessing a worker inside the elevator shaft using a welder. The arc or flame that was produced by the welder was quite visible from the waiting area where the family member was waiting for another elevator. Upon exiting onto the fourth floor, smoke and odours were present in the area in front of the elevators. According to the family member, the smoke from the welding operation traveled up the elevator shaft and onto each floor. The family member reported their concerns related to inhalation safety to registered staff and was told there were no safety concerns. The family member was not satisfied and reported their concerns to the ESM and the ED. The family member was informed that there was not much they could do about the issue. The ESM was interviewed regarding the incident and he confirmed that the welding process took three to four hours and that smoke did in fact migrate out from the elevator shaft into resident occupied spaces. He confirmed that he asked the worker to stop welding and that he asked the contractor to evacuate the smoke from the affected areas. A exhaust unit and ducting was brought in and connected to the outside. The licensee did not ensure that appropriate venting and exhaust equipment was implemented prior to the start of the project to address dust or other by products that would be created from grinding, welding and drilling activities.

According to the American Society of Safety Engineers, welding dust and fumes contain a plume of minute particles produced by the molten metals and by gases released during the welding process. They can include metals such as aluminium, nickel, manganese, lead, chromium, copper, iron oxide or cadmium oxides. Gases produced by fumes include carbon monoxide, fluorine, nitrogen oxide and ozone. Exposure to the particles may irritate the mucous membranes of the eyes and lungs. If not wearing appropriate eye protection, looking at the arc of light produced by the welder exposes the eyes to the full spectrum of ultra violet radiation emitted by the light causing irritation of the eyes. [s. 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 to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #9: 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 the home's falls protocol and procedure was complied with.

Between 2013 and 2014, resident #060 had 47 falls in the home. Interview with the DOC confirmed that it was the expectation of the home that when a resident falls, staff were to complete detailed progress note documentation and a head-to-toe skin assessment, as well as pain assessments if pain was identified.
Review of the resident's clinical health record revealed the following:
i. No progress notes were completed for four of the resident's falls;
ii. No skin assessments were completed for four of the resident's falls; and,
iii. Pain was expressed by the resident after the following falls, but no pain assessments were completed for three of the falls. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure the home's Personal Assistive Services Devices (PASD) policy was complied with.

The home's policy "Personal Assistive Service Devices (PASD)" (index number LTC-J-30, last revised December 2015) included the use of assistive rails as PASD's, and stated that informed consent for a PASD was to be obtained and documented in the interdisciplinary progress notes. Interview with the DOC confirmed resident #035 used one half bed rail while in bed for bed mobility, and confirmed no consent for the resident's use of the bed rail was obtained. [s. 8. (1) (b)]

3. The licensee failed to ensure that the home's wheelchair maintenance policy was complied with.

The home's Maintenance Services "Resident Owned Wheelchairs" (policy number ESP-B-35, dated September, 2004) indicated that resident-owned wheelchairs would be maintained in good operating condition and that hazardous equipment would not be used by residents.

During interview PSW's #052 and #117, and RPN #064, the staff stated that if direct care staff observed a resident's wheelchair to be in poor repair, they were to notify registered staff in the home and a requisition should be created for the wheelchair to be repaired. The home's PT confirmed this.

On an identified date in April 2016, resident #038 was observed to have altered skin integrity. During interview they stated that they became injured from a part of their wheelchair. On observation, the wheelchair had broken pieces with hazardous sharp edges. The resident stated that they told the registered staff who addressed the injury that they were injured due to the wheelchair. Registered staff #031 confirmed that this during interview and said that they notified the PT to assess the wheelchair for safety.

During interview, the PT stated that the particular function on the wheelchair was repaired but that they were not aware that the wheelchair safety was an issue. They confirmed that the part should have had a protective covering to prevent injury and applied these until a service provider could come. The DOC confirmed that the home's expectation and policy that resident #038's wheelchair be maintained in good repair was not complied with and that the wheelchair should have been repaired as soon as staff became aware of the risk for injury. [s. 8. (1) (b)]

4. The licensee failed to ensure that the home's concerns and complaints policy was complied with.

A review of policy #LP-B-10, titled "Management of Concerns/Complaints/Compliments" revised October 2011 indicated "the Quality team will record, review, analyze and monitor the outcome of all concerns/complaints and subsequent improvements on a quarterly basis, as part of the advancing excellence program".

A review of the quarterly Quality Council Minutes for the most recent meeting dated April 22, 2015, and the minutes of the three previous quarterly meetings did not include a review or analysis of the complaints/concerns and subsequent improvements.

An interview with the DOC and the ED confirmed the Quality team did not record, review, analyze and monitor the outcome of all concerns/complaints and subsequent improvements on a quarterly basis as indicated in the home's policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home's falls, PASD, maintenance, and concerns and complaints protocols, policies and procedures are complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The following were observed during the initial tour on April 1, 2016:
i. The servery on the fourth floor, west wing was unlocked and unsupervised. Inside the server was a warming table that was hot to touch and had hot water in it. Registered staff #104 confirmed the door should be locked when not in use and it posed a risk to residents.
ii. A door on the fourth floor across from the nursing station marked "oxygen in use" was unlocked. The room contained two large oxygen tanks, a treatment cart with treatment supplies, electrical panels and an IV pump. A key was hanging on the wall just outside the door. Registered staff #104 confirmed the door should be locked when not in use and it posed a risk to residents.
iii. Two servery room doors on the second floor, west wing were unlocked and unsupervised. Both rooms contained warming tables that were hot to touch, and had hot water in them. Registered staff #075 confirmed the door should be locked when not in use and it posed a risk to residents. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they were not being supervised by staff., to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure there was a written policy to promote zero tolerance of abuse and neglect of residents, and shell ensure that the policy was complied with.

A) The home's policy "Resident Non-Abuse-Ontario" (policy number LP-C-20-ON, that was last revised on September, 2014) directed "any staff member or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a Resident must immediately report that suspicion and the information on which it is based to the Executive Director (ED) of the Home or, if unavailable, to the most senior Supervisor on shift at that time. The person reporting the suspected abuse or neglect must follow the home's reporting requirements to ensure that the information is provided to the ED immediately".

According to the home's investigative notes, on an identified date in 2014, resident #037 complained to RPN #096 that a PSW had verbally abused them in the course of giving care. During interview with the LTC Inspector, the resident confirmed their concerns. The reporting RPN #096 confirmed that the notification was not made by email until three days later, even though they were aware of the resident's concern on the date they were brought forward to the RPN. During interview, the DOC confirmed that RPN #096 had not followed the home's abuse policy that any staff member who became aware of abuse or neglect of a resident should immediately notify the ED or the most senior Supervisor on shift at that time. (526).

B) Review of the home's internal investigation notes indicated that the home's ADOC forwarded a complaint letter written by resident #048 to the Director. The letter dated was addressed to the DOC regarding an incident that had occurred involving resident-to-resident physical abuse. PSW #033 responded to the call for help, witnessed the altercation, and escorted the resident out of the room.

Interview with the ADOC revealed she forwarded the written complaint by resident #048

immediately to the Director as a requirement for reporting complaints, but she did not submit a CIS for "Abuse" because the resident was not injured.

Interview with the DOC confirmed the details of the incident. The DOC confirmed that the home did not regard the incident as "abuse" and did not report it as such because the resident was not injured. The DOC confirmed the policy was not complied with. (591).

C) On an identified date in 2016, housekeeping staff #250 witnessed verbal abuse by PSW #061 toward resident #068. The staff member spoke to another staff member, PSW #197, about the incident, but did not report it. Three days later, housekeeping staff #250 and PSW #197 reported the incident to their supervisor. The DOC confirmed the home's abuse policy related to reporting was not complied with. [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 to ensure there is a written policy that promoted zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

Resident #046's RAI MDS assessment indicated that the resident required a specific level of assistance for transferring. The resident's documented plan of care indicated that the resident required the same level of assistance. During interview, PSW #120 confirmed this. Their health condition resulted in pain and an increased risk for altered skin integrity including skin tears and bruising.

On an identified date in 2015, resident #046 reported that the day before, they had been transferred roughly into their bed that resulted in hurting their legs and back. The home's investigative notes indicated that staff PSW's #086 and #008 had each transferred the resident between the bed and wheelchair using an level of assistance that did not meet the needs of the resident. PSW #008 was not available for interview. During interview with the LTC Inspector, PSW #086 stated that they did not see a transfer logo for the resident, did not refer to the kardex, and could have asked for assistance with the transfer. They stated that they were not the resident's regular care giver.

During interview, the DOC stated that the resident was at increased risk for bruising and pain associated with their health conditions. They stated that staff had transferred resident #046 between bed and chair with using a method that was not according to their plan of care. The DOC confirmed that staff did not use safe transferring and positioning techniques for resident #046 and placed them at risk for pain and injury. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #13: 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,
(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; O. Reg. 79/10, s. 50 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Resident #054 sustained an interruption to skin integrity as the result of a fall in 2014. They were sent to the hospital for assessment of their injuries. Review of their health record indicated that they had not received a skin assessment by a member of registered staff following return from hospital, and had not had weekly skin assessments completed of the alteration to their skin integrity that occurred during the fall. This was confirmed during interview with the home's RAI Coordinator. [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure that a resident who exhibited altered skin integrity,

including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On an identified date in 2016, resident #038 was observed to have a dressing applied to an area of altered skin integrity. Review of the health record indicated that they were at risk for alteration to skin integrity. Review of the health record did not include an initial assessment of the wound or weekly assessments using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. Progress note from an identified date in 2016, indicated that the wound had become infected. This was confirmed by RPN's #105 and #126 and the DOC. [s. 50. (2) (b) (i)]

3. The licensee failed to ensure that every resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian (RD) 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 were implemented.

A) On April 5, 2016, resident #038 was observed to have a dressing applied to an area of altered skin integrity. According to the health record, the resident was a moderate nutritional risk and had a history of alteration of skin integrity. The electronic treatment administration record (eTAR) indicated that staff began weekly treatment of resident #038's impaired skin; however, review of the health record revealed that the resident had not been assessed by a registered dietitian following alteration of skin integrity that required treatment. This was confirmed by the DOC. (526).

B) Resident #054 developed impaired skin after a fall in 2014. Review of progress notes indicated that a referral to the RD had been made on an identified date in December 2014. According to this chart review, the resident was not seen by the RD until 16 days later, and interventions referred to weight changes and not the resident's alteration in skin integrity. The RAI Coordinator confirmed that the RD had not assessed resident #054 following an alteration in skin integrity according to the home's expectations. (526).

C) Between 2013 and 2014, resident #060 had 47 falls in the home. Interview with the DOC confirmed that when a resident falls resulting in an open area to their skin, such as a skin tear or laceration, a referral to the RD was expected to be completed and the RD was to assess the resident. Review of the resident's clinical health record confirmed the resident sustained injury from six of the falls. Referrals to the RD were not completed, and the RD did not assess the resident after the falls. The above information was

confirmed by the DOC. [s. 50. (2) (b) (iii)]

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 to ensure that a resident who exhibited altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return from hospital, and receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques, including safe positioning, were used to assist residents with eating.

Resident #059's documented plan of care included a goal to minimize the resident's risk of choking and aspiration, and directed staff to position them at a 90 degree angle during feeding. Resident #062's documented plan of care indicated that the resident had difficulty chewing. Resident #063's documented plan of care indicated that the resident had a swallowing difficulty, and directed staff to feed the resident at a 90 degree angle.

During lunch meal observation on an identified date in April 2016, residents #059, #062 and #063 were observed in their wheelchairs in a reclined position while staff assisted the residents with eating. Interview with the FSM confirmed all residents should be positioned at a 90 degree angle to ensure safe eating practices, and interview with registered staff #067 confirmed the residents were not positioned appropriately, then proceeded to reposition the residents' wheelchairs. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that proper techniques, including safe positioning, are used to assist residents with eating, to be implemented voluntarily.

WN #15: 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. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee did not ensure that procedures were implemented for cleaning of the home, specifically soiled utility rooms and resident bedrooms. The housekeeping program for the home was being managed by a contracted service provider.

A) According to the contracted service provider's housekeeping policy "Utility Rooms" (policy number C-30-40), staff were required to clean the fixtures and horizontal surfaces in the rooms daily. All three soiled utility rooms were inspected on April 13, 14, 15, 18 and 21, 2016 and the room walls, floors, sinks and hoppers were dirty in appearance. The rooms were being used for the storage of garbage, sharps containers and bio hazard waste containers. The hopper on the second floor had heavy algal growth in it, the third floor hopper was clogged with dirty brown water and the one on the fourth floor had no water in it and the surface was coated in brown/black stains. According to housekeeping and non-registered staff, the hoppers were not being used on a regular basis. Based on observations, the cleaning routines were not implemented.

B) The housekeeping program consisted of written procedures to guide housekeeping staff in their duties and tasks around resident rooms and washrooms. Housekeeping policy "Daily Cleaning Sequence" (policy EC-10-05), with an additional area on the procedure tilted "detailed unit cleaning procedure" for twice monthly deep cleans, "High Dusting" (policy EC-10-10), "General Dusting and Spot Cleaning" (policy EC-10-15) and "Cleaning Washrooms" (policy EC-10-25) were reviewed. The procedures all required that bedrooms be cleaned daily (spot wipe walls, mop floors, change garbage etc.). Based on observations between April 13 and 21, 2016, it did not appear that the policies were being implemented on a daily basis or twice monthly. Visible wall matter was noted in washrooms, especially next to the garbage can in but not limited to #411, 408, 422, 437, 441, 240, 234, 300, 302, 304 and 334 on April 13, 2016 and on April 21, 2016. Walls were visibly soiled in and around resident beds, light switches or hand gel dispensing stations in rooms #207, 237, 404, 238, 233, 234 and 340. Closet tracks located in numerous resident rooms were full of dust and debris on all floors. The ceilings near the window incremental heating and cooling units were covered in dust in #404, 238, 234 and 231. Privacy curtains for the washroom in #437 remained visibly soiled from April 13 to April 21, 2016. A resident chair in room #233 was splashed with white marks that could easily be rubbed off and noted from April 13 to April 21, 2016. According to the detailed unit cleaning schedule bedrooms #431-441, #331-341 and #231-241 were to be cleaned during the week of April 11-17, 2016. Rooms that fell into

this schedule were required to have been given a deep cleaning which included walls however when observed, their state of cleanliness April 13-21, 2016 had not changed from observations noted above. [s. 87. (2) (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 to ensure procedures are implemented for cleaning of the home, specifically soiled utility rooms and resident bedrooms, to be implemented voluntarily.

WN #16: 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. The licensee failed to ensure that schedules or procedures were in place for remedial and preventive maintenance.

The maintenance services program for the home was being managed by a contracted service provider. According to the ESM and the contracted service provider's maintenance policies, no procedures were in place to guide maintenance or designated staff in their role in conducting preventive and remedial maintenance related to the condition of floors, carpets, doors, windows, ceilings, furnishings, fixtures and other interior surfaces. The ESM reported that the contracted service provider completed bi-annual maintenance audits of the home and submitted the results to the ESM for follow-up action. According to the contacted services auditor, only one full audit was completed in 2015. During the full audit, a random selection of 25 resident rooms was completed along with random common areas and bathing areas. The audit included a

check list of many types of interior surfaces and furnishings. In October 2015, a limited audit was completed which included a review of 6 resident rooms using the same detailed checklist. According to the auditor, the licensee was required to take the results of the audits and develop a schedule to not only repair the areas identified for follow up action, but to develop their own priority in home audits so that the remaining resident rooms and common areas were assessed. The licensee did not establish or develop any additional audits to keep themselves apprised of the condition of the interior surfaces and furnishings throughout the building with the exception of audits identified below. The following conditions were observed in the home by one or more inspectors between April 1 and 21, 2016;

A) Flooring/carpeting - No procedure or confirmed schedule was in place to address the condition of hard surface flooring and carpeting in the home.
i. The flooring material in the second floor tub room was split inside of the shower area. As of April 14, 2016, the ESM was not aware of the issue and therefore had not scheduled any repairs. According to the ESM, the second floor tub/shower room was slated for renovations in mid-2016.
ii. The carpet was loose with bulges in the centre of the south lounge on second floor. This observation was identified by the contracted service auditor in June 2015.

B) Plumbing Fixtures – No procedure or confirmed schedule was in place to address the condition of sinks, toilets and other fixtures.
i. Toilet tank lid split in #231.
ii. Rusty sink drains were observed in #207, 229 and 222.
iii. The hand sink in the second floor soiled utility was not functional (no hot or cold water) and the fixture was loose.
iv. The hopper on third floor was clogged and when flushed did not drain and hopper on fourth floor was dry and the flush handle was not working.

C) Windows – No procedure or confirmed schedule was in place to address the condition of windows, screens and surrounding surfaces such as sills.
i. The laminate on window sills in #201, 247, 369 and 438 were delaminating.
ii. Screens had holes in them in #401, screen missing in 402.

D) Furnishings - No procedure or confirmed schedule was in place to address the condition of furnishings (beds, night tables, wardrobes, chairs, sofas). An audit was completed by in home staff on November 10, 2015 with respect to night tables. The audit results included whether the tables were "old" or "new". The condition of the night

tables was not identified. According to the ESM, night tables and chairs were slowly being replaced, however no schedule was provided as to which chairs would be replaced and when. There was no interim plan to manage the condition of the chairs before replacement.
i. Chair frames (legs and arm rests) in resident rooms #400, 402, 404, 406, 408 (also had hole in seat), 422, 428, 441, were observed to have the dark finish worn down to an absorbent wood layer.
ii. A cushion on the sofa located in the second floor lounge had a large tear in it, exposing the foam underneath.
iii. The table surface located in the small kitchenette on the 2nd floor was rough, with exposed particle board.
iv. The backing on the storage cabinet in the 2nd floor kitchenette had penny nails sticking out of it and the back was not attached to the frame.
v. The head board to a bed (next to window) in room #324 was not connected to the frame April 13-21, 2016. Staff did not report the issue and inspector reported the matter to staff on April 21, 2016.
vi. Night table edge (identified as a "new" night table) was missing laminate along the front edge in bed room #400 and 402 and laminate was broken off with jagged edges on vanity in bathroom #430.
vii. Commode chair frame was rusty in #304.
viii. Two long sections of laminate on edge of counter top missing in third floor servery.
x. Wardrobe in #238 was in poor condition. The hinge on the door was not adequately attached and several screws were loose. Health care staff did not report the disrepair which was obvious April 13-21, 2016, despite using the wardrobe on a daily basis. The inspector informed the ESM on April 21, 2016. According to the ESM, part of the remedial program includes all staff reporting disrepair.

E) Door/trim/door hardware – No procedure or confirmed schedule was in place to address the condition of doors, trim and hardware.
i. A striker was not working on second floor shower door and could not latch. A non-functioning door knob identified on second floor chute room door on April 13, 2016. No handle was noted on April 21, 2016.
ii. Cracked and damaged door frame guards were identified during a Ministry of Health Resident Quality Inspection in 2015 and remained outstanding. The external auditor also identified the issue in October 2015. During this inspection, the damage was identified on various bedroom door frames on all floors (i.e. 336, 237, 239, 240). The ESM reported that he was aware of the problem, explained the reason for the damage and wanted to remove the guards but did not have time to arrange the work.

iii. The bedroom door in #403 could not open fully as it got stuck on the floor half way into the room and was observed in this condition April 13, 2016 until the conclusion of the inspection.
iv. The bathroom sliding door in #403, when pulled open, could not be closed without excessive pressure. It was not in good operating order.
v. Bathroom door casings in resident ensuite washrooms were rusted, had damaged non-intact surfaces or abutted a section of wall with missing tile or damaged plaster in but not limited to #307, 400, 402, 403, 405, 408, 409, 425 and 430.

F) Fixtures – No procedures available for interior fixtures and no confirmed schedule in place to address the condition of fixtures such as grab bars, mirrors, toilet paper holders, soap and hand sanitizer dispensers etc.
i. Grab bars, whether located on the wall or attached to a residential bath tub in private resident rooms were rusty in but not limited to #400, 409, 425, 340, 329, 302, 235, 231.
ii. Mirrored medicine cabinet interior very rusty in #324.
iii. Hand sanitizer dispensers were not useable due to broken release handle in #231 and #408 and outside room #428 on April 13, 2016 and outside room #425 on April 1, 2016.
iv. Toilet paper dispensers rusted in 2nd floor east wing shower room

G) Walls - The maintenance manual was reviewed and a procedure E-75-15 was identified and titled "painting" which was to be completed quarterly. According to the ESM, a painter was available in the home 10-14 days each month and was responsible for repairing wall damage and painting. The ESM reported that the painter decided where and when the walls would be repaired and painted. No particular schedule had been developed by the ESM for the painter to ensure priority setting. No painting schedule was available to ensure that all the walls in resident bedrooms and bathrooms were fully painted with the exception of the occasional resident room that became vacated. According to records, only three resident rooms were fully painted in 2015. The ESM provided invoices from the painter as confirmation that repairs and painting had taken place in 2015. According to the invoices, the painter referred to "touch ups" in resident rooms on floors two, three and four, and painting and repairing walls on a "painting list" but did not include the exact locations. Based on the documentation provided, it was very difficult to determine the time frames between any preventive auditing (identifying a wall surface for repair) and remedial action based on the amount of damage and unfinished plastering observed in the home between April 1 and 21, 2016.

During the inspection, inspectors identified numerous areas requiring touch ups, repairs and painting without being able to confirm when they were last painted or repaired.

When the painter's schedule was reviewed, he had not been in the home during the first 2 weeks of April 2016. Many of the rooms were seen with patches of plaster that were not sanded but painted over. These included washrooms #240, 304, 306, 431, 441 and bedrooms #304 (ceiling), 234 (behind a bed), 405 (behind a bed). The wall or ceiling surfaces were uneven and unsightly as a result. On April 15, 2016, the painter plastered multiple rooms on the 4th floor but they had not been sanded or finished by April 21st. Evident wall damage (holes or damaged plaster) was noted in either resident bedrooms or bathrooms of #226, 237, 240, 300, 304, 409, 406, 438, 2nd floor shower (shower area). Other walls such as in bathrooms #237, 304, 306 were water damaged from the wash basins that were observed hanging from hooks on the walls. [s. 90. (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 to ensure that schedules or procedures were in place for remedial and preventive maintenance, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee failed to ensure there are written policies and protocols developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A) A review of policy #LTC-F-20 titled "Medication Administration", revised January 2016 stated "All medication administered, refused or omitted will be documented immediately after administration on the paper/electronic MAR/TAR using the proper codes by the administering nurse".

On an identified date in April 2016, during inspection of a medication cart medication room, a pouch for resident #077 was found in the resident's drawer.

During an interview with registered staff #109, who was responsible for the medication administration of this resident, the staff member stated the resident refused to take their medication when offered and she did not have time to document the refusal. The staff stated the resident frequently refused to take their medication, and confirmed that she had not reported this behaviour to the charge nurse or physician. The staff denied that she missed administering the medication.

A review of the residents MAR revealed there was no documentation for refusal of 08:00 am medications by resident #077. A review of the progress notes revealed a note entered by registered staff #109, at 1318 hours which stated that the resident refused their morning medications but took their afternoon medications

An interview with the ADOC revealed it was the homes expectation that the above mentioned staff should have documented immediately after the administration or refusal of the medication and further that the registered staff #109 did not follow the home's medication policy. (591).

B) A review of policy #LTC-F-80 titled "Management of Narcotic and Controlled Drugs ", revised November 2015 stated "Two Nurses, one from outgoing shift and one from incoming shift, will count and sign off on the Narcotic and Controlled Drug Count Form every shift change."

On an identified date in April 2016, in the medication room, a review of the narcotic count sheet revealed the narcotic count for the that date, day shift was signed by the "outgoing" nurse but not signed by the "incoming" nurse. A review of the "individual narcotic count" sheets confirmed the count did not match the number of narcotic medications for four residents.

An interview with registered staff #109, who identified herself as the "incoming" nurse for the shift that day stated she performed the narcotic medication count with the night

nurse; however, she was busy and did not sign. The staff member stated the number of narcotic medications did not match the count sheet because she had already administered the 0800 hour narcotics to the four residents but did not have time to sign that they had been administered. The staff member then signed the narcotic count sheet and the individual narcotic sheets for the 0800 hour narcotics at 1240 hours.

An interview with the ADOC revealed that the home's expectation is the narcotic count was to be completed and signed at the end of every shift by the out-going and incoming nurses together. She further confirmed that immediately after the narcotic medications were given, they should have been signed for both electronically and on the narcotic medication count sheets. The ADOC and DOC confirmed that registered staff #109 did not follow the home's policy.

C) A review of policy #LTC-F-220, titled "Medication Incidents" (revised November 2015 stated), "Medications may be related to professional practice, drug products, procedures and systems, and include…administration, educating, monitoring and use" and, "The nurse will notify the Director of Care (DOC)/designate for all medication incidents immediately or within 12 hours depending on the severity of the incident".

On an identified date in April 2016, during inspection of a medication cart, a pouch for resident #077 was found in the resident's drawer.

During an interview with registered staff #109, who was responsible for the medication administration of this resident, the staff member stated the resident refused to take their medication when offered and she did not have time to document the refusal. The staff stated that the resident frequently refused to take their medication, and confirmed that she had not reported this behaviour to the charge nurse or physician. The staff denied that she missed administering the medication.

An interview with the ADOC revealed registered staff member #109 did not complete a medication incident report nor did she report the incident immediately to her supervisor. The ADOC and DOC confirmed that registered staff #109 did not follow the home's policy.

D) A review of policy #LTC-F-140, titled "Natural Health Products" (revised November 2015) stated "if the resident/SDM chooses to use the NHP(s) (Natural Health Products) without a Physician's/NP order, informed consent will be obtained from the resident/SDM will use the Utilization of a Natural Health Product Consent form and documented in the

Resident's Health record" and, "the NHP(s) will be listed on the Best Possible Medication History and included in Medication reconciliation".

An observation on an identified date in April 2016, revealed four bottles of unlabelled medications on resident #078's bedside table. An interview with resident #078 revealed the type of medications that these were. An interview with registered staff #075 revealed the resident's SDM brought the NHP's for the resident to be taken as they wished. The staff member produced a written list from the SDM which stated specifics about administration of the NHP's. The staff confirmed that the ingredients of the NHP's were unknown, the resident/SDM did not sign the above mentioned consent form, and the medications were not included in the medication reconciliation.

A review of the resident's MAR for April 2016, revealed the NHP's were not ordered by a physician or nurse practitioner. A review of the resident's health records could not produce the above mentioned consent form. A review of the record "Physician Medication Review" for March 2016, did not include the above mentioned NHP's. An interview with the ADOC confirmed the policy was not followed.

E) Resident #054 had 15 falls in 2014. They fell on an identified date in December 2014 and were diagnosed with a fracture. Progress notes indicated that they received analgesic medication on five dates in December. Review of the resident's eMAR revealed that the only analgesia documented in the eMAR was on two of these occasions. This was confirmed by the RAI Coordinator. During interview, the DOC confirmed that medications should be documented in the eMAR following administration according to the home's policy. [s. 114. (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 to ensure, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On an identified date in April 2016, four single medications were observed under a lounge chair cushion in front of the elevator bay on one of the floors. Several residents were sitting on other chairs and in their wheelchairs in the same area. An interview with registered staff #075 confirmed the medication should not be in the chair and it was the expectation that registered staff during medication administration should observe the resident and ensure the medication had been ingested or discarded if refused. This was also confirmed by the DOC [s. 126.]

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 to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #19: 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 has failed to ensure that drugs were stored in an area or a medication cart that is secure and locked.

The following was observed:
i. An observation by Inspector #649 on an identified date in April 2016, revealed a medication cart unlocked and unsupervised. The top drawer was open and contained various medications. Registered staff #145 confirmed the cart should have been locked when not supervised.

ii. An observation on an identified date in April 2016, revealed several bottles of prescribed medications on resident #078's bedside table. The medications were not secured. The home area the resident resides in had residents that have dementia and wander into other resident bedrooms, putting them at risk of accessing the medication. Registered staff #083, #075 and the ADOC confirmed the medication was not secured. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the home's investigative notes indicated that on an identified date in 2014, resident #037 complained to RPN #096 that during the course of care, a PSW was physically and verbally abusive to them, and provided specific details.

However, review of the resident's health record did not include documentation about these complaints, actions taken with respect to their complaints, including assessments, reassessments, interventions and the resident's responses to interventions. This was confirmed during interview with RN #104. During interview, RPN #096 confirmed that they did not always enter allegations of abuse into residents' health records. The DOC confirmed that the home's expectation was that staff document that there was a complaint and staff should refer to the home's risk management documentation system for further information. The DOC also confirmed that the risk management system was not part of the resident's health record and that incidents of abuse were not consistently completely documented in resident's health records. [s. 30. (2)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that resident #012 received oral care to maintain the integrity of the oral tissue that included physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth.

Observations of resident #012 on several days revealed their dentures had plaque on them and a foul odour coming from their mouth. A review of the resident's most recent documented plan of care indicated the resident required support for oral hygiene as evidenced by the inability to complete the task independently, and staff were to clean the dentures every morning and put them in for the resident. During an interview, PSW #094 stated they provided care for resident #012 daily and the resident was able to brush their teeth independently with set up. In the mornings they applied toothpaste to the denture brush and gave it to the resident to brush their dentures. Registered staff #126 confirmed the resident was unable to perform their own denture care related to cognitive impairment. Resident #012 was not provided assistance with oral care to meet their needs. [s. 34. (1) (b)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident receives fingernail care, including the cutting of fingernails.

A) Observations of resident #004 on several days revealed they had long, untrimmed fingernails. A review of the residents most recent documented plan of care indicated finger and toe nails were to be trimmed on bath days. During interview, the resident stated that their nails were too long with edges that keep getting caught in their clothing and confirmed their nails had not been trimmed on their bath day. PSW #012 confirmed that resident nails should be trimmed as necessary on bath days and documented in Point of Care (POC). The PSW confirmed the resident's nails were long and untrimmed. Registered staff #126 revealed unless they are diabetic, the resident's fingernails should be cut with every bath as needed. The staff member confirmed the resident was bathed the previous evening; however, their nails had not been cut.

B) Observations of resident #003 on several days revealed they had long, untrimmed fingernails. A review of the residents most recent documented plan of care indicated their finger nails were to be trimmed on bath days. PSW #012 confirmed the resident's finger nails were long and should have been cut on their bath day. An interview with registered staff #126 confirmed the resident's fingernails were not cut. The following day it was observed that resident #003's fingernails had been cut. [s. 35. (2)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident had fallen, they were assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

According to resident #054's health record and the home's risk management documentation, they fell 15 times in 2014. They were diagnosed with an injury after one of the falls. Review of health records provided by the home revealed that the resident had not been assessed using a clinically appropriate assessment instrument that was specifically designed for falls following three of these falls. During interview, the DOC and RAI Coordinator confirmed the home's expectation that residents be assessed using a clinically appropriate assessment instrument after having fallen. According to documentation provided by the DOC, and during interview, the RAI Coordinator confirmed that resident #054 had not received an assessment for three of their 15 falls. [s. 49. (2)]

WN #24: 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 failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

During the initial tour of the home, the LTC Inspector observed the following hazardous substances located in an unlocked cabinet in the home's main activity room where at least one resident was observed unattended in the room:

i. Suma Star DM Hand dish washing liquid #5379056 about 500 ml: indicated that it caused eye and skin irritation;
ii. "Comet" cleanser with bleach about 1/2 of 480 g; indicated that it may irritate eyes and skin; dangerous fumes when mixed with other products.

During interview, the ESM confirmed that the cupboard should have been locked and that the hazardous substances located inside were not kept inaccessible to residents at all times. [s. 91.]

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. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

Review of resident #048's health record and review of the home's 2015 complaint binder did not a documented record as outlined by the legislation of their written complaint dated August 3, 2015, addressed to the DOC regarding an incident that had occurred on August 2, 2015, where it was alleged that resident #079 entered their room while they were asleep and beat their legs with a shoe.

An interview with the RSC, who confirmed that she is responsible for the maintenance of verbal complaints, stated that a "Client Service Response" (CSR) form collects all of the information as required by the legislation but it is only completed for verbal complaints.

An interview with the DOC revealed all written complaints were forwarded to the ADOC or DOC, who then forwards it to the Director and to the home's regional director. The DOC stated that she was responsible for the management of verbal complaints, a CSR was not completed for written complaints, but briefing notes were documented on the Virtual Private Network (VPN) system. The DOC stated that VPN system eventually deletes notes, and confirmed she could not produce a documented record of the above mentioned complaint. [s. 101. (2)]

Issued on this 9th day of June, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA PALADINO (586), BERNADETTE SUSNIK (120), NATASHA JONES (591), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2016_344586_0007
Log No. / Registre no:	007231-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 1, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	WESTSIDE 1145 Albion Road, Rexdale, ON, M9V-4J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lydia Baksh

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following;

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

2. An interdisciplinary team shall assess all residents using the bed safety assessment tool and document the results and recommendations.

3. Update all resident health care records to include why bed rails are being used, how many, the size and any accessories that are required to mitigate any identified entrapment risks.

4. Health care staff providing care to residents shall be provided with and follow directions related to each resident's bed rail use requirements.

5. Institute a monitoring program that will ensure that residents who require accessories to reduce entrapment zones will continue to be provided with those accessories.

6. Accurately document the results of any future bed assessments and continuously maintain the document when changes to the bed system occurs (i.e. mattress changed, rail replaced).

7. Establish an identification system for the beds and mattresses. Label all mattresses with the same identifier used to identify the bed frame when the bed is being measured/assessed.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (1) and compliance history (2), in keeping with s.299(1) of the Regulation, in respect of the potential for harm for residents of the home, the scope of the issue, and the environmental hazard associated with the Key Risk Indicator (KRI).

The licensee failed to ensure that, where bed rails were used that the residents' bed system was evaluated and that residents were assessed in accordance with prevailing practices, to minimize risk to the resident.

A) The licensee commissioned a company to test resident bed systems on April 16, 2015 for entrapment zones 1-4. The results provided by the DOC identified that 42 beds failed one or more entrapment zones 2, 3 or 4 and that another bed system audit was pending for late April 2016. According to the bed system audit results and the DOC, all of the failed beds had some remedial modifications completed shortly after the audit but no dates were made available of when the remedial work was completed. Some of the 42 identified beds received new mattress stops, had bed rails tightened, received new mattresses or had bed rails removed or replaced since April 2015. However, as the home did not have their own bed system entrapment measuring tool, verification was not conducted to verify that the changes that were made were effective in eliminating any of the identified entrapment zones. The status of the 42 resident bed systems that previously failed an entrapment zone was therefore unknown at the time of inspection.

B) According to prevailing practices tilted "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and endorsed by Health Canada), residents are to be evaluated while sleeping in bed over a period of time by an interdisciplinary team to determine if the bed rail is a safe alternative for the resident after trialling other options (as listed in the guidelines). According to the guidelines, questions would need to be developed and answered related to but not limited to the resident's falls history, medication use, toileting habits, sleeping patterns, behaviours, environmental factors and other relevant information that would guide the assessor to make a decision, with either the resident or Substitute Decision Maker, about the necessity for a bed rail. The information would be documented on a form (either electronically or on paper) as to why one or more bed rails are required, what type of rail is required, when the rails are to be applied, how many and on what sides. The interdisciplinary team members involved in the assessment for each resident would include but not be limited to a registered staff member, physiotherapist and personal support worker (PSW), all individuals who would be involved in caring for the resident.

The DOC provided a copy of the assessment tool that was used to evaluate residents who used a rail titled "Side Rail and Alternative Equipment Decision Tree". When reviewed, it was noted to be missing signatures from an interdisciplinary team and a component related to identifying whether the

resident was offered any alternatives to bed rails, whether the alternative was successful or not, how long the alternative was used for and whether an evaluation of safety risks was completed including but not limited to entrapment risks when a bed rail was applied. The assessment tool was geared towards resident bed mobility and repositioning and transfers in or out of bed. The assessment tool was therefore not developed fully in accordance with prevailing practices as identified in the guideline.

At the time of inspection, five residents were observed lying in bed, each with one or more rails elevated. In order to determine why residents required a bed rail, the most recent plan of care for each resident was reviewed. The plans for the six residents reviewed included the reason for bed rail use, but the statements were very generic. The statements were either "bed rails up on either R/L or both sides and used to facilitate bed mobility" or "assist rail use to facilitate bed mobility and repositioning".

According to the home's "Side rail alternative equipment decision tree" form, the assessing staff members were to apply additional precautions to mitigate entrapment risks for residents residing on therapeutic air surfaces and who used a bed rail due to the additional risks posed by such surfaces. The form identified a cautionary statement stating that therapeutic air surfaces could not be assessed for entrapment and therefore it may pose additional risk to the resident when using side rails.

* Resident #073 was observed to be in bed lying on a therapeutic air surface with both of their quarter rails elevated by inspector #120 between 1030 and 1130. The resident's bed system was assessed on April 16, 2015 and determined to have ½ rails on at the time with a therapeutic surface that failed zones 2 and 3. The bed was either changed or different rails were applied. The entrapment status of the bed at time of inspection was unknown. The resident's plan of care identified that the resident was to have "either the left or right bed rail up when in bed to facilitate bed mobility". The assessment tool could not be located in the resident's chart.

*Resident #032 was observed to be in bed lying on a therapeutic air surface with both of their ¾ length rails elevated or raised by inspector #120 between 1030 and 1130. The resident's bed system was assessed on April 16, 2015 but at the time was identified to have a flat foam mattress on the bed frame. A different mattress was therefore applied and not re-tested. The entrapment status of the

bed was unknown at time of inspection. The resident's plan of care identified that "assist rail to be used for bed mobility and repositioning". The assessment tool was partially completed on February 22, 2016 requiring the resident to have a hi-low bed and side rails. No additional precautions were identified on the tool to mitigate possible entrapment risk.

*Resident #074 was observed by inspector #653 to be lying on a therapeutic air mattress with both rotating assist rails elevated between 1330 and 1400. Resident's care giver was asked why the rails were elevated while in bed and the PSW reported that it was to prevent falls. The resident's plan of care dated March 23, 2016 identified the resident as a low risk for falls and did not have any direction for staff to apply the rails to prevent falls. The plan identified that the resident was to have "assist rail use to facilitate bed mobility and repositioning". The assessment tool was partially completed on February 17, 2016 requiring the resident to have a hi-low bed and side rails. No additional precautions were identified on the tool to mitigate possible entrapment risk.

*Resident #071 was observed to be lying in bed on a conventional foam mattress by inspector #120 with both of their assist rails in the guard position (positioned centrally alongside of the bed). The resident's plan of care required that "bed rails up on either R/L or both sides and used to facilitate bed mobility". A completed assessment tool could not be located in the resident's chart. The resident was admitted in January 2016.

*Resident #076 was admitted to the home on April 12, 2016. The resident was observed to be lying in bed on a conventional foam mattress by inspector #653 with two bed rails in use between 1330-1400. As of May 3, 2016, no information was provided in their care plan regarding the application or use of any bed rails. No completed assessment tool could be located in the resident's chart.

During a tour of the resident rooms on all floors after the lunch period on April 13, 14 and 15, 2016, when most residents were out of their rooms, approximately 50% of the beds had one or more bed rails elevated. When the Director of Care was asked why, some reasons given related to staff habits or resident preference. As not all of the bed entrapment status was known at time of inspection, residents returning to these beds either alone or assisted, would have been placed at risk of zone 2, 3 or 4 entrapment unless interventions were specified in the plan of care and those interventions applied. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure that every resident, including residents #038, #040, #054, #020, #035 and #059, is reassessed and their plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. This shall include, but not be limited to, changes with responsive behaviours, sleep and rest routines, visual correction, injury including fracture, bathing, and urinary tract infections.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s.299(1) of the Regulation, in respect of the actual harm that resident #035 experienced, the scope of eight incidences, and the licensee's history of non-compliance (VPC) on the June 8, 2015 Resident Quality Inspection with the s. 6 (10) (b) .

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

A) The document the home referred to as resident #038's care plan indicated the resident exhibited certain responsive behaviours of a sexual nature. Review

of the resident's health record indicated that they did not have a cognitive impairment and no entries in progress notes between January 2015 and April 2016 indicated that the resident had exhibited inappropriate behaviours.

Resident #038's RAI MDS Assessments indicated that the resident had not exhibited responsive behaviours during these assessments. During interviews, PSW's #052 and #117, and the DOC stated that the resident had not exhibited responsive behaviours for over a year. The DOC confirmed that resident #038's plan of care had not been updated when their care needs changed in relation to responsive behaviours.

B) Resident #038 did not have cognitive impairment and was their own decision maker regarding their care. During interview, they told the LTC Inspector that some evening staff assist them to bed much earlier than their preferred bed time; sometimes two hours earlier.

Review of the document the home referred to as resident #038's care plan directed staff to assist the resident to bed at two different times, one much earlier in the evening than the other.

During interview, PSW #007 confirmed the resident liked to go to bed at the later time. Registered staff #105 stated that interventions in the care plan that the resident liked to go to bed earlier were from when the resident was initially admitted and confirmed that the resident's plan of care had not been updated and may be unclear to staff not familiar to resident #038's bedtime preferences.

C) Resident #040's RAI MDS indicated that they had impaired vision but did not use visual appliances. During interview, PSW #089 and RN #104 stated that the resident did not use glasses. During interviews, PSWs #086 and #120 stated that the resident had glasses but they were not sure when or why they would wear them. Review of the document the home referred to as resident #040's care plan did not include any information about their limited vision or their use of glasses.

Resident #040 confirmed that they used glasses on occasion but were not wearing them at the time of the observation. Two days later, the resident was observed wearing their glasses and their family member reported to the LTC Inspector that they notified the home one month ago that the resident needed to wear their glasses all the time; prior to then they required glasses for reading.

During interview, the ADOC stated that the family had brought in glasses but staff had not updated the RAI MDS assessment or plan of care to direct staff on resident #040's use of glasses to correct their vision.

D) According to resident #054's health record and the home's risk management documentation, they fell 15 times in 2014. They were diagnosed with an injury after a fall. Prior to this time, they had been ambulating independently using a walker. They were assessed by the PT and it was determined that they would benefit from the use of a wheelchair due to risk for falls and their inability to ambulate safely using the walker after their injury. They began using a wheelchair and according to progress notes and interview with the PT, the wheelchair was periodically tilted for the resident's comfort.

Review of the document the home referred to as the resident's care plan as of their discharge indicated that they continued to use a walker for ambulation and not a wheelchair, did not indicate how the tilt should be applied to the wheelchair, and did not include a plan of care regarding change in needs associated with their injury. The RAI Coordinator and PT confirmed that resident #054's plan of care had not been reviewed and revised when their care needs changed after sustaining an injury.

E) Interviews and record review confirmed resident #020 often refused care. POC documentation from early 2016 to present demonstrated that the resident refused 19 out of 30 offers for a specific type of care. Interviews with PSWs #129 and #080, and registered staff #062, confirmed that the resident almost always refused this, but would at times accept an alternative method of care. Review of the resident's documented plan of care and kardex, which front line staff use to direct care, did not include any information regarding the resident's refusal or acceptance of an alternative. No information was included about successful interventions or techniques staff use to aid in the resident`s acceptance. This was confirmed by the DOC.

F) Interviews and record review confirmed that resident #020 exhibited responsive behaviours toward staff on a regular basis. Interviews with PSWs #129 and #080, and registered staff #062, confirmed that one of the there was one specific method that was most effective for calming the resident down. A physician's progress note confirmed this method. Review of the resident's documented plan of care and kardex, which front line staff use to direct care, did

not include any information on this intervention to manage the resident's responsive behaviours.

G) During Stage 1 of the RQI, Inspector #526 noted resident #035 to have a strong frank urine odour upon observation. Over a three day period, resident #035 had three documented reports to their clinical record indicating the resident was experiencing restlessness, anxiety, and confusion. There were two documented reports of the resident experiencing typical symptoms of a urinary tract infection (UTI). Registered staff #110 confirmed the resident had a history of UTI's, with the last occurrence the month prior; this included a progress note, indicating the resident was demonstrating a usual symptom they expressed when they had a UTI. The physician was not informed of the resident's status until three days later when the inspector brought the information to registered staff #110 and the DOC's attention, whereby the physician ordered a urine specimen as the resident's symptoms progressed and they experience further symtoms. The DOC confirmed the physician should have been notified sooner, and that the home did not review and revise the resident's plan of care when the resident's care needs changed.

H) On an identified date in 2015, resident #059 was discovered by their family member lying in bed with the bed in an unsafe position. Interview with PSW #003, who put the resident to bed, confirmed PSW #003, who put the resident to bed, indicated that they put the bed remote underneath the resident's pillow to prevent them from playing with it. Internal investigation notes determined the resident was "likely randomly pressing remote control buttons thereby changing the position of headboard & footboard without intention". Interview with PSW #003 confirmed the resident was known to play with the bed remote prior to the incident. In the home's investigation notes the PSW stated "[they] will press buttons without knowing what [they] are doing". Review of the resident's documented plan of care in place at the time of the incident did not include any information regarding the resident's behaviour of playing with the bed remote, including any interventions to assist in preventing potential negative outcomes. The plan of care was not updated when the resident's care needs changed. This was confirmed by the ADOC. (526)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 do the following:

1. Review, revise as needed, and implement the home's policy to promote zero tolerance of abuse and neglect to include strategies that foster a culture of respect for residents, and the prevention of abuse and neglect.

2. Re-train all staff in the home regarding the home's policy to promote zero tolerance of abuse and neglect of residents to include but not limited to:
i) Review the findings of this compliance order as examples of abuse and neglect in the home and in relation to the definitions of abuse and neglect;
ii) Discussion about each individual staff person's role in how each of these incidents of abuse and neglect could have been prevented;
iii) Discussion of each staff person's responsibility in resident centered approaches to care that demonstrate respect of residents and that are free from abuse and neglect; and
iv) Discussion of each staff person's responsibility toward the safety of the residents who have been abused or neglected and reporting incidents of abuse and neglect to the home and MOHLTC.

3. Document each allegation of abuse in the resident's health record.

4. Investigate and analyze each incident of abuse and document this analysis.

5. Discuss the incidents of abuse and their analysis monthly, quarterly and annually to plan and implement additional abuse prevention strategies; document these discussions.

6. Annually evaluate the home's policy to promote zero tolerance of abuse and neglect according to legislative requirements.

7. Notify respective Colleges of Regulated Health Professionals of a Regulated Health Professional who was confirmed as having committed abuse or neglect upon a resident.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (2) and compliance history (4), in keeping with s.299(1) of the Regulation, in respect of the actual harm that the residents experienced, the scope of 11 incidences, and the licensee's history of non-compliance (VPC) on the June 8,

2015 Resident Quality Inspection with the s. 19 (1) related to the protection of residents from abuse and neglect.

The licensee has failed to ensure that residents protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) Resident #040 had a health condition that limited their movement. The document the home referred to as their care plan directed staff to provide care with two staff persons at all times due to resident's behaviour specific needs.

Review of the home's CIS submission and the home's internal investigative notes indicated that on an identified date in 2015, PSW #071 pulled resident #040's arm and inflicted pain while providing care with one person. According to these notes, the resident motioned that the staff was hurting them and when the staff person did not stop pulling. During interview with the LTC Inspector, resident #040 confirmed that the PSW had hurt them by pulling on their arm during care.

PSW #071 was not available for interview. During interview with the DOC, they confirmed the above details and stated that the PSW #071 had inflicted physical abuse upon resident #040. (526).

B) A review of the home's internal investigation notes indicated that resident #050 reported to the staff educator that when PSW #082 gave them a shower on an identified date in 2014, they were rough with them. The resident was interviewed and stated that the PSW hit them and was rough with them in the shower. Interview with the DOC confirmed that resident #050 was not protected from abuse. (591).

C) A review of the home's internal investigation notes indicated registered staff #109 witnessed PSW #027 tell the resident to go back to their room as they were coughing a lot. The resident was on isolation for respiratory symptoms. When the resident did not move, the PSW yelled at them and was physically aggressive toward them. The resident was interviewed and stated that the PSW hit them and took away their drink. An interview with registered staff #109 revealed she had witnessed the incident as described above and reported immediately to the charge nurse. The DOC confirmed that resident #050 was not protected from abuse. (591).

D) On an identified date in 2015, resident #049 observed PSW #030 yell at resident #066. Resident #049 reported that the PSW always raised their voiced and yelled at residents. In an interview with the LTC Inspector, resident #049 confirmed the incident, stating that the PSW was yelling at resident #066 and speaking in a rude tone, and that they felt upset by the occurrence. Interview with PSW #030 confirmed they spoke loudly and this upset the resident. The home's internal investigation notes and interview with the DOC confirmed that the PSW spoke loudly to residents, and confirmed that resident #066 felt upset. Residents #049 and #066 were not protected from verbal abuse. (586).

E) In an interview, resident #038 told the LTC Inspector that in 2015, a PSW staff approached them and asked them why they complained about the care that they had provided. The resident said that they felt afraid and intimidated by the staff person's questions and approach. Review of the home's investigative notes indicated the following:

i. PSW #301 had negotiated with resident #038 that they would "be allowed" to have certain items if the resident did not complain about them;
ii. On an identified date in June 2015, RPN #096 had been questioned by a LTC Inspector regarding resident #038's allegations against PSW #300;
iii. On an identified date in June 2015, PSW #300 was observed by RPN #096 to approach resident #038 and told them that they were spoken to about something the resident had complained about; they asked the resident why they complained;
iv. During interview, the resident said that they felt intimidated by PSW #301; and
v. During interview, PSW #301 confirmed that they approached the resident because they did not want the resident to complain about them.

During interview with LTC Inspector, resident #038 stated that they felt afraid to complain about care in the home since they felt intimidated and afraid when PSW staff #301 approached them about their complaint about care. During interview, RPN #096 stated that PSW's remarks toward resident #038 were intimidating and threatening. The PSW who made the remarks was not available for interview as they had been terminated. These details were confirmed by the DOC who also confirmed that PSW #301's remarks to resident #038 were abusive since they were threatening and intimidating to the resident. (526).

F) Review of the home's internal investigation notes indicated the home's ADOC

forwarded a complaint letter written by resident #048 to the Director. The letter from an identified date in 2015 was addressed to the DOC regarding an incident where it was alleged that resident #079 entered their room while they were asleep and physically assaulted them. PSW #033 responded to the call for help, witnessed the altercation and escorted resident #079 out of the room.

Resident #048 confirmed the details of the CIS during interview. The resident stated that the incident left them fearful. The resident stated that they reported the incident to the DOC who responded by acknowledging the incident and outlining the steps and specific interventions that would be taken to prevent the incident from happening again. The resident stated the interventions were not sufficient for their security.

Review of progress notes indicated registered staff #054 noted the incident and completed an assessment of resident #048 but found no injury. Review of interview notes of PSW #033 confirmed the incident details.

Interview with the DOC confirmed the details of the incident, the steps taken to protect the resident, and that the home did not regard the incident as "abuse" because the resident was not injured. The DOC confirmed resident #048 was not protected from abuse. (591).

G) During interview RN #104 confirmed that resident #037 was cognitively intact in 2014, and that they were more confused during this inspection. They stated that in 2014, the resident could accurately communicate their concerns.

According to a CIS submission on August 15, 2014, resident #037 complained that a PSW had been physically and verbally abusive. Review of the home's investigative notes confirmed these allegations, listing specific instances.

During interview, RPN #096 verified the above complaints that resident #037 had told them regarding PSW #300's treatment of them. RPN #096 and RN #104 confirmed that the resident was an accurate historian in 2014. PSW #300 was not available in the home for interview.

During interview an identified date in April 2016, resident #037 exhibited an anxious look on their face when they stated that a staff person had made verbally abusive comments to them. Their family member told the LTC Inspector that PSW #300's comments that were made in 2014 continued to upset the

resident up to the time of this inspection. During interview, the DOC confirmed that PSW #300's actions against resident #037 constituted verbal and physical abuse. (526).

H) In April 2016, resident #068 voiced concern to housekeeping staff #250 about another resident and the housekeeper encouraged the resident to report their concern. PSW #061 then approached the resident and questioned them in an intimidating tone about whom and what they were going to report. This was witnessed by housekeeping staff #250 and activity staff #197. The resident indicated they felt intimidated and afraid. Review of the home's internal investigation notes and interview with the DOC confirmed the PSW asked the resident questions in a very intimidating manner, and confirmed the resident felt intimidated. The DOC confirmed resident #068 was not protected from verbal abuse. (586).

I) On September 11, 2015, resident #056 reported that they were provided care by PSW #057 and #025 even after saying they did not want the care, and said the staff roughly handled them during the procedure. The resident also stated that the two PSW's, along with registered staff #013, were also verbally abusive to them and spoke in a language other than English while in the resident's room which the resident could not understand. Resident #056 was not available for interview with the LTC Inspector; however, review of the home's internal investigation notes and interview with the DOC confirmed the occurrence, and confirmed PSW's #057 and #025 and registered staff #013 physically and verbally abused resident #056. (586).

J) On an identified date in 2016, PSW's #088 and #194 witnessed PSW #097 yell at resident #067 and push them down into a chair. PSW #097 denied this; however, this occurrence was confirmed through video surveillance that was reviewed by the DOC. Review of the home's internal investigation notes and interview with the DOC confirmed the resident was physically and verbally abused by PSW #097. The DOC confirmed resident #067 was not protected from abuse. (586).

K) Resident #064's written plan of care indicated that resident had a specific bathing preference due to privacy concerns, and was able to complete most of their care on their own but needed some assistance for certain aspects.

According to interview with the resident, on an identified date in April 2016, PSW

#064 assisted them to shower. The resident reported that the staff person was rough with them during care to the point of pain, and that the staff would not let the resident independently complete parts of their own care according to their plan of care, even though they asked repeatedly. The resident stated that they felt abused and said they were in tears after the occurrence. They reported the incident to RPN #105 and to the DOC.

During interview, PSW #007 confirmed that they were working on the day of the incident as described above. They confirmed the resident's care preferences and needs as per their plan of care. They stated that it seemed that PSW #053 rushed resident #064's care and that this resulted in the resident crying.

During interview, RPN #105 stated that PSW #053 should have asked another PSW to assist them when resident #064 indicated that they were upset or distressed. During interview, the DOC stated that PSW #053 told them that they were not familiar with resident #064's plan of care. During interview, PSW #053 told the LTC Inspector that they did not have time to review the resident's plan of care. They stated that they hurried the resident through the care and did not check with the resident about preferences.

The DOC confirmed that PSW #053 had inflicted abuse on resident #064 since they used physical force that caused pain to the resident; the staff did not follow the resident's plan of care, did not ask the resident about their preferences, and did not seek assistance from a staff member who was more familiar with the resident's needs. (526). (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

The licensee shall prepare and submit a plan that summarizes who will assess the lighting levels in the home to ensure compliance with the lighting table (section titled "All other homes") and time frames for completing the necessary upgrades following the assessment.

The plan shall be submitted via email to Bernadette.Susnik@Ontario.ca by September 30, 2016 for review. The plan shall be fully implemented by September 30, 2017.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (1), scope (3) and compliance history (2), in keeping with s.299(1) of the Regulation, in respect of minimal harm, the scope of being widespread throughout the home, and the licensee's history of non-compliance in other areas.

The licensee failed to ensure that the lighting requirements set out in the lighting table were maintained.

The home was built prior to 2009 and therefore the section of the lighting table that applied was titled "In all other areas of the home". A handheld non-digital light meter was used (Sekonic Handi Lumi) to measure the lux levels in one ward bedroom, one semi-private room and one private room, several resident ensuite washrooms, corridors on all three floors, dining rooms and lounge. The meter was held a standard 30 inches above the floor and held parallel to the floor. Window coverings were drawn in the resident bedrooms tested and lights were turned on five minutes prior to measuring. Areas that could not be tested due to natural light infiltration were dining rooms and common areas. Outdoor conditions were semi-bright during the measuring procedure. The minimum required lux for all resident areas excluding corridors is 215.28 lux (bedrooms, washrooms, lounges, dining rooms, showers, tub rooms). The minimum required lux for all corridors is a continuous and consistent lux of 215.28 lux.

A) Resident Bedrooms

A private bedroom (#207) was measured on April 13, 2016 and was similarly equipped with the same light fixtures as all of the other private rooms. Each room had a wall mounted over bed light fixture consisting of two fluorescent tubes (top and bottom) and a recessed pot light with a compact fluorescent light bulb at the entrance to the room. None of the bedrooms were equipped with

bedroom ceiling light fixtures. The entrance into the bedroom was 90-100 lux under the pot light. The centre of the room was 60 lux with the over bed light on. The lux under the over bed light was 245.

A semi-private room (#405) was measured on April 21, 2016 and was similarly equipped with the same light fixtures as all of the other semi-private rooms. Each room had a wall mounted over bed light fixture consisting of two fluorescent tubes (top and bottom) and a recessed pot light at the entrance of the room. None of the rooms were equipped with ceiling light fixtures. The entrance into the bedroom was 20 lux due to a burnt out bulb. The centre of the room or near the foot end of the beds was 90 lux and the lux between beds was 200 lux.

A four-bed ward room (#440) was measured on April 21, 2016 and was similarly equipped with the same light fixtures as all of the other four-bed ward rooms. Each room had a wall mounted over bed light fixture consisting of two fluorescent tubes (top and bottom) and a recessed pot light at the entrance of the room. The centre of the room was 90 lux, the area under the entry pot light was 100 lux, the side of bed #1, #2 and #3 was 180-190 lux, the foot of bed #1 and bed #3 was 75 lux and the over bed lights were approximately 350 lux. The area that included the wardrobes was near the entry to the room and was 100 lux.

The minimum required lux level for resident bedrooms in areas where activities of daily living take place such as sitting, dressing, walking is 215.28 lux. The minimum required lux level under the over bed light is 376.73

B) Corridors

The homes three resident occupied corridors were measured on April 21, 2016 and each had unique lighting configurations. The corridors on the south wing beyond the fire doors were adequate on all floors. The east and west wings were not adequate. The entrance to each of the three corridors, including the south wing were not adequate as they were equipped with three pot lights for a 12 foot long section of corridor.

* Elevator area on floors 2, 3 and 4

Each floor was equipped similarly with three wall lights on the same side as the

elevators, large windows opposite the elevators and fluorescent tube lighting running along the window wall and across the top of the windows. The tubes were housed behind a wood valence and louvered lens. The area was 12 foot wide by 40 feet long. No ceiling lights were provided. The fourth floor was measured as it had thick curtains that were drawn across the windows. The lux was 150-190 lux along path of travel from the nurse's station and around the corner towards the dining room doors. The area in front of the dining room doors had three pot lights which were 150 lux.

*West Corridor

The west wing had recessed fluorescent tube lights on either side of the corridor on all resident occupied floors. Due to a number of burnt out lights, the lux was 110-150 lux. In areas fully lit, the lux was 190-200 lux.

* South Corridor

The entrance to the south corridor had a low ceiling with two pot lights on all three floors. The distance between the entrance of the corridor and the fire doors and resident rooms beyond was approximately 12-14 feet. The lux for the pot lights on each floor ranged from 60 to 125 lux.

* East Corridor

The east wing on all floors was similarly equipped with recessed fluorescent tube lights on either side of the corridor ceiling. At the time of inspection, the fourth floor east corridor had 5 bulbs burnt out and the lux was very low in some areas, especially at the beginning of the corridor which was 50 lux. Otherwise, where all of the bulbs were lit, the lux met minimum requirements.

C) Main floor

The home's main floor dining room and main foyer lounge area was equipped with over 10 chandelier light fixtures with six bulbs each. Due to the excessive natural light infiltration, the levels could not be measured. A small section with tables #16 and #17 was measured as it was not impacted by natural light. This area had a lower ceiling height with pot lights instead of chandelier light fixtures. The lux was 100-195. The lounge in front of reception was equipped with the same chandelier light fixtures as the dining room. They produced approximately

155 lux of light. The lounge area on the main floor behind the reception area was equipped with 8 pot lights spaced out on the ceiling, in decorative sectioned areas and 11 pot lights around the perimeter of the room. The area not as affected by natural light was measured and was 90 lux by the fish tank and 150 lux by the television. This area was furthest from the windows. The main corridor leading past the elevators to the activity room could not be measured but was suspected of not being adequate due to the number and type of fixtures provided. The LTC inspector discussed with the ESM that the lighting levels would need to be independently verified when outdoor conditions were dark.

D) Lounges

Due to the fact that most lounges were missing window coverings, many could not be verified for lighting levels. One section of the west lounge on the fourth floor was measured and blinds pulled. The room was equipped with two ceiling lights with two fluorescent tubes each. One was burnt out in each fixture. The lux was 350 under the lights and the lux dropped to 110 four feet away from the lights. The minimum required lux for lounge space is 215.28 lux throughout (excluding corners).

E) Bathing areas/resident washrooms

Resident washroom #234 had a lux of 93 lux over the toilet.
3E Shower- 130 lux under opaque lens in the shower.
Resident washroom #308 had a lux of 220 at the vanity but it dropped to 50 lux at the toilet.
Fourth floor tub room - five pot light fixtures noted without bulbs thereby reducing the lust to 150 at the and the lux in the shower was 120. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall do the following:
1. Re-train all registered staff in the home of the following:
i) Policy #LTC-F-20 titled "Medication Administration", revised January 2016,
ii) Policy #LTC-F-80 titled "Management of Narcotic and Controlled Drugs ", revised November 2015
iii) Policy #LTC-F-220, titled "Medication Incidents" revised November 2015.

The above training shall include, but not limited to:
i) Review the findings of this compliance order as examples of medication incidents in the home,
ii) Discussion of each registered staff's responsibility in ensuring resident safety in medication administration.

2. Document each medication incident in the resident's health record.

3. Investigate and analyze each medication incident and document the analysis according to legislative requirements.

4. Discuss the medication incidences and their analysis quarterly to plan and implement additional prevention strategies and document these discussions.

5. Quarterly and annually, evaluate the effectiveness of the home's medication management system and keep a record of the evaluation according to legislative requirements.

6. Submit confirmation that all registered staff have received the above mentioned training.

7. Submit all training materials provided in the above mentioned training.

8. Submit written confirmation that the College of Nurses has been notified regarding the conduct of registered staff #109 related to Medication administration and documentation standards.

Please forward the above mentioned documentation to natasha.g.jones@ontario.ca. This order shall be complied no later than September 1, 2016.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (1) and compliance history (4), in keeping with s.299(1) of the Regulation, in respect of the potential for harm, the scope of one isolated incident, and the Licensee's history of non-compliance (VPC's) on the June 8, 2015 Resident Quality Inspection and the August 22, 2014 Complaint Inspection, with the r.131 (2) related to the home's medication administration.

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

On an identified date in April 2016, during inspection of a medication cart in the medication room, a pouch labelled for resident #077 was found in the resident's drawer.

During an interview with registered staff #109, who was responsible for the medication administration of this resident, stated the resident refused to take their medication when offered and she did not have time to document the refusal. The staff stated that the resident frequently refused to take their medication, and confirmed that she had not reported this behaviour to the charge nurse or physician.

A review of the residents #077's MAR's (Medication Administration Records) for the past 6 months indicated there were no documented incidences of refusal of medication. A review of the resident's most recent written plan of care including revisions dated March 21, 2016, did not include information related to refusal of medication, nor did it include information to indicate the resident had any resistive or other behaviour.

Interviews with registered staff #033 and #091 confirmed they had medicated the resident in the past and recently; however, the resident had never refused to take their medication, nor was the resident known to have resistive behaviour related to medication. Staff #091 stated that she had medicated the resident that week and all of last week and they did not refuse their medication.

An interview with the ADOC revealed it is the home's expectation that medication is administered within one hour before and after the prescribed time in the MAR, documentation of administration should occur immediately after administration, and all medication incidences should be reported immediately to the ADOC. The ADOC stated that medications should be removed from the

pouch, taken to the resident and if refused, discarded and the refusal documented immediately in the resident's MAR. The ADOC and DOC confirmed that registered staff #109 did not administer medication to resident #077 as per the physician's orders. (591)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee shall do the following:

1. Immediately assess residents who demonstrate pain using a clinically appropriate assessment instrument specifically designed for this purpose when the pain is not relieved by initial interventions.

2. Administer analgesia as prescribed and reassess the effectiveness of the analgesia on managing the resident's pain.

3. Notify a Physician or Registered Nurse in Extended Class if the resident's pain worsens or persists.

4. Retrain all staff in pain management to include responsive behaviours as related to pain.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (2), in keeping with s.299(1) of the Regulation, in respect of the actual harm that resident #054 experienced in relation to the pain they experienced that was not managed.

The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) According to their health record and the home's risk management system, resident #054 fell 15 times in 2014. One of these falls resulted in injury. They were sent to hospital and diagnosed with an injury. Progress note entries indicated that they were experiencing pain and were not assessed for pain using a clinically appropriate instrument specifically designed for this purpose upon return from hospital or when initial interventions were ineffective until the resident's next fall which was 14 days later.

During interview, the RAI Coordinator confirmed that resident #054's pain should have been assessed using a clinically relevant pain assessment instrument, upon return from hospital and when initial interventions for pain management had not been effective. (526).

B) Between 2013 and 2014, resident #060 had 47 falls in the home. Interview with the DOC confirmed that it was the expectation of the home that when a resident falls, staff were to complete a pain assessment if pain was expressed by the resident as a result of the fall. According to the resident #060's health record and the home's risk management system, the resident was experiencing pain after falling on three instances, and the DOC confirmed no pain assessments were completed. (586)

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

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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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

Issued on this 1st day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jessica Paladino

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