Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 18, 2019	2019_808535_0014	006545-19, 006669-19, 015606-19	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Westside
1145 Albion Road ETOBICOKE ON M9V 4J7

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

VERON ASH (535)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 28, 29, 30, September 3, 4, 5, 6, 9, 10, 11, (off-site) 16, 17, 23, 24, 25, 27, 30, 2019.

The following intakes were inspected during this report: Log #015606-19 (related to abuse), #006669-19 (related to skin and wound/flooding), #006545-19 (related to flooding).

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant DOC (ADOC), Physiotherapist (PT), Behavior Support Outreach (BSO) Nurse, Resident Assessment Instrument (RAI) Coordinator, Skin and Wound Care Lead, registered staff RN/RPN, personal support workers (PSWs), substitute decision-maker (SDM) and resident.

During the course of the inspection, the inspector made observations, conducted record reviews of residents' health and staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Critical Incident Response
Dignity, Choice and Privacy
Food Quality
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

8 WN(s)
6 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all foods were prepared, stored and served using methods which preserve taste, nutritive value, appearance and food quality.

During an interview on an identified date, resident #002 informed the inspector that the meals prepared by the home were not very good in terms of the appearance and taste. The resident stated that the food does not have a good flavor and vegetables were overcooked.

On a second identified date, the inspector observed the lunch meal in one of the dining rooms. The lunch meal consisted of the menu items posted on the board for that day. During observation of the meal, the vegetables appeared to have been over-cooked. The main protein meal appeared hard and dry, and the green leafy vegetables in the salad appeared brownish along the rims, signifying the level of freshness was diminishing. The inspector interviewed resident #019 regarding enjoyment of the meal, and the resident stated that the protein was not cooked on one side, and same with the potatoes; and the vegetables were overcooked.

On a third identified date, the inspector observed the supper meal in the dining area. The supper meal consisted of the menu items posted on the board for that day.
During the meal, the inspector interviewed resident #015 regarding the enjoyment of their supper meal. The resident was removing items of food from their plate and stated that the protein was not cooked on one side. The resident also indicated that the green vegetables were over-cooked. During the meal, the inspector also observed that resident #019 removed their plate from the table which contained the second choice of protein and placed the plate with food in the soiled basin to be returned to the kitchen. The resident was offered and accepted a sandwich instead of the meal.

Record review of the Residents' Council and Family Council meeting minutes indicated multiple documented complaints related to the home's meal service and residents' dining experience.

The inspector reviewed the home's electronic meal items 'temperature report' on two identified dates. The reports indicated staff inconsistencies related to taking and recording of food items temperature in the kitchen and on all floors. Both temperature reports also indicated a decrease in prepared food items temperature from the kitchen during transfer to the floors for meal service. The home was issued a finding related to dining and snack services, specifically to ensure food was served at a temperature that was palatable to residents.

During an interview, cook #111 responded to the above food production/preparation concerns as follows:

Overcooked vegetables – the cook stated that they steam the vegetables for the required amount of time in the steamer, however the current steamer was old and does not work too well sometimes. Because of these challenges with the steamer, the first couple of residents who were served would get their vegetables cooked better than residents on the bottom of the serving list, who would have their vegetables more cooked. The cook also stated that a new steamer was requested for the kitchen.

Uncooked fried foods - the cook stated that the home does not have a deep fryer, therefore these items must be cooked in the convection oven. The crispiness one would normally get from using a deep fryer for food which would be better in a deep fryer, does not work because those items must be baked in the oven instead. The cook stated that if the items remain in the oven a bit too long, they would get very dry. The cook also stated they try to be creative, however meal preparation has become very challenging. Cook #111 explained that they do not have enough steam tables with only five wells in the kitchen, and it was not enough. Therefore, food items were kept in the steamer prior to and during serving. In addition, the cook stated that the work space in the kitchen was fine many years ago; however today they must prepare two meal choices at each meal, and considering the size of the kitchen, it was challenging to prepare, store and maintain a high temperature for prepared meal items prior to serving.

On a fourth identified date, the inspector toured the kitchen with the Nutrition Manager (NM); and observed a small computer screen facing the work area where the cook

prepared all the meals. The kitchen area was observed to be challenged for space given the size of the home and the amount of food to be prepared for each meal. The inspector also observed that there were prepared food items being kept warm on top of the convection oven.

During an interview, the NM verified the following: the kitchen had one steamer oven and one convection oven, however, a warmer and deep fryer were not available. There was one steam table in the kitchen and one steam table available in each dining room on each floor. The home does not have a warmer cart; therefore, the cook places the prepared meal items on top of or back into the oven to keep warm, or the items were placed on the main steam table. They used warming lamps above the steam table to keep the prepared foods warm. The steam table has hot water on the bottom and heating lamps on top, that was considered a temporary warmer. Therefore, the home failed to ensure that all foods were prepared, stored and served using methods which preserve taste, nutritive value, appearance and food quality. [s. 72. (3) (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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 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:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #002 was fully respected and promoted the residents' right to be treated with courtesy and respect and that staff respected their dignity.

The Ministry of Long-Term Care (MLTC) received a complaint on an identified date, related to multiple concerns including the lack of staff response to the call bell system.

On a second identified date, resident #002 informed the inspector during an interview, that the call bell response time in the home was approximately 15 minutes and longer. The resident further stated that sometimes PSWs would enter residents' rooms and cancel the call bell, without addressing their issue.

The inspector expanded the sample by interviewing two additional residents on different floors in the home. Resident #018 from the third floor stated that their call bell was answered in a reasonable time and did not have any concerns. Resident #015 from the fourth floor stated that they observed staff took at least 15 minutes to answer the call bell when activated. Resident #015 stated that they felt badly for their roommates whenever they had to use the call bell.

During an interview on a third identified date, resident #015, who lived in a room with other residents, informed Inspector #768 of their concerns related to direct care staff's lack of response when the call bell was activated. Upon activation of the call bell in the resident's washroom, Inspector #768 observed that PSW #114 took approximately 16 minutes to respond to the activation of the call bell.

A review of the home's Call Bell Reports for an identified month, which included the location, date, time and duration of activation/response related to residents' call bell activation and response times, indicated prolonged response times greater than fifteen minutes on all floors, particularly on one identified floor in the home.

During an interview, Director of Care (DOC) #112 and the ED #110 both acknowledged that a reasonable response time for staff to answer the call bell on the floors should be approximately ten minutes. During separate interviews, residents #002 and #015 expressed feelings of helplessness, anger and frustration at times. Therefore, as indicated by record review and residents' interviews, the home failed to ensure residents were fully respected and treated with courtesy, and that direct care staff respected residents' dignity. [s. 3. (1) 1.]

2. The licensee has failed to ensure that resident #002 was respected and promoted the rights' to live in a safe and clean environment.

During an interview, resident #002 informed the inspector that the shower room on their unit was kept in an unclean state.

On an identified date, the inspector observed and took pictures of all six shower rooms in the home. All shower rooms had a moderate amount of hardened, black substance between the tiles on the lower portion of the walls, and especially in the corners on the floors. In all shower rooms, the light switch covers had spots of orange-colored stains on them, there were broken tiles on the shower room floors, and broken edges on some of the white cabinets in the shower rooms.

During separate interviews, the pictures were reviewed with the housekeeping staff and the ESM, and both verified that the condition of the shower rooms were unclean as observed in the pictures. The ESM also acknowledged that these concerns should have been identified and entered in the electronic Maintenance Care reporting system for immediate follow up action by the staff; and they stated that these concerns should have also been identified during the daily rounds on each floor. Therefore, the home failed to fully respect and promote the residents' right to live in a clean environment. [s. 3. (1) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance -to ensure that every resident's has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, and -to ensure that every resident's right to live in a safe and clean environment, is fully respected and promoted, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Record review of the resident's plan of care and interviews with PSW #107 and registered staff #103 indicated that resident #002 displayed specific preferences when personal care was being provided. The resident's primary PSW #107 informed the inspector of the resident's preferences.

Record review of the resident's current written care plan related to providing personal care did not included the resident's specified preferences.

During separate interviews with the Behavior Support Outreach (BSO) Nurse, Director of Care and Executive Director, each acknowledged that the plan of care did not include specific details related to providing personal care for the resident since admission to the home in 2014. They agreed that the plan of care did not provide clear directions. The

BSO Nurse further stated that a new care plan was being developed, and that the new care plan would be reviewed with the resident, SDM, and staff prior to implementation. Therefore, the licensee has failed to ensure the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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

Record review of the resident's plan of care and interviews with PSW #107 and registered staff #103 indicated that resident #002 displayed specific preferences when personal care was being provided and if/when their care was not aligned with their specified preferences, they would display responsive behaviors.

Record review also indicated that those specific preferences were not included in the resident's written care plan for access and review by all direct care staff.

During an interview, primary PSW #107 verified the resident's specific preferences. The PSW also verified that the resident's preferences were not documented in the plan of care; and that they should have been included in the plan of care for all direct care staff to be aware.

During an interview, BSO RPN #103 stated that the resident's individualized plan of care was not updated with specific preferences and verified that if the plan of care was updated with the resident's preferences since their admission in 2014, it would have prevented the resident's display of responsive behaviors towards direct care staff.

During an interview, the home's ED and DOC verified that the plan of care should have included the resident's specific preferences. Therefore, the home failed to ensure the plan of care was based on an assessment of the resident and the resident's needs and preferences. [s. 6. (2)]

3. The licensee has failed to ensure staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

The MLTC received multiple complaints related to resident #002 on three separate identified dates.

Record review indicated that resident #002 was admitted to the home on an identified date. The resident was assessed on another identified date, using the home's Resident Assessment Instrument-Minimum Data Set (RAI-MDS).

Record review and multiple interviews with PSWs and registered staff indicated that resident #002 displayed specific preferences, and if the care provided by staff was not aligned with their preferences, they would display responsive behaviors.

Record review and staff interviews revealed that the resident displayed multiple identified responsive behaviors which were considered preferences by some members of the team and therefore, the responsive behavior triggers were not identified, and strategies implemented to address those behaviors over a period of years.

During an interview, PSW #107 verified they witnessed some of the responsive behaviors, however, they did not experience difficulties when providing care, and therefore did not report to the team nor document the behaviors.

During an interview, the Resident Assessment Instrument (RAI) Coordinator RPN #106 verified that over the years since the resident's admission, the home's quarterly and annual RAI-MDS assessments indicated no documented mood or behaviors for resident #002 until recently when the behavior assessment was captured by the BSO Nurse.

During an interview, the BSO Nurse RPN #103 stated that they believed resident #002 had specific preferences instead of responsive behaviors. And, they verified that their assessment showed the resident had only one identified behavior which was being addressed in the resident's recently updated written care plan. The BSO Nurse verified that until a recent meeting held by the team with identified staff included, they were not aware of the extent of the resident's specific preferences and their displayed behaviors.

During an interview, the home's DOC and ED verified that prior to the above mentioned team meeting, they were not aware of the extent of the resident's responsive behaviors; and verified that the home had failed to ensure staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other. [s. 6. (4) (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 the plan of care sets out clear directions to staff and others who provide direct care to the resident,
that the plan of care is based on an assessment of the resident and the resident's needs and preferences, and
that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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 has failed to ensure that when resident #002 exhibited altered skin integrity, they were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review indicated that resident #002 was admitted into the home and assessed with an identified skin condition prior to admission. Record review also indicated that the home's registered dietitian, skin and wound care lead and the primary physician were frequently consulted and actively involved in the care and treatment of the altered skin integrity.

During an interview, SDM #135 informed the inspector that during one of their visits to the home on an identified date, resident #002 displayed poor skin integrity to an identified area of the body. The SDM also stated that they were prompted to accompany the resident to see a specialist for treatment immediately.

Record review indicated that on an identified date, the registered staff documented in the progress note that the resident refused to be assessed by the assigned RN, and by another nurse who attended the unit. The resident also refused prescribed treatment and transfer to hospital for acute assessment and treatment related to their altered skin integrity.

During separate interviews, the home's Skin and Wound Care Lead #133 and Clinical Lead #102 both verified the above information; and verified that the weekly skin and wound assessment tool was not completed by registered staff during the above incident.

During an interview, DOC #109 stated the expectation was that registered staff complete the weekly skin and wound assessment using the clinically appropriate tool for all altered skin integrity. Therefore, the home failed to ensure resident #002 received a weekly skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument related to their bilateral lower leg rash and vascular lesions. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance -to ensure residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers,
skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically
indicated,
-that , to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that behavioral triggers were identified for the resident demonstrating responsive behaviors, where possible.

Record review of the health records, onsite observations/interactions and multiple interviews with direct care staff revealed that resident #002 had identified responsive behaviors since their admission into the home.

During an interview, BSO Nurse #103 informed the inspector that they recently identified the behavior trigger related to one of the resident's identified responsive behaviors. BSO Nurse #103 also stated that they were currently working closely with the resident and the team to identify additional triggers related to the other identified behaviors. According to the BSO Nurse, the plan was for them to continue to work with the resident to support identifying behavioral triggers, develop an interdisciplinary responsive behavior plan of care, and implement the plan slowly with the support of the resident, SDM, staff and Management team to ensure a successful outcome. Therefore, the home failed to ensure behavioral triggers were identified for resident #002's demonstrated responsive behaviors. [s. 53. (4) (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 behavioral triggers are identified for the resident demonstrating responsive behaviors, where possible, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During an interview on an identified date, resident #002 informed the inspector that the meals prepared by the home were not served hot enough.

On another identified date, the inspector observed the lunch meal in an identified dining area. The lunch meal consisted of the menu items posted on the board for that day.

The inspector interviewed resident #002 and #016 regarding the enjoyment and temperature of their meals, and both residents commented that the meal was not served hot enough.

Record review of the Residents' Council and Family Council meeting minutes indicated multiple documented complaints related to the home's meal service and residents' dining experience.

During an interview, cook #111 stated that they try to keep the meal as hot as possible after cooking and before transferring to the floors by removing the items from the oven and placing them in the steam table located in the main kitchen. The home used several warming lamps placed on top of the steamers to help keep the meal items hot. The cook stated that if they had a warmer to keep the serving pans warm that would keep the food hotter for a longer period. The cook acknowledged that they have heard complaints from residents that the meals were not served hot enough, however they were doing their best with the equipment they have available in the kitchen.

The inspector reviewed the home's electronic meal items 'temperature report' on two identified dates. The reports indicated staff inconsistencies related to taking and recording of food items temperature in the kitchen and on all floors. Both temperature reports also indicated a decrease in prepared food items temperature from the kitchen during transfer to all dining areas for meal service.

During an interview, the NM verified that the kitchen does not have a warmer available, however, the cook places the prepared food items on top of the oven or back inside the oven to keep warm. In addition, NM stated that prepared food items were sometimes placed on the main steam table, and they used warming lamps above the steam table to

keep the prepared food warm. The steam table has hot water on the bottom and heating lamps on top, that was considered a temporary warmer. Therefore, the home failed to ensure that food was served at a temperature that are both safe and palatable to residents. [s. 73. (1) 6.]

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 food is served at a temperature that are both safe and palatable to residents, to be implemented voluntarily.

WN #7: 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,
(c) removal and safe disposal of dry and wet garbage; and O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for the removal and safe disposal of dry and wet garbage.

During an interview, resident #002 informed the inspector that on an identified date, a PSW #128 removed and disposed of the soiled incontinent product in the garbage bin in the shared room. During an interview, the resident stated that they called Nurse Manager #134 to witness the incident. A review of the resident's written care plan indicated that Nurse Manager #134 updated the resident's care plan following the incident.

Record review of the Family Council meeting minutes indicated that on an identified date, family member observed the PSW leaving soiled incontinent product in residents' washroom sink after providing care instead of disposing of the soiled incontinent product directly into the hamper outside the room. The Family Council Concerns Form indicated that on another identified date, the home conducted Education Huddles on all floors to

ensure staff were aware of using proper personal protective equipment, performing hand hygiene, and proper disposing of incontinent products when providing personal care to residents. In addition, a Memo was developed and placed in the staff communication book to educate and remind all staff, particularly those who had not attended the Education Huddle.

Record review of the home's Complaint Binder indicated that on another identified date, resident #002 also reported to the registered staff on the unit, that PSW #136 attended their room to provide care. After providing care, the PSW removed the soiled incontinent product from the resident's garbage bin in their washroom and placed it in their basin prior to removing it from the room and placing it into the hamper outside the room. The Client Services Response Form indicated that the home completed an investigation based on the resident's complaint; the PSW was counseled and reminded to place soiled incontinent product in a small garbage bag, tie the bag and dispose of the bag in the proper hamper in the hallway for pick up by housekeeping staff at regularly scheduled times.

A review of the staff Education Huddle records indicated that PSW #134 and #136 did not sign the attendance list.

During an interview, the housekeeping staff verified that recently, they occasionally removed soiled incontinent products from the shower rooms garbage bins, and the garbage bins in some residents' rooms.

During separate interviews, the Environmental Service Manger (ESM) and Continence Care Lead both verified the procedure for proper disposal of soiled incontinent products. The ESM also verified that consistent and proper disposal of used incontinent products remained a challenge in the home as reported by their housekeeping staff. Therefore, the licensee has failed to ensure procedures were implemented for the removal and safe disposal of soiled incontinent care products by staff. [s. 87. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for the removal and safe disposal of dry and wet garbage, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's substitute decision-maker was notified when there was a flood in the resident's room, in accordance with the instructions provided by the resident and their SDM.

Record review indicated that resident #002 was admitted into the home and assessed using the home's Resident Assessment Instrument-Minimum Data Set (RAI-MDS).

Record review of the home's complaint binder and investigation notes indicated that on an identified date, the home's leadership team met with the resident and the resident's SDM #135 to discuss documented care concerns. During that meeting, the ED documented in the notes that resident #002 had agreed that the home should contact their SDM for specific incidents.

Record review of the progress notes indicated and an interview with the resident verified that on an identified date and time, an incident occurred in their room which rendered the room unsafe. During the incident, the charge nurse immediately offered to move the resident to an available private room on the same floor; however, the resident declined to move. The charge nurse contacted and informed the home's DOC of the incident, and the resident also refused to be moved following a discussion with the DOC by telephone. The incident kept multiple staff involved to maintain the resident's safety, while the charge nurse attempted to contact the ESM, the maintenance worker and the plumber listed in the home's policy document. The incident was contained after approximately 3 hours, and the area was cleaned after approximately 5-6 hours.

During an interview, the resident's SDM stated that they were not notified of the incident by staff or management in the home.

During an interview, the ED verified that they had not notified the SDM because the resident was competent and capable of making their own decisions. The ED also stated that they had forgotten that the SDM had requested to be notified when an incident occurred, with the resident's documented permission. The ED verified that the SDM should have been notified when the resident's room flooded. Therefore, the home failed to ensure the resident's substitute decision-maker was notified when there was a flood in the resident's room, in accordance with the instructions provided by the resident and their SDM. [s. 107. (5)]

Issued on this 25th day of October, 2019

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

Original report signed by the inspector.