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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 23, 2015	2015_337581_0011	H-002393-15	Resident Quality Inspection

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

BILLINGS COURT MANOR
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

DIANNE BARSEVICH (581), CYNTHIA DITOMASSO (528), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 4, 5, 8, 9, 10, 11, 12, 15, 16, 17 and 18, 2015.

CIS Inspections H-001760-14 and Complaint Inspections, H-000878-14, H-001415-14, H-001489-14, H-001527-14, H-001626-14, H-002151-15 and H-002181-15 were conducted concurrently during this Resident Quality Inspection (RQI) and are included in this Inspection Report.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Associate Director of Care (ADOC), Administrative Assistant, Director of Therapeutic Recreation Services, recreation staff, Resident Assessment Instrument (RAI) Coordinator, Food Service and Nutrition Manager, Registered Dietitian (RD), Dietary Aides, Cook, Environmental Services Supervisor (ESS), Housekeeping Supervisor, housekeeper, Registered Nurse (RN), Registered Practical Nurse(RPN), Personal Support Workers (PSW's), families and residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
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
Skin and Wound Care
Sufficient Staffing

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

In April 2015, resident #042 was admitted to the home and assessed to require one three quarter bed rail raised when in bed for repositioning. Review of the home's Bed Entrapment Audit completed prior to the resident's admission in March 2015, noted that the resident's bed system failed zone two. Interviews held with the ESS and DOC in June 2015, confirmed steps had not been taken to prevent entrapment risk for zone two. The ESS identified the resident required a bolster mattress to mitigate zone two entrapment risk. [s. 15. (1) (b)]

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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents were not neglected by the licensee or staff.

The licensee submitted a Critical Incident Report (CIS) to the Ministry of Health and Long-Term Care, that identified in March 2015, resident #063 was allegedly left on a soiled bedpan for two hours.

The night PSW was interviewed in June 2015 and reported that they placed the resident on a bedpan to void. While providing care, the resident told the staff they had too much blanket on, so the PSW moved their top blanket down. The PSW then left the room, as the resident was able to use their call bell to alert the staff when they required assistance. The night PSW stated that their resident assignment changed at 0600 hours, so they informed oncoming day PSWs and the night RPN that the resident was sitting on a bed pan. The night PSW finished their shift at 0700 hours.

The day shift PSW who found the resident later that morning was interviewed in June 2015 and reported that the resident told them "I was here a long time, no one came to help", that they had been on the bedpan for a long time and their call bell was not within reach.

Interviews on multiple days in June 2015 with day staff PSWs and the night RPN working at the time of the incident revealed they had not received communication from the night PSW that the resident was on the bed pan.

The night PSW stated in their interview that the resident's call bell was usually attached to the resident's top blanket, however; likely became out of reach when they adjusted the top blanket. The resident was interviewed at the time of the inspection and confirmed the incident occurred and caused them distress. The licensee failed to ensure the resident was not neglected, as they were left seated on a bed pan for approximately two hours, absent from care by staff and without access to a call bell. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

On an identified day in October 2014, resident #081 requested from both PSW and registered staff to go to bed after lunch, however; they were not transferred back to bed until after dinner.

Interviews with registered staff and PSW's identified the resident was routinely transferred back to bed after breakfast or after lunch with the opera lift. PSW's reported the opera lift had broken that day after the resident was transferred to their wheelchair that morning.

Review of the home's investigation notes from October 2014, revealed the resident reported they were very upset they were up in the wheelchair the whole day and had to wait until the staff borrowed a lift from another unit. They also stated they had discomfort as a result of sitting in their wheelchair for an extended period of time.

Interview with registered staff confirmed the resident asked them to go back to bed. They informed the resident that the lift was broken, to stay up until after dinner and then they would be the first resident back to bed. Registered staff stated that the resident was visibly upset about being up in their wheelchair all day. Interviews with the PSW's confirmed they were aware the resident wanted to go back to bed after lunch. PSW's stated they did borrow a lift from another unit to transfer a co-resident, however; resident #081 was not transferred back to bed until several hours later. DOC confirmed that the resident was not cared for in a manner consistent with their needs. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #4: 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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident

that set out the planned care for the resident.

A) Resident #015 was observed eating in the dining room and received limited assistance from staff. The resident's plan of care was reviewed and did not include information regarding the type and level of assistance they required for eating. Interviews with PSWs and registered nursing staff reported the resident required limited to extensive assistance with eating. An RPN confirmed the resident's written plan of care did not set out the planned care for the resident.

B) Resident #006's plan of care was reviewed and indicated they had a catheter. Interviews with PSWs reported the resident wore a day liner during the day and sometimes a brief at night at the resident's request to protect from leakage. The resident stated they wore a liner during the day and they sometimes wore a brief at night for protection. Review of the written plan of care did not indicate they wore a liner or brief. Registered staff confirmed that the written plan of care did not set out the planned care for the resident. (581)

C) Resident #081's plan of care was reviewed and indicated they were toileted with two person assistance and the mechanical lift. The PSW and resident indicated they used a urinal for bladder continence during the day and night. Registered staff confirmed that the resident did use a urinal and the written plan of care did not set out the planned care for the resident. (581) [s. 6. (1) (a)]

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

A) Resident #015 was observed to have long and dirty finger nails on June 4, 2015. On June 8 and 9, 2015, their fingernails were observed clean and cut. Review of the Skin Assessment and Bathing Documentation revealed that the resident's finger nails had not been cut by PSW's since April 2015. Interviews with the PSW's and registered staff stated the resident was resistive to having their nails cut by staff and their family generally completed this task. The plan of care indicated assistance of staff was required to provide finger nail care and trimming, however; it was not identified that family would cut their finger nails due to identified responsive behaviours. The written plan of care was not based on the assessment of the resident's known needs and preferences related to finger nail trimming.

B) Resident #006 was observed on multiple days in June 2015, sitting in a wheelchair

with seat belt fastened. They were able to fasten and unfasten the seat belt independently. Interviews with the resident and PSW's stated that the seat belt was always fastened when up in the wheelchair for safety and staff often assisted with the fastening of the seat belt. Review of the plan of care revealed there was no documentation related to the resident's preference for the seat belt to be fastened when up in the wheelchair nor any related assessments. Registered staff confirmed that the written plan of care was not based on the assessment of the resident's known preferences related to their seat belt being fastened when up in the wheelchair. [s. 6. (2)]

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

A) In April 2015, resident #021's Minimum Data Set (MDS) assessment noted they exhibited identified responsive behaviours daily in the last seven days and the behaviour was not easily altered. PSW flow sheets during the seven day look back period were reviewed and did not indicate the resident exhibited responsive behaviours. Multiple PSWs were interviewed and reported the resident did not exhibit responsive behaviours during the April observation period. The Resident Assessment Instrument (RAI) Coordinator reported the resident had a history of demonstrating responsive behaviours, however; confirmed no identified responsive behaviours were noted during the seven day look back, and the MDS assessment was inconsistent from the PSW's assessment.

B) Resident #006's plan of care was reviewed and indicated they had a catheter. The MDS assessment completed in May 2015, identified they were frequently incontinent of bladder and the quarterly Bowel and Bladder Assessment completed in May 2015, indicated that the resident was incontinent and had inadequate control. Review of the flow sheets documented by the PSW's identified that the resident was incontinent of bladder once during May 2015. The registered staff confirmed that the resident was usually continent of bladder and that the assessments did not collaborate and complement each other. (581) [s. 6. (4) (a)]

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

In May 2015, resident #016 was observed with their main course and dessert served simultaneously, on the same plate. The resident's plan of care was reviewed and did not indicate that both courses were to be served together. A dietary aide serving, reported the resident was quickly distracted by other resident's dishes on the table once they finished their own course, so serving courses together seemed to help promote their intake and minimize distraction. The dietary aide reported they had implemented the intervention for one week and had not informed the FSS or RD about this intervention. A PSW stated the intervention may be appropriate for the resident, but was unaware of any recent change to their plan of care. The dietary aide did not collaborate with staff in the development and implementation of the plan of care. [s. 6. (4) (b)]

5. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) In June 2015, resident #041 was observed in bed with two bed rails activated and the bed was raised off the floor in a high position. Review of the plan of care indicated the resident was a potential risk for falls and directed staff to ensure that the high-low bed was in the lowest position when in bed. Interview with the registered staff confirmed that the bed was not in a safe position for the resident and was lowered to the lowest position, as required in the plan of care.

B) Resident #060 had a plan of care to receive a weight reducing diet, as an intervention to promote a healthy weight. In June 2015, during lunch meal service, the resident received a regular portion of the cheese, fruit salad and scone cold plate, as well as the date square dessert. The dietary aide confirmed the resident received a regular portion of the cold plate. Another dietary aide confirmed the small portion of date square was to be in a smaller bowl, which was not served to the resident. Staff and the resident's family confirmed the resident was to receive weight reducing portions at meals. The care set out in the resident's plan of care was not provided as specified in the plan. (585) [s. 6. (7)]

6. The licensee failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the plan of care and were given convenient and immediate access to it.

Resident #060 had a plan of care to receive prune juice with all meals and puree soup. In June 2015, during an observation of lunch meal service, the resident received regular texture soup and did not receive prune juice. The PSW who distributed beverages was

interviewed and was not aware the resident was to receive prune juice with meals. The PSW who distributed soup was interviewed and was not aware the resident was to receive puree soup. The RD confirmed they were to receive prune juice and puree soup at each meal. [s. 6. (8)]

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

A) In December 2014, the quarterly Minimum Data Set (MDS) and Resident Assessment Protocol (RAP), identified that resident #016 was at risk for altered skin integrity and had a history of frequent skin tears. Interview with registered staff confirmed the resident was prone to skin tears. Furthermore, the staff member also listed interventions in place to prevent further skin breakdown, including but not limited to, applying a barrier cream to dry skin, repositioning the resident and frequent observations. Review of the written plan of care did not include a focus statement related to the resident's altered skin integrity or the potential risk, nor, did it include the interventions in place as described by staff. Registered staff confirmed the written care plan was not updated to include skin and wound.

B) Review of the written plan of care for resident #012 indicated the resident was using a borrowed wheelchair. Resident was observed sitting in a tilt wheelchair on multiple days in June 2015. Interviews with registered staff, PSW's and family stated the resident received a personal wheelchair over one year ago. Registered staff confirmed that the plan of care was not reviewed and revised when the resident's care needs changed. (581)

C) Review of the written plan of care for resident #012 indicated that the resident was ambulating with assist of two staff. Interviews with the registered staff and PSW's stated that the resident was no longer walking and had not walked for a long time. Registered staff confirmed that the plan of care was not reviewed and revised when the resident's care needs changed. (581)

D) Review of the written plan of care for resident #012 indicated that the resident was being transferred in and out of bed and into the wheelchair with the sit/stand lift. Interviews with registered staff and PSW's stated that the resident was now transferred with a ceiling lift for all transfers. Registered staff confirmed that the plan of care was not reviewed and revised when the resident's care needs changed. (581)

E) Review of the written plan of care for resident #015 indicated they had a bed bath. Interviews with the PSW's and review of the Skin Assessment and Bathing documentation sheets revealed they received a shower. Registered staff confirmed that the plan of care was not reviewed and revised when the resident's care needs changed. (581)

F) In April 2015, the Skin and Risk Assessment for resident #005 identified that the resident had a high risk for altered skin integrity, however; was not identified in the written plan of care. Interview with direct care staff and registered staff in June 2015, confirmed that the resident was high risk for altered skin integrity, with recurring altered skin alterations related to regularly administered medications. Staff also described daily interventions including but not limited to barrier cream and additional caution when transferring the resident. Registered staff then confirmed that the written plan of care was not updated to include the resident's potential risk and ongoing altered skin integrity or interventions in place to prevent further alterations in skin integrity. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care for each resident set out the planned care for the resident, the plan of care is based on an assessment of the resident and the resident's needs and preferences, to ensure that the staff and others involved in the different
aspects of care of the resident collaborated with each other, in the assessments of the resident so that their assessments are integrated, consistent with and complement each other, that the staff and others involved in the different aspects of care of the resident collaborate with each other 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, that the care set out in the plan of care is provided to the resident as specified in the plan, that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and are given convenient and immediate access to it and to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home's Policy "CN-C-21-2, Cleaning Nursing Equipment", dated May 2011, stated that brushes and combs were kept at residents' bedside and to ensure that brush and combs were clean and labeled with resident's name, was not complied with.

During the initial tour of the home the following combs and brushes were observed to be unlabeled and were not stored at the residents' bedsides:
i. On Crown Derby home area, one comb in the shower room, one pink bath brush/sponge in the tub room, one comb and razor in the public washroom.
ii. On Wedgewood home area, one comb in the public washroom.
iii. On Ansley home area, two combs and one brush in spa area.
iv. On Bristol home area, one comb in the public bathroom and one brush in the program centre

Interview with direct care staff confirmed brushes and combs should be labeled and stored at residents' bedsides.

B) The home's policy "CN,M,01-1, Administration of Medication", dated July 2010, directed staff to administer oral mediation and remain with resident while he/she takes the medication (never leave a drug with a resident).

In June 2015, during medication administration for four residents at lunch hour the RN was observed placing medication cups filled with oral medications in front of residents on dining tables. After placing the medication on the resident's dining table, the RN then walked out of the dining room back to the medication cart. The RN was not observed staying with each resident while they took the medication. Interview with the registered staff confirmed they did not remain with the resident while they took the medications, however; monitored all residents from the medication cart located outside of the dining room. Interview with the DOC confirmed registered staff were expected to comply with the home's policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #6: 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 failed to ensure the home, furnishings and equipment were kept clean and sanitary.

During the course of the inspection, floor debris was observed in resident #008's room: under the bed, under the side table and on the floor mat, for four consecutive days. Review of the home's housekeeping procedure included daily inspection/cleaning of bedrooms using the "Bedroom Cleaning Procedure". The daily task form listed but was not limited to, floor and floor corners. Interview with a housekeeper confirmed the floor in resident #008's room was not clean. Interview with the Housekeeping Supervisor confirmed that housekeeping staff were expected to clean the resident's rooms daily. [s. 15. (2) (a)]

2. The licensee failed to ensure the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A) In May 2015, resident #005 stated their mattress was uncomfortable, as confirmed by the resident and direct care staff. Review of the Bed Entrapment Audit from March 2015, documented the condition of their mattress had failed and did not include any indication the mattress was replaced. In June 2015, when the LTC Homes Inspector applied light pressure to the mattress, they could feel the springs. Interview with ESS, who examined the bed at that time, confirmed the mattress was old and needed to be replaced.

B) During the initial tour of the home, five alenti lifts, used by multiple residents, were observed to have large areas of worn plastic to the seat, backs and arm rests of the chairs. The worn plastic was rough and scratched, posing a potential for microbial growth, contamination or transmission of infection. Interview with registered and direct care staff confirmed that the integrity of the plastic was not maintained in good state of repair. Interview with ESS identified that they were unaware of the condition of the lifts. [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, furnishings and equipment are kept clean, sanitary, maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #7: 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 failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by the resident.

It was identified on the initial tour of the home that eleven out of the thirteen outdoor resident areas were not equipped with a resident-staff communication and response system. Interview with floor staff on all of the home areas confirmed that the residents used the outdoor areas and staff monitored the residents. Interviews with the Administration team confirmed that the home's outdoor areas, accessible by residents were not equipped with a resident-staff communication and response system. [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 that is available in every area accessible by the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(a) the device is used in accordance with any requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was being restrained by a physical device under subsection (1), the device was used in accordance with the requirements set out under section 110. 1 (1) of the Regulations.

Resident #016 was observed with a loose, front fastening seat belt, not applied as per manufacturer's instructions. In June 2014, the resident was observed in their wheelchair with a fastened front seat belt, greater than six fingers widths from their torso. The resident was unable to undo the seat belt on request. Review of the plan of care, identified that the belt was a restraint and was to be applied when the resident was in the chair to prevent injury. Two PSWs stated they were unaware how the belt was to be applied. Registered staff confirmed the belt was used as a restraint and was not applied correctly. The registered staff attempted to tighten the belt, however; noted it still appeared loose. Staff had to remove the resident from the chair to adjust the belt to ensure it was applied properly. [s. 31. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident was being restrained by a physical device under subsection (1), the device was used in accordance with the requirements set out under section 110. 1 (1) of the Regulations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system, at a minimum, provided for standardized recipes and production sheets for all menus.

The home's menu included a weight reducing therapeutic menu. On June 9, 2015, a cheese, fruit and scone salad plate was served. The weight reducing therapeutic menu listed the item portion as 'lite', however; did not specify what a lite portion was. A dietary aide reported the lite portion was a little bit smaller than a regular portion, but was unable to specify what a smaller portion was. The FSS confirmed the home's therapeutic menu did not include what the lite portion was and there was no documentation or instruction in the home to direct staff. [s. 72. (2) (c)]

2. The licensee failed to ensure that the food production system, at a minimum, provided for preparation of all menu items according to the planned menu.

A) On June 4, 2015, during lunch meal service in the Kent dining room, puree bean salad was served. This item appeared runny and pooled on plates when served.

B) On June 8, 2015, during lunch meal service in the Kent dining room, pureed chicken burger, red cabbage salad, and bread was served. These items appeared runny and pooled on plates when served.

C) On June 10, 2015, during lunch meal service in the Wedgewood dining room, pureed tuna salad, bread, and spinach salad was served. These items were observed pooling on a plate that was served.

On June 10, 2015, a dietary aide serving the meal reported that puree items were to be prepared to a honey thick consistency. A regular cook, who prepared the identified menu items on June 10, 2015, also stated puree items were to be honey thick. They reported the salad was prepared two hours before meal service and the puree bread and tuna was prepared two and a half hours before meal service.

The home's recipes for puree items stated for nutrient retention, texture modification should be done within one hour before meal service and prepared to a pudding consistency. The cook confirmed the menu items were not prepared as outlined in the recipe. The FSS confirmed puree items were to be prepared to a pudding thick consistency. As a result of staff not following recipes, the nutritive value, appearance and food quality of these items were compromised. [s. 72. (2) (d)]

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 food production system, at a minimum, provided for preparation of all menu items according to the planned menu, to be implemented voluntarily.

WN #10: 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the weekly menu was communicated to residents.

On June 4, 8 and 11, 2015, in the Kent home area, no weekly menu was posted. The FSS reported the weekly menu was regularly posted but was would frequently be removed and go missing. The FSM confirmed the weekly menu should be posted. [s. 73. (1) 1.]

2. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who were assisting residents to eat.

A) On multiple days in June 2015, residents #015, #064, and #065 were observed sitting at dining room tables that were inappropriate for their height. The tables were significantly higher than the residents in their chairs. The residents needed to lean up to reach items on the table.

i) On June 8, 2015, resident #015 was drinking soup out of a bowl, lifting it down below the table to consume it. They also positioned their sandwich at the edge of the table to reach it.

ii) On June 11, 2015, resident #065 was observed eating soup with the bowl positioned at the edge of the table, with soup spilled on the hanging piece of table cloth in front of them.

On multiple days, resident #015 and #064 were both noted to consume small amounts at meals. The RD confirmed the three residents were seated at tables that were inappropriate heights for the residents.

B) On June 11, 2015, a staff was observed standing when feeding resident #066, who required total assistance with eating. No additional chairs were noted in the dining room for the staff to use. The staff confirmed they should be seated when assisting residents to eat, but no chairs were available. The staff proceeded to find another chair in another area of the home, then continued to assist with feeding. [s. 73. (1) 11.]

3. The licensee failed to ensure that staff members assisted only one or two residents at the same time who needed total assistance with eating or drinking.

On June 8, 2015, a PSW was observed providing simultaneous assistance to three residents with eating. Resident #061 and #063 required total assistance and resident #067 required extensive assistance. The PSW confirmed they first assisted resident #061 with part of their meal, moved on to assist resident #067, returned to assist resident #061 with their main course, then proceeded to assist resident #063 with their main

course and dessert. Resident #061 was observed sitting twenty five minutes without staff present and had cups of fluids in front of them. After the resident sat alone for twenty five minutes, another PSW proceeded to escort them out of the dining room. The inspector asked if resident #061 had dessert yet and the PSW who was assisting the resident with feeding confirmed they had not. The staff feeding confirmed they were assisting the three residents and the practice was that staff would assist residents as soon as possible, however; there was no particular assignment for staff with feeding. The RD confirmed staff should not assist more than two residents requiring total assistance simultaneously and reported they were challenged to have adequate staff to assist with feeding in the dining room. [s. 73. (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 that the weekly menu is communicated to residents, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

On June 12, 2015, a medication cart was noted to be in the hallway unlocked with approximately three cups of medication tablets opened and prepoured for administration. The RPN responsible for the medication cart was observed administering medications behind the curtain of the resident closest to the window, out of the staff's view. The LTC Homes Inspector was able to open and close medication cart drawers without the registered staff being aware. When registered staff exited the room after approximately two minutes, they confirmed that they held keys to the cart and it should have been locked when unattended. [s. 130. 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 all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that on every shift symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and the symptoms were recorded and that immediate action was taken as required.

Based on Best Practices in Ontario outlined by Provincial Infectious Diseases Advisory Committee (PIDAC), the home's Surveillance Protocols consisted of, but were not limited to, establishing baseline information about the frequency and types of infections that existed within the Long-Term Care (LTC) home. Both passive surveillance involving identification of infection while providing daily care activities or active surveillance, seeking out residents with infectious process care. The goal of surveillance was to ensure early identification of symptoms in residents and staff that precede a potential outbreak or in an outbreak in its early stages so that control measures can be instituted.

The home's policy "CIC-02-18-3 Surveillance Protocols", last revised Dec 2014, defined resident surveillance to include daily monitoring of residents for signs of infections, all infections were documented on the monthly infection line list which included site, symptoms, diagnostics and treatments by the registered staff on the unit.

A) In January 2015, resident #010 began displaying symptoms of respiratory infection and was placed on isolation the following day. Review of the resident's clinical health record did not include consistent monitoring and documentation of the resident's symptoms every shift. Interview with registered staff confirmed that the resident's respiratory symptoms were not consistently monitored, including but not limited to; fever cough and shortness of breath; and symptoms were not recorded every shift once identified.

B) In March 2015, resident #019 was re-admitted to the home with symptoms of respiratory infection. Review of the resident's clinical health record did not include consistent monitoring and documentation of the residents symptoms every shift. Interview with registered staff confirmed that the resident's symptoms, including but not limited to, level of consciousness, confusion, shortness of breath, respiratory rate, were not consistently monitored every shift in the progress notes or the home's line listing. [s. 229. (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 on every shift symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 9. Restorative care

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that there is an organized interdisciplinary program with a restorative care philosophy that,
(a) promotes and maximizes independence; and 2007, c. 8, s. 9 (1).
(b) where relevant to the resident's assessed care needs, includes, but is not limited to, physiotherapy and other therapy services which may be either arranged or provided by the licensee. 2007, c. 8, s. 9 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was an organized interdisciplinary program with a restorative care philosophy that promoted and maximized independence and where relevant to the resident's assessed care needs, included, but was not limited to, physiotherapy and other therapy services which may be either arranged or provided by the licensee.

It was identified during the course of the inspection that the home did not have a Restorative Care Program. Interview with the DOCs confirmed that the home has not had a Restorative Care Program for approximately two years, however; as part of their Continuous Quality Improvement Plan, will be initiated in the fall 2015. [s. 9. (1)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy, "Abuse – Prevention, Reporting and Elimination of Abuse and Neglect, CA-05-37-9", effective June 2010, stated, "any person who suspects that abuse or neglect has occurred must report it to the Registered staff" and "Registered staff must contact the Administrator or his/her designate immediately for direction on sanctions to be imposed immediately and for direction on how to proceed with the investigation of any alleged, suspected or witnessed abuse or neglect".

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care in March 2015, regarding alleged staff to resident abuse/neglect. The report indicated that in the early morning in March 2015, resident #063 was left on a soiled bed pan for approximately two hours, with their call bell out of reach.

On multiple days in June 2015, staff working at the time of the incident were interviewed. The day shift PSW who found the resident reported the resident was upset, sitting on a bedpan, with their call bell out of reach. The PSW immediately informed registered staff, as they understood it was neglectful. The registered staff was interviewed and confirmed the PSW reported the incident, but the registered staff was unaware of how long the resident was left, stating they thought it was at most fifteen to twenty minutes and did not interpret the situation as neglect.

The following day, the resident's family brought forth information of the incident to the home, at which time management was made aware and submitted a CIS. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Resident #081 stated they requested to go back to bed after breakfast or after lunch daily. Review of the written plan of care did not indicate the resident's sleep patterns and preferences. PSW stated that the resident was transferred back to bed after breakfast or after lunch daily and that was the resident's choice. Registered staff confirmed there was no interdisciplinary assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) In October 2014, a physician ordered staff to collect a urine sample for testing for resident #060. Clinical records were reviewed and did not indicate any actions taken in regards to the testing for several days, at which time nursing staff documented that the initial sample sent was unlabeled and another sample was required to complete the test. Registered staff confirmed they received notification from the lab that the sample was unlabeled, however; was unable to confirm any other actions taken including when the sample was obtained, sent to the lab, and the date the lab notified the home that the sample was unlabeled.

B) Review of resident #080's plan of care indicated that the resident was to receive a bath or shower two times a week. Review of the Skin Assessment and Bathing Documentation form from January to June 2015, revealed that the resident did not receive a bath or shower twice a week on seven occasions. Interviews with the registered staff and PSW stated that the resident did receive their bath twice a week but it was not documented. (581) [s. 30. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage).

During the course of the inspection, it was identified by five residents and two family members that, at times, residents had to wait a long time for staff assistance. Review of the staffing plan identified that it did not include the following; a back-up plan for nursing and personal care staffing addressing situations when staff can not come to work. Interview with registered and direct care staff identified a variety of interventions that may be put in place if staff can not come to work, however; the home was unable to provide a formal back-up plan for nursing and personal care staff that addressed those situations. Interview with Administration indicated that it was up to the team to determine priority nursing care when staff cannot come to work and staff could contact management for direction. The Administrator and DOC confirmed the home did not have a written back-up plan for when staff can not come to work. [s. 31. (3) (d)]

2. The licensee failed to ensure there was a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Review of the Nursing Practice Committee minutes from March and April 2015, identified that the nursing staff discussed staffing issues monthly, including but not limited to: staffing changes and communication of those changes to staff. The home was unable to provide a written record of annual evaluation for the staffing plan. Interview with the DOC confirmed that a formal annual evaluation of the staffing plan was not completed in 2014/2015, however; staffing was discussed with the nursing team continuously. [s. 31. (4)]

WN #18: 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 failed to ensure that the use of a Personal Assistance Services Device (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 were satisfied:

1. Alternatives to the use of a PASD had been considered, and tried where appropriate.
2. The use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASD's that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

On multiple days in June 2015, resident #012 was observed sitting in their tilt wheelchair which was in the tilted position. PSW and RPN staff stated they were in the tilt wheelchair for positioning and to assist them with activities of daily living. Review of the clinical record indicated there was no documented assessment for the use of the tilt wheelchair as a PASD, nor any documented consent or approvals for its use. The DOC and registered staff confirmed that the tilt wheelchair was not assessed as a PASD nor did they have documented consent or approval for its use. [s. 33. (4)]

WN #19: 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 failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

From March 2015, to June 2015, resident #016 was identified as having multiple areas of ongoing altered skin integrity. Review of the plan of care did not include a referral to the RD. Interview with the RD confirmed that a referral was not sent by registered staff related to altered skin integrity and therefore a nutritional assessment related to altered skin integrity was not completed. [s. 50. (2) (b) (iii)]

2. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

In March 2015, registered staff documented areas of altered skin integrity for resident #016. Review of the clinical health record did not include weekly assessments for three weeks in April 2015 and three weeks in May 2015. Interview with registered staff confirmed that the resident continued to have ongoing areas of altered skin integrity, which had not been not consistently assessed weekly by registered staff. [s. 50. (2) (b) (iv)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written record relating to each evaluation that includes the date of the evaluation, names of the persons who participated, summary of the changes made, and date that those changes were implemented.

In an interview with the DOC on June 16, 2015, it was reported that the home did not have a written record for the evaluation of the responsive behaviour program for 2014. However, the annual evaluations and Quality Improvement Plans have been initiated for 2015. [s. 53. (3) (c)]

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours strategies are developed and implemented to respond to these behaviours, where possible.

In December 2014, during meal service, a PSW was attempting to change resident #061's shirt saver. The resident was lifting their arms possibly resisting the care, however; the PSW continued to remove the shirt saver. The written plan of care identified that the resident had a history of refusing care and directed staff that if the resident refused care to re-approach them within five to ten minutes. Interview with the PSW confirmed that they did not implement the strategy outlined in the plan of care for resident #016 when they continued to change the resident's shirt saver. Interview with registered staff confirmed that the PSW was trying to keep the resident clean, however; the 're-approach technique' was not used. [s. 53. (4) (b)]

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within ten days of receiving Residents' Council advice related to concerns or recommendations.

Review of the Residents' Council minutes from October 27, 2014 to May 25, 2015, identified that not all concerns or recommendations received were responded to in writing within ten days.

Meeting minutes for October 27, 2014, included a concern that residents felt they are coming to meal time too early and some staff were rushing residents to the dining room forty-five minutes before meal service. Another concern was about unused wheelchairs and walkers left around the home in resident space areas.

Meeting minutes from November 24, 2014, included concerns about the inconsistency with housekeeping staff especially on week-ends, inconsistent heat throughout the home and that the dining experience was still an issue, very loud environment with staff still talking and discussing personal and work related issues during meal service.

Meeting minutes from January 2015, included that menus in hallways were never accurate and the tea cart was always giving bananas, an apple slicer was never used and orange slices were always given rather than an orange. A recommendation was that salt and sugar were on every table and possibly it should be on the serving cart and used by staff to assist residents.

Interview with the Director of Therapeutic Recreation Services confirmed that the concerns in October, November, 2014 and January 2015, were not responded to in writing within ten days. [s. 57. (2)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that planned menu items were offered and available at each meal and snack.

On June 9, 2015, a cheddar cheese fruit salad and scone plate was on the planned menu for lunch. During meal service, resident #063, who had a plan of care to receive a regular diet, requested this menu item. The dietary aide reported that they did not have enough scones left and provided resident #063 with half a scone instead of a full one. This was confirmed by the dietary aide. [s. 71. (4)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written record of of the evaluation of the policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and any changes and improvements required to prevent further occurrences, and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented was promptly prepared.

During the course of the inspection, the home was unable to provide a record of the evaluation of the policy to promote zero tolerance including any changes and improvements required to prevent further occurrences and the implementation of those changes. Interview with the DOC confirmed that the home had discussed evaluation of the policy to promote zero tolerance of abuse and neglect of residents, but there was no written record of the evaluation for 2014/2015. [s. 99. (e)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included: the nature of the written complaint; the date it was received; the type of action taken to resolve the complaint; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response and any response made by the complainant.

Resident #006 identified that they had lost personal property approximately four or five months ago. A review of the resident's clinical progress notes during this time did not include an entry that their personal property was missing. Interview with the registered staff confirmed knowledge of the missing personal property and that the family was notified and purchased a new item for the resident immediately but the original item was never found. A review the Concern and Complaint Log for 2014 and 2015 did not include an entry for the identified missing item. The DOC and ADOC were interviewed and were unable to locate a report of the missing personal property in the home's Concern/Complaints Log and were both unaware that the item was missing. They stated it was an expectation that any missing items, complaints or concern be reported immediately to the Administrator or manager on call or the RN on duty and then the ADOC completed the Concern and Complaint Log. As the registered staff did not notify management of the missing personal property, the item was not included on the log. The ADOC and DOC confirmed that a documented record was not in place regarding the missing item as required. [s. 101. (2)]

2. The licensee failed to ensure that the documented record was reviewed and analyzed for trends, at least quarterly and the results of the review and analysis were taken into account in determining what improvements were required in the home, and a written record was kept of each review and of the improvements made in response.

Review of the summary of the quarterly complaints indicated that the complaints received were not reviewed and analyzed for trends for the second and fourth quarter of 2014, nor the first quarter of 2015 as confirmed by the Administrator. [s. 101. (3)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept, that was promptly prepared of: the monthly analysis, the annual evaluation and the changes and improvements required; the date of the annual evaluation; the names of the persons who participated in the evaluation; and the date that the changes were implemented.

In an interview with the DOC on June 16, 2015, it was reported that the home had changes to the restraint programs in the last year, including but not limited to, bed rail assessments. The home was unable to provide a written record of the annual evaluation for restraints in 2014, as confirmed by the DOC. [s. 113. (e)]

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

Issued on this 19th day of August, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANNE BARSEVICH (581), CYNTHIA DITOMASSO (528), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2015_337581_0011
Log No. / Registre no:	H-002393-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 23, 2015
Licensee / Titulaire de permis :	MARYBAN HOLDINGS LTD 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	BILLINGS COURT MANOR 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lori Turcotte

To MARYBAN HOLDINGS LTD, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

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

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

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

Order / Ordre :

The license shall mitigate any entrapment zone risk(s) for any resident who currently occupies a bed where one or more entrapment zone risks have been identified.

Grounds / Motifs :

1. This order was previously issued on September 2014 and January 2015, which was complied in April 2015.

The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

In April 2015, resident #042 was admitted to the home and assessed to require one three quarter bed rail raised when in bed for repositioning. Review of the homes Bed Entrapment Audit completed prior to the resident's admission in March 2015, noted that the resident's bed system failed zone 2. Interviews held with the ESS and DOC in June 2015, confirmed steps had not been taken to prevent entrapment risk for zone 2. The ESS identified that the resident required a bolster mattress to mitigate zone two entrapment risk. (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 14, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure:
1) All residents are free from neglect by the licensee or staff in the home;
2) The home and its staff use effective communication practices at all times, including but not limited to periods when staffing duties or assignments change, to ensure they are continually informed and aware of all residents care needs;
3) Resident #063 is provided with care consistent with their needs to ensure they are free from neglect

Grounds / Motifs :

1. The licensee failed to ensure that residents were not neglected by the licensee or staff.

The licensee submitted a Critical Incident Report (CIS) to the Ministry of Health and Long-Term Care, that identified in March 2015, resident #063 was allegedly left on a soiled bedpan for two hours.

The night PSW was interviewed in June 2015 and reported that they placed the resident on a bedpan to void. While providing care, the resident told the staff they had too much blanket on, so the PSW moved their top blanket down. The PSW then left the room, as the resident was able to use their call bell to alert the staff when they required assistance. The night PSW stated that their resident assignment changed at 0600 hours, so they informed oncoming day PSWs and the night RPN that the resident was sitting on a bed pan. The night PSW finished their shift at 0700 hours.

The day shift PSW who found the resident later that morning was interviewed in June 2015 and reported that the resident told them "I was here a long time, no one came to help", that they had been on the bedpan for a long time and their call bell was not within reach.

Interviews on multiple days in June 2015 with day staff PSWs and the night RPN working at the time of the incident revealed they had not received communication from the night PSW that the resident was on the bed pan.

The night PSW stated in their interview that the resident's call bell was usually attached to the resident's top blanket, however; likely became out of reach when they adjusted the top blanket. The resident was interviewed at the time of the inspection and confirmed the incident occurred and caused them distress. The licensee failed to ensure the resident was not neglected, as they were left seated on a bed pan for approximately two hours, absent from care by staff and without access to a call bell.

(585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 14, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 23rd day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dianne Barsevich

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