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

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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 24, 2018	2018_598570_0011	009736-18	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

Winbourne Park
1020 Westney Road North AJAX ON L1T 4K6

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

SAMI JAROUR (570), CRISTINA MONTOYA (461), JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 18-22, and June 25-27, 2018

Intake Log #000587-18 - Critical Incident Report, related to an emergency hazard due to burst pipe in the kitchen, was inspected concurrently during the RQI.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Food Services Manager (FSM), Housekeeping Aides, Heavy Duty Cleaner, President of Residents' Council, President of Family Council, Families and residents.

During the course of the inspection, the inspector(s) toured the home, observed resident to resident interactions, and staff to resident interactions; reviewed clinical health records, medication incidents, Residents' Council Meeting Minutes; and reviewed licensee's policies, specifically, meal services, weight and height monitoring, housekeeping services, bed rails and bed entrapment.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **5 WN(s)**
- **5 VPC(s)**
- **0 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 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).

Findings/Faits saillants :

1. The licensee had failed to ensure that the plan of care for resident #002 set out clear directions to staff and others who provide direct care to the resident.

On two identified dates, Inspector #461 observed resident #002 in their room during meal time, drinking a glass of nutritional supplement and a bottle of water. Resident #002 indicated to the inspector that they only had specified items for meals in their room.

A review of resident #002's written plan of care indicated the resident was at nutritional risk. The interventions included: provide meals in the dining room, resident was able to eat on their own, but may require intermittent set up assistance and supervision, provide an identified diet and nutritional supplements.

A review of the Registered Dietitian (RD) assessment completed on an identified date, revealed that resident #002 preferred a specified intervention. Resident ate in the unit's dining room.

In interviews with PSWs #116, #113, and Dietary Manager (DM) #109, all indicated that resident had their meals in the room most days and occasionally came to the dining room. PSW #113 indicated that resident did not require supervision at meals because they had an identified diet.

In separate interviews with the RD and Director of Care (DOC), the RD indicated that resident had the identified diet since admission. The RD acknowledged that they were not aware that the resident was eating or drinking in their room without supervision. Residents eating in their rooms should be supervised, especially when the resident was on a specified diet. Resident #002 should not had been in their room while eating or drinking during meal times.

The DOC indicated that for residents choosing to eat their meals in their room, it was expected to provide supervision as if they were in the dining room. The DOC acknowledged that resident #002's written plan of care should be revised to indicate that they may eat in their room and supervision was required.

The licensee did not ensure that resident #002's plan of care set out clear directions to staff and others who provide direct care to the resident specific to the need for supervision while consuming food or liquid in their room at meal times. [s. 6. (1) (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 the plan of care for residents sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure the home, furnishings and equipment were kept clean and sanitary.

The following observations were made during the initial tour of the home:
- On one specified area of the main floor: stain on carpet in mid open area.
- In an identified residents` home area: multiple visible stains (dark stains and dry food like stains) in hallway across from dining room; dark stain on carpet across from identified resident`s rooms and Spa room.
- In an identified residents` home area: two dark stains on carpet in hallway across from identified residents` rooms.
- In an identified residents` home area: dark stains on carpet in hallway across from dining room; multiple stains noted on carpet and dark/black spots and brownish stains on walls in TV lounge; dark stains on carpet in hallway across from identified residents' rooms; paint stain on carpet in hallway across from Spa room; brown stains on wall

between two identified residents' rooms.
- In an identified residents` home area: dark stain on carpet in hallway across from nursing station; multiple dark stains in TV lounge; dark stain in hallway across from two identified residents' rooms.

During observations of identified residents' rooms, the following was noted:
- Identified resident`s room: unclean carpet with dark spots/stains noted on carpet.
- Identified resident`s room: grey stains noted on carpet between bed and window; between bathroom door and closet. Dirt buildup at edges between carpet and walls.
- Identified resident`s room: dark/black spots on laminate flooring; brown stains on wall below window; dirt buildup noted on floor and baseboard junctions.

During separate family interviews, the SDM of resident #003 indicated the carpet in the resident's room was not cleaned or vacuumed. The SDM of resident #004 indicated the dining room floor was sticky and that they had to clean the resident's room once a week.

Interviews with RN #100 and PSW #108 by Inspector #570 indicated that when a stain is noted on the carpet, the environmental service department will be notified. Both RN and PSW observed the stains on the carpet in the hallway in an identified residents`home area and indicated that the carpet needed to be cleaned.

An interview with housekeeping staff #112 by Inspector #570 indicated that they reported to the heavy duty cleaner and to the Environmental Services Manager (ESM) that the carpet in TV lounge, in an identified residents`home area, needed to be shampooed and walls needed to be painted. The housekeeping staff #112 further indicated that carpets in residents' rooms are vacuumed and if the carpet required spot cleaning/shampooing that will be reported to the heavy duty cleaner.

An interview with housekeeping staff #106 by inspector #570 indicated the carpet in residents' rooms are vacuumed by a deep cleaning process which is completed once a week for every resident's room. Any stains or spots on carpet will be reported verbally to the heavy duty cleaner for spot cleaning.

An interview with maintenance person #110 by Inspector #570 indicated they were assigned heavy duty cleaning at the home. Maintenance person #110 indicated that the carpet extractor was out of order and that they had to rent one to do spot carpet cleaning in an identified residents`home area when requested by the charge nurse of that home area. Maintenance person #110 further indicated that the carpet is cleaned once a year

by an outside contractor and after that spot cleaning is done if needed.

An interview with the Executive Director (ED) by Inspector #570 indicated they were aware of the carpet stains and that those stains would show if the cleaning was not done on ongoing basis. The ED indicated the expectation is that the home should be kept clean, tidy and maintained in a satisfactory manner.

The licensee did not ensure the home was kept clean and sanitary specific to carpets and floors in hallways and identified residents' rooms. [s. 15. (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 the home, furnishings and equipment were kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

During this inspection the following issues were observed:

- an enclosed courtyard accessible by residents through an identified residents' home area did not contain a resident-staff communication and response system so that residents could call for help if necessary.

- an enclosed courtyard accessible by residents through another identified residents' home area did not contain a resident-staff communication and response system so that residents could call for help if necessary.

- an enclosed balcony had an unlocked door and it was accessible to residents; no resident-staff communication and response system was available for residents to call for help if necessary.

During an interview, RN #100 indicated to Inspector #570 that the court yard accessible through an identified residents' home area is considered a resident designated area and residents can go to the court yard with staff or family members. The RN further indicated that resident #011 goes by themselves to the court yard. The RN confirmed that there is no resident-staff communication and response system available in the court yard for residents' use.

During an interview, RPN #104 indicated to Inspector #461 that residents have access to the court yard through an identified residents`home area . RPN #104 indicated that the door to the court yard is not kept locked. Residents without cognitive impairment can go outside on their own. Family members also take residents to the court yard. RPN #104 confirmed to Inspector #461 there is no resident-staff communication and response system available in the court yard for residents' use.

During an interview, the Executive Director (ED) confirmed that the two identified court yards and the balcony were accessible by residents and that none of those areas had a resident-staff communication and response system available in the court yard for residents' use.

The licensee did not ensure that the home was equipped with a resident-staff communication and response system in two courtyards and one balcony accessible by residents. [s. 17. (1) (e)]

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 equipped with a resident-staff communication and response system available in every area accessible by residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that the use of a Personal Assistance Service Device (PASD) to assist a resident with a routine activity of living was included in resident #006's plan of care only if all of the criteria required under LTCH Act, 2007, c. 8, s. 33 (4) was satisfied.

On identified date and time, inspector #570 observed resident #006 lying in bed with a specified device in place in the up position.

On two identified dates, inspector #461 observed resident #006 lying in bed with the specified device in the up position.

A review of the home's policy # CARE10-O10.04, last revised on March 31, 2018, directed the staff that the use of any specified device, regardless of its intended use will be assessed based on resident's assessed medical/physical needs or resident's preference and will be documented clearly in the plan of care. A written consent will be obtained for any specified device (including the specified device being used as PASDs) using the Restraint/specified device Consent Form.

A review of resident #006's written plan of care on an identified date showed that the specified device observed had not been included as an intervention. In addition, the resident had not had a risk assessment completed or a written consent from the Substitute Decision Maker (SDM) since their admission.

In separate interviews conducted with PSWs #107 and #115, both indicated that resident #006 had been using the specified device for bed mobility since their admission. The resident liked to hold onto the specified device to help with turning and repositioning.

On an identified date, resident #006 reported to Inspector #461 that they had been using the specified device since they moved into the home. The resident used the specified device to move around the bed and hold onto something when assisted by staff.

In an interview conducted on an identified date, RPN #104 indicated that resident #006 had been using the specified device since admission, the resident was able to use the the specified device and wanted them to be in place while they were in bed. RPN #104 acknowledged that an assessment and consent from the SDM to use the specified device for resident #006 had not been completed.

In an interview conducted on an identified date, the DOC indicated the specified devices in the home are used as PASDs to aid residents with bed mobility, transferring, and positioning. The identified specified devices were not used either as a restraint or as a fall prevention strategy. The registered staff were expected to meet the following criteria before implementing the specified devices: obtain a written consent from the resident's SDM, complete a 72-hour sleep study, complete a risk assessment, obtain a doctor's order for the use of specified device as a PASD, and update the care plan. The DOC confirmed that none of the above mentioned criteria for the implementation of specified devices were met for resident #006.

The licensee had failed to include in the resident's written plan of care, the use of a PASD in the form of the specified device to assist resident #006 with bed mobility,

transferring and positioning. [s. 33. (4) 3.]

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 use of a Personal Assistance Services Device (PASD) to assist a resident with a routine activity of living is included in resident's plan of care only if all of the criteria required under LTCH Act, 2007, c. 8, s. 33 (4) was satisfied, to be implemented voluntarily.

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).

Findings/Faits saillants :

1. The licensee had failed to ensure that drugs administered to resident #003 was in accordance with the directions for use specified by the prescriber.

Resident #003 was admitted to the home on an identified date with multiple identified medical diagnosis.

Inspector #672 completed a medication administration observation during an identified medication pass for resident #003 on an identified date, as part of the RQI process. In preparation for the identified medication observation, Inspector #672 reviewed resident #003's health care record and Physician's orders, which revealed the following orders, specific to an identified medication:
1) For an identified medication:
Administer an identified medication at an identified meal - If the resident only eats an identified amount of the meal, administer an identified amount at an identified medication pass.

Administer identified medication at an identified meal.
Administer identified medication at another identified meal - If the meal is refused, hold the medication of an identified medication pass.
2) For a second identified medication – check and complete identified intervention at identified times.
3) For third identified medication - Administer identified amounts at identified times.

Prior to an identified meal, resident #003 was assessed by RN #100. The RN indicated that resident #003 would not receive the identified medication until after the meal had been fully consumed, regardless of the assessment. At a later time, RN #100 administered an identified medication as specified by the prescriber.

During a record review, Inspector #672 reviewed an identified four months period of electronic Medication Administration Records (eMAR) and progress notes for resident #003:
A review of the first identified month's eMAR revealed the following:

On an identified date,an identified medication at a specified medication pass was held. The progress notes indicated the identified medication was held due to resident #003 refusing their meal. The progress notes indicated that resident #003 had an increased reading of the intervention and the Physician needed to be notified.

On two identified dates of the month, the identified medication was held at an identified medication pass. The progress notes indicated that on one identified date, the resident refused their identified meal, and on another identified date, the resident ate an identified portion of the meal.

On three identified dates of the month, an identified medication was held. The progress notes indicated that on one identified date, resident #003 ate an identified portion of the meal, but the identified medication was held; on another identified date, the eMAR indicated that resident #003 was “not available”; and on third identified date, the resident ate a partial meal, but the identified medication was held.

During an interview, RN #100 indicated that resident #003 “never” left the home, and that sometimes the nurse would mark the resident as “not available” if they were sleeping.

A review of an identified month's eMAR and progress notes revealed the following:

On two identified dates,an identified medication was held. The progress notes indicated that on one identified date, the resident ate an identified percentage of the meal, but the identified medication was held. The progress notes further indicated that on the other identified date, the resident refused their meal, therefore the identified medication was held.

On three identified dates, the progress notes indicated the resident received a specified amount of an identified medication due to the resident eating an identified portion of their meal. On an identified date, the progress note indicated that the resident ate most of the meal, specified amount of the identified medication was given. On three identified dates, the eMAR record was signed as the identified medication had been administered, despite the documentation in the progress notes which indicated that resident only received an identified amount of the medication.

On an identified date, the progress notes indicated that resident #003 had eaten an identified portion of their meal, the identified medication was held.

A review of an identified month's eMAR and progress notes revealed the following:

On an identified date, the progress note indicated that the resident ate an identified portion of the meal, therefore an identified amount of an identified medication was given, although the eMAR record had been signed to indicate that the identified medication had been administered.

On an identified date, the progress notes indicated that an identified medication was held before an identified meal. The progress note indicated that the resident ate an identified portion of the meal, therefore an identified amount of the identified medication was given. On an identified date, the progress note indicated that an identified medication pass was held and was given at a later time. The eMAR record was signed as both of the identified medication being given correctly, and on time. There was no notation to indicate that the Physician was notified, or an order received.

A review of an identified month's eMAR and progress notes revealed the following:

On an identified date, the progress notes indicated that resident #003 only ate an identified amount of an identified meal, therefore only an identified amount of an identified medication was administered.

On an identified date, the progress notes indicated that resident #003 ate well during an identified meal, but the nurse administered a partial amount. Neither the progress notes nor the eMAR indicated the amount of medication which was administered to the resident.

During an interview, RN #100 indicated that if resident #003 only ate part of an identified meal, a specified amount of an identified medication was given, and if the resident refused the meal, the medication was held altogether. RN #100 further indicated that the Physician was not notified when an identified medication was altered or held, as an order was already in place. Upon review of resident #003's Physician's order regarding the identified medication, RN #100 acknowledged that there were no directions specific to the identified meal. RN #100 indicated that Physician's order would be required if a nurse felt the need to administer a medication differently than it was originally prescribed.

During an interview, RN #101 indicated that during an identified shift, the nurse would hold resident #003's identified medication when the resident ate a partial meal. RN #101 further indicated that at times, an identified medication pass of the identified medication would be held until later into that shift, to assess if the resident ate later, and the Physician would only be notified of an alteration to the amount or administration time of the identified medication. Upon review of resident #003's Physician's order for an identified medication pass of the administration of the identified medication, RN #101 indicated that there were no directions specific to holding the medication, or if the resident ate a partial meal or took a snack.

During an interview, the DOC indicated that if a nurse wanted to alter or hold a resident's identified medication, for reasons not specified in the directions in the Physician's order, the Physician would need to be contacted, and an order would be required. The DOC further indicated that it was against the licensee's internal policy for staff to sign an eMAR to indicate a medication had been administered, if the medication had not been administered as per the Physician's order.

The licensee had failed to ensure that resident #003's identified medication was administered as per the Physician's order on multiple identified dates within the review period. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 29th day of November, 2018

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

Original report signed by the inspector.