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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 7, 2018	2018_679638_0013	016287-18	Resident Quality Inspection

Licensee/Titulaire de permis

Woods Park Care Centre Inc.
110 Lillian Crescent BARRIE ON L4N 5H7

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

Woods Park Care Centre
110 Lillian Crescent BARRIE ON L4N 5H7

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

RYAN GOODMURPHY (638), CHAD CAMPS (609), LOVIRIZA CALUZA (687), SHANNON RUSSELL (692), TRACY MUCHMAKER (690)

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): July 16 - 20 and 23 - 27, 2018.

The following intakes were inspected during this Resident Quality Inspection:
-Two logs were related to a critical incident the home submitted to the Director regarding two falls which resulted in actual harm;
-Twp logs were related to a critical incident the home submitted to the Director regarding alleged incidents of staff to resident physical abuse;
-One log was related to a critical incident the home submitted to the Director regarding an alleged incident of staff to resident verbal abuse;
-One log was related to a critical incident the home submitted to the Director regarding an incident where a resident struck a damaged wall, which resulted in an injury to the resident; and
-One log was related to a critical incident the home submitted to the Director regarding an alleged incident of resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Maintenance Manager, Scheduling Coordinator, Director of Resident and Family Services (DRFS), Pharmacist, Housekeeping Aid, Dietary Aid, Resident Assessment Instrument Minimum Data Set (RAI MDS) Coding Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and their family members.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant staff personnel files, internal investigation notes, licensee policies, procedures, programs, relevant training and resident health care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
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
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Resident #013 was identified through a record review as having developed skin integrity concerns within the first 30 days of admission by Inspector #638.

On July 16, 2018, Inspector #692 observed resident #013 in their mobility aid with specific transfer equipment underneath them.

Inspector #692 reviewed resident #013's health care records and was unable to identify an assessment completed to determine the appropriateness of leaving the specific transfer equipment underneath the resident. A review of resident #013's care plan failed to identify any direction related to leaving the specific transfer equipment under the resident while using their specific mobility aid.

During an interview with Inspector #692, PSW #126 verified that they leave the specific transfer equipment underneath resident #013 when they were using their mobility aid.

In an interview with Inspector #692, RPN #127 indicated that there was no assessment completed to determine whether the specific transfer equipment should be left under the resident. The RPN outlined there were risks related to skin breakdown or personal injury when leaving the specific transfer equipment under any resident.

During an interview with RPN #144, they verified the home did not have an assessment to determine if it was appropriate to leave the specific transfer equipment underneath a

resident. The RPN indicated that it was normal practice to leave transfer equipment under residents, when using a specific mobility aid.

During an interview with Inspector #692, the Administrator and ADOC both verified many residents were left with specific transfer equipment under them when using a specific mobility aid. The Administrator and ADOC were not sure how or who decides to leave the specific transfer equipment under the residents. They both verified there was no assessment to determine the appropriateness of the equipment placement once transferred and they should have one. [s. 6. (2)]

2. Inspector #638 and Inspector #692 observed resident #022 on July 18, 2018, in a small lounge room in a specific mobility aid. Upon closer observation the resident was noted to have a part of their specific transfer equipment wrapped around a specific part of their body which had the potential to cause serious injury. Inspector #638 immediately notified direct care staff, while Inspector #692 remained with the resident to ensure their safety.

Inspector #638 reviewed resident #022's health care records and identified in their Minimum Data Set (MDS) assessment that the resident was severely impaired and demonstrated repetitive physical movements, which were not easily altered. The Inspector identified in the resident's care plan under the transferring foci that the resident required specific assistance for all transfers. The care plan identified that the resident was totally dependent on staff for the entire process.

The Inspector reviewed resident #022's progress notes and identified a note created by RPN #124 regarding the aforementioned incident. The note stated that a PSW informed registered staff that the resident had their specific transfer equipment around a part of their body. The Inspector identified a second progress note written in 2018, which stated that the resident was found with a part of their specific transfer equipment around the same specific part of their body, as what was observed by the Inspector. It was also identified in an "Interdisciplinary Care Conference Summary Note" in 2018, that the resident played with their specific transfer equipment while using their specific mobility aid.

Inspector #638 observed resident #022 on July 25, 2018, alone in the small lounge room playing with the specific transfer equipment again.

In an interview with Inspector #638, PSW #145 stated that resident #022 constantly

fidgeted and played with items in their vicinity. The PSW indicated that the specific transfer equipment could have potentially posed a risk to resident safety, if they fidgeted with them.

During an interview with Inspector #638, RPN #124 stated that the specific transfer equipment was used for transferring residents. The RPN indicated that the equipment was generally kept under the residents because it could be difficult to remove. The RPN stated that there were certain risks associated with leaving the transfer equipment under a resident which included; skin breakdown or getting a part of their body wrapped in the device. If a risk was identified, staff would request reassessment by the special support services nurse. Upon reviewing progress notes with RPN #124, they indicated that they were made aware of the incident on July 18, 2018, by PSW #103 and if they were aware this incident occurred more than once, they would have referred the resident to the special support services nurse or DOC for reassessment. When asked if they believed leaving the specific transfer equipment under resident #022 was appropriate based on their condition, the RPN stated “not in this case”.

Inspector #638 interviewed the ADOC who indicated that the specific transfer equipment was generally kept under residents to minimize risk of skin breakdown from friction when removing them. They stated that PSWs were to report the concern if they identified a risk leaving the transfer equipment under a resident and if concerns were identified, the special projects nurse would reassess and determine the appropriateness of the equipment. The Inspector reviewed their observations and resident #022's progress notes with the ADOC who indicated that there could have been a risk of a specific type of serious injury based on the specific incident identified. The ADOC indicated that the device may not have been appropriate to remain under the resident based on their condition. [s. 6. (2)]

3. The licensee has failed to ensure that the provision of care as set out in the plan of care was documented.

Inspector #638 identified resident #013 as having a new area of altered skin integrity within the first 30 days of admission, through a record review.

On July 16, 2018, Inspector #692 observed resident #013 using a specific mobility aid with a pressure relieving device in place.

Inspector #692 reviewed resident #013’s care plan which indicated that staff were to

check the specific pressure relieving device daily to ensure proper inflation. Upon reviewing resident #013's health care records, the Inspector was unable to identify any documentation related to the specific pressure relieving device being checked daily or if the device was set up properly.

During an interview with Inspector #692, PSW #126 verified that they checked the specific pressure relieving device daily for proper inflation and that these checks were not documented anywhere.

During an interview with Inspector #638, RPN #125 verified there was no documentation in resident #013's health care records indicating that the specific pressure relieving device was checked daily.

The home's policy titled "Documentation - Plan of Care - VII-C-10.70" last revised April 2018, directed staff to provide care as specified in the resident's plan of care and to document on the care provided.

During an interview with Inspector #692, the Administrator and ADOC both verified that there was no documentation record related to the daily checks for the proper inflation of resident #013's specific pressure relieving device and that there should have been. [s. 6. (9) 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 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, 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 has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

a) On July 16, 2018, during a tour of the home, Inspector #690 identified;

-Unfastened corner guards on the shower stall and a broken toilet roll holder in one unit's tub room;
-Chipped and cracked tiles on the wall on the same unit's shower room;
-Chipped tiles and an unfastened corner guard on the shower stall on a second unit's shower room;
-Unfastened corner guards and a broken toilet roll holder on the second unit's tub room;
-Unfastened corner guards and a broken tiles in the shower stall on a third unit's shower room; and
-A broken latch on the second unit's linen room door, which would not lock. Inside the linen room, three canisters of liquid oxygen were noted.

In an interview with Inspector #690, PSW #146 verified that the door to the linen room stored canisters of liquid oxygen and should have been locked and kept inaccessible to residents. The PSW indicated that the door was broken and that the maintenance department was notified "some time ago".

The home's policy titled "Preventative Maintenance Program - V-C-10.00" last revised November 2017, indicated that the home shall establish and implement a maintenance program to ensure both interior and exterior areas and operational systems were in good repair and maintained. The policy further indicated that an automated work requisition system (Maintenance Care) would be in place for all team members to be used when

reporting required repairs.

Inspector #690 reviewed the "Maintenance Care Requisition" record and identified only one of the five broken tiles identified in the tour (20 per cent) had a requisition which identified the damage. The Inspector was unable to identify a requisition related to the linen room door latch on the third unit identified.

During an interview with Inspector #690, the Maintenance Manager acknowledged the disrepair to the tub and shower rooms and the broken latch on the third unit's identified linen room. The Maintenance Manager indicated that they were unaware of the disrepair, until it was identified by the Inspector.

b) A Critical Incident Systems (CIS) report was submitted to the Director related to an incident in 2017, where PSW #128 was assisting resident #019 in their specific mobility aid when they slipped in the unit's shower room. This caused resident #019 to strike the corner wall in their specific mobility aid, where there was a sharp edge noted, due to a missing tile. The resident was noted to have an injury, which required medical intervention.

During an interview with Inspector #638, PSW #128 indicated that they were assisting resident #019 out of the shower room when they slipped and the resident struck the side of a wall which had broken tiles. The PSW stated that the tile had been broken for "quite a while" (roughly a month) but was unsure of the exact length of time the tile was broken.

Inspector #638 reviewed the "Maintenance Care Requisition" which identified that the broken tile in the shower room had been identified on the date of the incident and was identified as repaired two days after the incident.

On July 16, 2018, Inspector #690 observed another broken tile in the same shower room.

A review of the "Maintenance Care Requisition" record revealed a requisition was made in "Maintenance Care" approximately one month prior, indicating that tiles in the unit's shower room were cracked and broken. There were no notes indicating that any repairs had been done to the broken tiles in the specific shower room.

In an interview with Inspector #690, the Maintenance Manager indicated that they were only made aware of the broken tile in the specific shower room after the Inspector's

observation. The Maintenance Manager verified that the tiles and unfastened corner guards were in a state of disrepair, posed a safety risk to residents and that they should have been repaired in a timely manner. [s. 15. (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 the home, furnishing and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to respect and promote that every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

A CIS report was submitted to the Director related to an alleged incident of staff to resident verbal abuse.

Inspector #687 reviewed the home's investigation notes and identified that PSW #102 acknowledged they had uttered inappropriate words directed towards resident #009 and resident #010 on a specific date in 2017. The notes identified that their statements were unprofessional and breached resident confidentiality.

The home's policy titled "Confidential Information - II-B-10.40" last revised May 2015, indicated that individual medical conditions are only discussed within a professional context and under no circumstances will any individual divulge to, or discuss with, any unauthorized person, any matter pertaining to residents or any information contained in the resident health record.

During an interview with Inspector #687, PSW #102 stated that on a specific date in 2017, they were assisting resident #009 with their transfer and PSW #139 was helping them. They stated that resident #009 did not like the specific transfer methods they required and when the resident saw the specific transfer aid, the resident "freaked out". PSW #102 reported this incident to RN #142 and received direction from the RN to continue to get the resident up as requested by the family. PSW #102 stated that their finger got stuck in the specific transfer device as a result of resident #009's behaviours and admitted that they became upset and used vulgar language down the hallways.

In a separate interview with PSW #102, they stated that on a specific date in 2017, resident #010 rang their call bell numerous times within a short period of time and when the PSW went to check the resident, they requested assistance and was yelling for help. The PSW stated they went to inform RN #114 about resident #010's concerns. The PSW acknowledged that while they were walking down the hallway, they voiced inappropriate comments about the resident.

During an interview with Inspector #687, Housekeeping Aid #108 stated that they overheard PSW #102 yelling down the hallway towards the nurses station on the specific date in 2017. The housekeeper was concerned about resident #010's privacy and sense of dignity from the PSW's comments because some residents were in their rooms resting and visitors were visiting at that time.

During an interview with Inspector #687, the Administrator stated that PSW #102 breached the privacy and confidentiality of resident #009 and resident #010 due to their conduct on the specific date in 2017. The PSW received disciplinary action. [s. 3. (1) 1.]

WN #4: 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 has failed to ensure where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, procedure, strategy or system, that it was complied with.

Section 114 (2) of the O. Reg. 79/10, states that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispending, receipt, storage, administration and destruction and disposal of all drugs used in the home.

During a medication administration observation Inspector #692 noted a used bottle of eye drops that did not have a label indicating the date the container was opened or when the date the container was supposed to be discarded.

The home's policy titled "Expiry and Dating of Medications - #5-1" last reviewed February 2017, required designated medications like eye drops, to be dated when opened and removed from stock when expired.

During an interview with Inspector #692, RN #122 verified the bottle of eye drops was not labelled with the date they were opened and they should be labelled.

During an interview with Inspector #692, Pharmacist #138 verified that registered staff were supposed to label eye drops to include the date when they were opened.

Inspector #692 interviewed the ADOC who confirmed eye drops were supposed to be labeled with the date they were opened and that in this instance this did not occur. [s. 8. (1) (b)]

WN #5: 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 has 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 that those doors were kept closed and locked when they were not being supervised by staff.

During a tour of the home, Inspector #690 identified the following doors unlocked and unsupervised;
-One unit's humidifier room door. In an interview with Inspector #690, PSW #148 verified that the door to the humidifier room was unlocked and that it should have been locked;
-A second unit's electrical room door. In an interview with Inspector #690, PSW #149 verified that the door to the Electrical Room was unlocked and that it should have been locked;
-The second unit's linen room door, which contained three canisters of liquid oxygen had a broken latch which would not lock; and
-The second unit's clean utility room. In an interview with Inspector #690, PSW #146 verified that the door to the clean utility room was unlocked and that it should have been locked.

In an interview with Inspector #690, the Maintenance Manager verified that these doors to non-residential areas were supposed to be kept locked when unsupervised. [s. 9. (1) 2.]

WN #6: 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 has failed to ensure that a written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A CIS report was submitted by the home to the Director in 2018, which outlined an alleged incident of physical abuse by PSW #112 towards resident #008.

Ontario Regulation (O. Reg.) 79/10 defines physical abuse as the use of physical force by anyone other than a resident that caused physical injury or pain.

Inspector #687 reviewed the home's internal investigation notes which identified, PSW #113 and PSW #112 were assisting resident #008 who had a specific medical diagnosis. The notes identified the resident would not let go of their specific transfer aid while the two PSWs attempted to transfer the resident out of their bed into their specific mobility aid. PSW #113 stated that the resident was not following directions and when the resident released the specific transfer aid, PSW #112 had slapped resident #008's hand and pulled back on their thumb to which the resident called out in pain.

Inspector #687 reviewed resident #008's care plan, which indicated that staff were to provide specific interventions when communicating with the resident and to explain each activity or care procedure prior to beginning the activity. The care plan further indicated that staff were to cue the resident to use the specific transfer aid and to provide the resident with an opportunity to perform portions of their Activities of Daily Living (ADL) on their own as tolerated.

Inspector #638 reviewed the "Licensee Reporting of Physical Abuse" decision tree guidance tool. The Inspector noted that, in light of resident #008's care plan, the use of

force was not appropriate to the provision of care or assisting the resident with their ADLs.

During an interview with Inspector #687, PSW #113 stated resident #008 was attempting to transfer themselves and was grabbing the specific transfer aid. The PSW stated that resident #008 was not following direction, so they spoke in a loud voice to get their attention. The PSW stated that they gently held the resident's hand to transfer them and denied slapping or prying the hands of resident #008.

The home's policy titled, "Prevention of Abuse & Neglect of a Resident - VII-G-10.00" last revised June 2017, abuse was defined as the abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. The policy identified abuse and neglect are not tolerated in any circumstance by anyone and that any deviation from this standard will not be tolerated.

In an interview with Inspector #687, the ADOC stated they referenced the abuse decision tree as part of their prevention of abuse and neglect policy. The ADOC stated that when they did their investigation, the ADOC did not believe there was physical abuse from PSW #112's actions towards resident #008, because they assessed the resident after the incident and found no pain or injury to the resident. However, when reviewing the incident with the definition of physical abuse in the O. Reg. 79/10, the ADOC recognized that physical abuse occurred.

In an interview with the Administrator, they stated that it was unintentional physical abuse on the part of PSW #113, but it happened. The Administrator further stated that they would recommend training for all staff on how to care for residents who have specific medical diagnoses as a result of this incident. [s. 20. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items labelled within 48 hours of admission and of acquiring, in the case of new items.

On July 16, 2018, during a tour of the home, Inspector #690 noted;

-Two used and unlabelled sticks of deodorant in one unit's tub rooms;
-One used and unlabelled tube of toothpaste and one used and unlabelled stick of deodorant in the first unit's other tub room;
-One used and unlabelled tube of toothpaste, two used and unlabelled toothbrushes and one used and unlabelled stick of deodorant on the second unit's shower room;
-One used and unlabelled bottle of shampoo on the second unit's tub room;
-Two used and unlabelled bottles of shampoo on the second unit's shower room; and
-One used and unlabelled stick of deodorant and a used and unlabelled shampoo bottle on the third unit's tub room.

Additionally, on July 17, 2018, during a tour of the home;

-Inspector #692 noted in resident #023's shared bathroom an unlabelled and used shampoo and lotion bottle;
-Inspector #638 noted in resident #024's shared bathroom an unlabelled and used brush and comb; and
-Inspector #687 noted in resident #025's shared bathroom; two used and unlabelled combs, one bottle of face wash and mouth wash; in resident #027's shared bathroom, one comb and bottle of body wash. One denture cup with dentures which were unlabelled was noted in resident #026's shared bathroom; and resident #028's shared bathroom had one used and unlabelled hair brush.

In an interview with Inspector #690, PSW #136 observed the unlabelled personal care items found on the third unit's tub room with the Inspector. The PSW verified that personal items such as roll on deodorant and shampoo bottles were supposed to be labeled with the resident's name.

The home's policy titled, "Clothing Care & Personal Effects - VII-C-10.10" last revised January 2015, indicated that all personal items that were to be kept in a resident's room must be labeled with the resident's name.

In an interview with Inspector #638, the Administrator verified that all resident personal care items should have been labelled with the resident's name. [s. 37. (1) (a)]

WN #8: 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 for each resident demonstrating responsive behaviours, that strategies were developed and implemented to respond to these behaviours, where possible.

During a resident interview, resident #015 alleged an incident of staff to resident abuse. Upon reporting this incident to the Administrator and DOC, it was identified the resident had responsive behaviours towards staff.

Inspector #638 reviewed resident #015's care plan and was unable to identify any foci or interventions developed and implemented to manage the resident's responsive behaviours. Upon further review the Inspector identified that the resident's foci related to their specific responsive behaviours had been "resolved" a couple of months prior in 2018.

In an interview with Inspector #638, PSW #116 stated that their role when dealing with responsive behaviours included implementing interventions. The PSW indicated that resident #015 sometimes demonstrated specific responsive behaviours towards staff, because they would often attempt to complete their care independently.

During an interview with Inspector #638, RPN #117 indicated that staff were supposed to refer to the resident's care plan and kardex for responsive behaviour interventions that have been specifically developed for the resident. The RPN indicated that resident #015 demonstrated severe specific responsive behaviours towards staff. The RPN stated that this resident's behaviours have been consistent since admission. Upon reviewing the resident's care plan with the RPN, they indicated that the resident's care plan was focused on other interventions and the specific responsive behaviours interventions had been removed. The RPN indicated they were re-initiating these foci and interventions because it was very important to identify, so staff could implement them to respond to the resident's specific responsive behaviours.

The Inspector interviewed RAI MDS Coding Coordinator #118, who stated that resident #015 had a change in condition. They stated that they believed their interventions related to their specific responsive behaviours were removed on a specific date because the resident was deemed a specific health status and no longer demonstrated these behaviours. The RAI MDS Coding Coordinator indicated that if the resident demonstrated these behaviours again, staff should have updated the care plan to include the identified behaviours again.

The Inspector reviewed resident #015's progress notes and identified that the resident returned from hospital on a specific date in 2018. The Inspector identified a "Behavioural Note" one day prior to resolving their responsive behaviours and resistance to care foci and interventions, which stated the resident demonstrated specific responsive behaviours towards staff. Upon further review of the progress notes the Inspector identified "Behavioural Note(s)" that the resident demonstrated specific responsive behaviours on 13 occasions and another specific responsive behaviour towards staff on

seven occasions over a three month period in 2018, since the interventions to their specific responsive behaviours were resolved.

The home's policy titled "Responsive Behaviours - Management - VII-F-10.20" last revised March 2018, indicated that the Interdisciplinary Care Team will evaluate effectiveness of plan and revise, as needed.

In an interview with Inspector #638, the ADOC indicated that staff were supposed to refer to a resident's care plan for resident specific responsive behaviour interventions because everything was identified in their care plan. The ADOC stated that resident #015 demonstrated specific responsive behaviours. When asked if the resident's responsive behaviours were identified in their care plan the ADOC stated that RAI MDS Coding Coordinator #118 had already informed them that this was not in the care plan. The ADOC stated that these foci and interventions should have been identified in the resident's care plan so staff could implement the strategies that were developed. [s. 53. (4) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars, washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

During a tour of the home, Inspector #690 noted;

-Corrosion on the plumbing fixture under the sink and on the sink faucet in one unit's tub rooms;
-Corrosion on the plumbing fixture under the sink and on the faucet in the first unit's shower rooms;
-One dripping and loose faucet in a public resident washroom and in the dining room of a second unit;
-Corrosion on the shower head connectors in both of the third unit's shower rooms;
-One loose faucet in one of the third unit's tub rooms; and
-Corrosion on the faucet in a public resident washroom and on the shower head connector in a fourth unit's shower room.

The home's policy titled "Preventative Maintenance Program - V-C-10.00" last revised November 2017, indicated that the home shall establish and implement a maintenance program to ensure both interior and exterior areas and operational systems were in good repair and maintained.

During an interview with Inspector #690, the Maintenance Manager acknowledged the disrepair to the faucets and the corrosion to the plumbing fixtures and indicated that they were unaware of the disrepair and corrosion, until it was brought to their attention by the Inspector. [s. 90. (2) (d)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure in making a report to the Director under subsection 23 (2) of the Act, that names of any staff members or other persons who were present at or discovered the incident were identified.

A CIS report was submitted to the Director related to an alleged incident of staff to resident verbal abuse, where PSW #102 used vulgar language about resident care in the hallway of a resident care area. Please refer to WN #3 for details.

During an interview with Inspector #687, PSW #102 stated that on a specific date in 2017, they were assisting resident #009 with their transfer and PSW #139 was assisting them.

Inspector #687 reviewed the home's CIS report and investigation notes and was unable to identify any documentation related to PSW #139's involvement or account of the incident.

The home’s policy titled “Prevention of Abuse & Neglect of a Resident - VII-G-10.00” last revised June 2017, indicated when abuse is suspected, the Executive Director/Administrator or designate initiates the investigation by requesting that anyone aware of or involved in the situation write, sign, and date a statement accurately describing the event, reiterating anonymity and protection against retaliation.

In an interview with Inspector #687 in relation to the alleged incident of verbal abuse, the Administrator stated that PSW #102 was interviewed about the incident. The Administrator stated that they did not have a record of any interview with PSW #139 (who witnessed the interaction) about what may have prompted the incident and was not identified in the CIS report. [s. 104. (1) 2.]

Issued on this 7th day of September, 2018

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

Original report signed by the inspector.