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 sions de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Oct 7, 2016	2016_240506_0019	027768-16	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

LESLEY EDWARDS (506), CAROL POLCZ (156), LISA VINK (168)

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): September 20, 21, 22, 26, 27, 28, 29, 30 and October 4, 2016

During this inspection the inspections listed below were conducted concurrently:

Complaints

034879-15 - related to skin and wound care, lost items, complaints process and

plan of care.
001847-16 - related to staffing, nutrition and hydration and pest control.
003501-16 - related to pest control.
019692-16 - related to abuse and neglect and responsive behaviours.

Critical Incident Inspections

006054-16 - related to abuse and neglect and responsive behaviours.
008153-16 - related to abuse and neglect.
011468-16 - related to abuse and neglect and responsive behaviours.
018247-16 - related to abuse and neglect and not following the plan of care.
020312-16 - related to falls prevention.
028915-16 - related to responsive behaviours and reporting to the Director.
029063-16 - related to abuse and neglect.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food Service Manager (FSM), Registered Dietitian (RD), Environmental Maintenance Supervisor (ESM), registered nursing staff, Personal Support Workers (PSWs), Resident Assessment Instrument Co-ordinator (RAI), dietary Staff, laundry and housekeeping staff, recreation staff, administration staff, Behavioural Supports Ontario staff (BSO), residents and families.

During the course of the inspection the inspectors toured the home, observed the provision of care and services, reviewed relevant records including meeting minutes, policies and procedures and resident health records and conducted interviews.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
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

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **8 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 O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the programs included weight on admission and monthly thereafter.

Resident #004 was admitted on an identified date in March 2016 and noted to be at nutritional risk. There was no weight taken for the months of June and August 2016, as confirmed with the RD on an identified date in September 2016. The weight was taken on an identified date in September 2016, at which time, there was a significant weight loss of 7.1 kg (10.1 % loss) when compared to the last weight taken in May, 2016. [s. 68. (2) (e) (i)]

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 weights are taken on admission and monthly thereafter, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (b) identifying and implementing interventions.

i. On an identified date in April 2016, staff heard resident #023 shouting in the hallway and when staff arrived to the area it was noted that the resident #023 was holding an identified area which was bleeding. Resident #024 pointed to resident #022 and reported they punched resident #023. The home's Risk Management report indicated that the environmental trigger for this incident was noise and resident #023 most likely was yelling at resident #022 as will often yell at the resident for no reason.
Interview with staff #116 confirmed that the home did not take steps to minimize the risk of potentially harmful interactions by implementing the interventions that were identified as a trigger for resident #022.
ii. On an identified date in September 2016, staff #117 heard a thud and found resident #025 lying on the floor in the hallway with a laceration to an identified area. Resident #023 was heard shouting. Resident #023 was agitated and restless as confirmed by staff #117 prior to this incident and it was documented in the progress notes that the resident refused to take their medication as resident was anxious and restless. Resident #023's plan directs staff when the resident is agitated and pacing they are known to shout and the staff are to direct the resident away from co-residents to prevent escalation and physically responsive behaviours.
Interview with the ADOC confirmed that the home did not take steps to minimize the risk of potentially harmful interactions by implementing the interventions that were identified as a trigger for resident #023. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by implementing the interventions identified, to be implemented voluntarily.

WN #3: 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 the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #040 demonstrated altered skin integrity, on an identified area beginning in March of 2014, which was brought to the attention of the staff at the home by the substitute decision maker. According to the progress notes the physician was notified, the same day and treatment was ordered the following day. A review of the clinical record did not include an initial assessment of the area using a clinically appropriate assessment instrument as required. Interview with RPN #124, who first documented the area in the progress notes, identified that based on the implementation of the home's skin and wound program at the time that the area was identified they would not have completed an initial assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #004 was noted to have an injury on an identified date in May 2016, a new area of altered skin integrity in May 2016 and another area of altered skin integrity on an identified area and several other areas identified in June 2016. As confirmed with the ADOC on an identified date in September 2016, a skin assessment was not completed by the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment for these three incidents of altered skin integrity. [s. 50. (2) (b) (i)]

3. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian (RD) who was member of the staff of the home.

Resident #040 demonstrated altered skin integrity, on an identified area beginning in March of 2014, which was assessed and treatment ordered by the physician. A review of the clinical record did not include an assessment of the resident related to the area of altered skin integrity when it was first identified, by the RD. Interview with the FSM identified that at the time that the area was identified the home utilized both an electronic and paper system to communicate referrals to the dietary department. Interview with RPN #124, who first documented the area identified that she would not have completed a referral to the RD when it was identified due to the implementation of the skin and wound program at that time. (#168) [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents who exhibit altered skin integrity receive a skin assessment using a clinically appropriate assessment and receive an assessment by the RD, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

i.On an identified date in September 2016, the bedroom call bell cord in an identified room was pushed by the inspector and could not be activated. PSW staff #100, #101 and the ADOC confirmed that the call bell could not be activated and therefore, the communication and response system was not able to be used by residents in the room. The equipment was not maintained in a safe condition and in a good state of repair.
ii.On an identified date in September 2016, during a walk-through of the third floor servery with the Administrator, it was noted that there was a missing tile on wall by the dishwasher area exposing the open area in behind and a leaking pipe for over a month as reported by dietary staff #132
iii.There were doors exposed to the outside area near the kitchen where light could be seen from underneath. As confirmed with the Administrator on an identified date in September 2016, the doors required a barrier underneath to prevent pests from entering the building. [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's furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a cleaning schedule for all the equipment related to the food production system, dining and snack areas, and that staff comply with this schedule.

On an identified date in September 2016, during a walk-through of the kitchen area, dry storage area and serveries with the Administrator, it was noted that:

i. The dry storage area and kitchen were found to be very cluttered making effective cleaning difficult. Food carts used for transportation for food and used for the snack carts were in need of cleaning.
ii.The third floor servery was found to be in need of cleaning including the floor corners, dishwasher area, the garbage container, both steam tables - one steam table noted to have caked food debris down the side and both had several food splashes. Food debris was found in the drawers and the bottom area of the steam table which may not deter pests effectively.
Cleaning schedules were provided by the home, however, as confirmed with the FSM on an identified date in September 2016, staff had not complied with all of the cleaning schedules for all the equipment related to the food production system, dining and snack areas. [s. 72. (7) (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 there is a cleaning schedule for all equipment related to the food production system, dining and snack areas and that staff comply with this schedule, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, 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 the resident was protected from abuse by anyone.

On an identified date in June 2016, resident #041 was seated in the doorway of their room when they were approached by resident #042. Resident #041 identified that the co-resident approached them, asked them a question before becoming agitated and attempted to physically remove them from their chair. PSW #114 verified that they heard resident #041 calling out for help and arrived to find resident #042 attempting to pull resident #041 out of the chair. The PSW took immediate action to separate the residents and got additional assistance. Resident #041 sustained two identified injuries a result of this incident. Interview with resident #042 in September 2016, identified that this incident upset them for quite sometime and although they were satisfied with how the home responded to the situation they were concerned for potential recurrence.
Resident #041 was not protected from abuse from resident #042 on an identified date in June 2016. [s. 19. (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 residents are protected from abuse, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

The plan of care for resident #041 identified, under the focus statement related to transferring, that the resident required extensive assistance with two persons for physical assistance during toileting and to use the sit to stand lift; however, the focus statement related to toileting identified that two staff were to assist with toileting routine due to unpredictability and two persons constant supervision and physical assist for safety. During an interview with PSW's #120, #121 and #122 each identified that two staff were to toilet the resident with the use of the sit to stand lift. A review of the plan of care with registered staff #115 verified that the plan of care did not give clear direction to staff regarding the toileting and transferring status of the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Resident #042 had a history of responsive behaviours, according to the plan of care. The resident's plan of care identified this responsive behaviour indicating that it may occur when approached for the completion of care. In June 2016, resident #042 approached resident #041 and after making a few statements became aggressive, resulting in injury to resident #041. In July 2016, progress notes identified that the home put measures in place in an effort to prevent other residents from wandering into resident #042's room. Registered staff #129 and #123 verified that the resident was territorial of their room, did not like other residents entering this space and may demonstrate behaviours if others entered their room. A review of the plan of care included the potential of responsive behaviours related to care; however, did not include the potential for behaviours if others entered the resident's room. The lack of clear direction on the plan of care was verified with registered staff #111, who had revised the plan of care to direct staff who provided care to the resident. [s. 6. (1) (c)]

3. 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.

During various times identified in September 2016, the doorway of resident #041's room had an intervention hanging on the right side of the frame, when observed by the inspector. A review of the progress notes identified that the intervention was in place and across the bedroom door on an identified date in June 2016. Interview with registered staff #115 identified that to their recall the intervention was in place prior to the progress note in June 2016, at the request of the resident. A review of the plan of care did not include the use of the intervention which was supported during an interview with

registered staff #115. The plan of care was not based on the preferences of the resident. [s. 6. (2)]

4. The licensee 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.

The initial MDS assessment for resident #004 in March 2016, indicated that the resident was coded as requiring supervision, one person physical assist with the activity of eating. The next assessment dated June 2016, as well as the current assessment indicated that the resident had changed to being totally dependent, one person physical assist with the activity of eating. The plan of care for this resident remained the same since admission indicating that the resident required limited assistance of one staff member depending on the day. The resident was observed during two days of the inspection at meal service requiring total assistance with eating. Review of the PSW Documentation Record for the Activity of Daily Living (ADL) of Eating for the month of September 2016, showed that the resident required total assistance on all days and was dependent on others for eating. Interview with registered staff #106 on an identified date in September 2016, confirmed that the resident was initially able to feed themselves with limited assistance when first admitted; however, only for a short time and since has been totally dependent on others for eating. Interview with registered staff #127 on an identified date in September 2016, confirmed that there had been no change in the resident and always required total assistance of staff for eating. Interview with the RAI Coordinator on an identified date in September 2016, confirmed that the care set out in the plan of care was not based on an assessment of the resident and the needs and preferences of that resident with respect to eating. [s. 6. (2)]

5. 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 are integrated and are consistent with and complement each other.

i. The plan of care indicated that resident #004 had a diagnosis and was deemed to be at nutritional risk by the RD since admission and showed that the resident had multiple pressure ulcers and areas of altered skin integrity. The minimum data set (MDS), resident assessment instrument (RAI) skin and risk assessment in June 2016, indicated the resident did not have the specific diagnosis, was not deemed to be nutritional risk and the resident had not had any previous pressure ulcers or areas of altered skin integrity. Interview with the RAI coordinator on an identified date in September 2016,

confirmed that 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.

ii. The initial MDS assessment for resident #004 in March 2016, indicated that the resident was coded as requiring supervision, one person physical assist with the activity of eating. The next assessment in June 2016, as well as the current assessment in September 2016, indicated that the resident had changed to being totally dependent, one person physical assist with the activity of eating. The plan of care for this resident remained the same since admission indicating that the resident required limited assistance of one staff member depending on the day. The resident was observed during two days of the inspection at a meal requiring total assistance with eating. Review of the PSW Documentation Record for the ADL of Eating for the month of September 2016, showed that the resident required total assistance on all days and was dependent on others for eating. Interview with PSW staff on an identified date in September 2016, confirmed that there had been no change in the resident since admission and had always required total assistance of staff for eating. Interview with the RAI Coordinator on an identified date in September 2016, confirmed that staff and others involved in the different aspects of care of the resident had not collaborated with each other and that the resident MDS assessments were not consistent with each other. [s. 6. (4) (b)]

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

Resident #020's plan of care directed staff resident #020 likes to be in bed by a specified time. It was confirmed on an identified date in June 2016, resident #020 was restless and wanting to go to bed; however, staff were busy and kept telling the resident they would be back to help them. The resident was found lying on the floor. The administrator confirmed that the resident's plan of care was not followed and the resident was not put to bed by the specified time as the plan of care directed. [s. 6. (7)]

7. 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.

The plan of care printed on an identified date in March 2016, identified that resident #041 required "two person physical assist for transfer only" for the task of bathing, which was an identified intervention since 2014. On an identified day in March 2016, PSW

#112 transferred the resident from their wheelchair to the bathing chair independently, without the assistance of a second staff member. According to the clinical record there was no injury to the resident as a result of the provision of care; however, PSW #112 verified that at the time of the incident they transferred the resident independently and not according to the plan of care. [s. 6. (7)]

8. 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.

Resident #040 demonstrated altered skin integrity to an identified area which was first identified in March of 2014, for which treatment was ordered by the physician. A review of the clinical record identified that staff did not consistently sign for the administration of the treatments as ordered by the physician. Interview with the DOC confirmed that the treatments were not consistently signed as completed on the Treatment Administration Records (TAR). A progress note on an identified date in July 2015, identified that a treatment was not available as ordered for use by the resident. Interview with staff #110, #120 and #121 identified that there had been occasions in the home where prescription treatments and/or creams, in general, were not available. During an interview, by the DOC with PSW #125 on an identified date in December 2015, it was identified by the PSW that there were occasions when the ordered interventions were not available for use in the home. Care was not provided as per the plan of care. [s. 6. (7)]

9. 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.

i. The plan of care and kardex for resident #004 indicated that the resident was to receive double protein portions at meals. During the observed lunch meal on an identified date in September 2016, the resident was not provided with double protein portions as confirmed with PSW #104 and PSW #105.

ii. The plan of care for resident #009 indicated that the resident was to receive the home fortified food protocol at meals and snack and fortified foods at supper. During the observed lunch meal on an identified date in September 2016, the resident was not provided with the intervention as confirmed with Therapeutic Recreation staff #107.
iii. During the observed PM snack pass on the same date, the resident was not provided with fortified intervention as there was none available on the snack cart. The residents' plan of care indicated that the resident had been changed from minced texture to puree texture on an identified date in August 2016. The "Diet type report" on the snack cart

listed the resident to receive minced texture as it had not been updated. The resident was almost provided with a wrong texture food item; however, PSW staff #108 interjected and was aware of the texture change and provided the resident with the appropriate texture.
iv. The plan of care for resident #007 indicated that the resident was to have two incontinent products in their bathroom at all times. The RAP indicated that the resident may not ask for one. Interview with the resident and observation of the room on an identified date in September 2016, did not show any extra products in the bathroom. Interview with registered staff #107 on the same date confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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 planned care sets out clear directions to staff who provide care and residents plans of care are based on the needs and the preferences of the residents and that the plan of care is followed, to be implemented voluntarily.

WN #8: 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 are documented.

During stage one of the Resident Quality Inspection (RQI), an interview with staff #111 confirmed that resident #008 sustained a fall on an identified date in September 2016. A progress note was written to indicate how the resident was found and what interventions took place. A review of the clinical record confirmed that this information was also documented in the risk assessment and the progress notes. Staff #109 confirmed that their documentation did not reflect what actions were taken and were not documented. [s. 30. (2)]

2. 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 are documented.

Resident #040 demonstrated altered skin integrity on an identified area which was first identified in March of 2014, for which treatment was ordered by the physician. The resident had a number of changes to their treatment orders due to the changes in skin integrity. A review of the clinical record identified that staff did not consistently sign for the administration of the treatments as ordered by the physician. Interview with the DOC confirmed that the treatments were not always signed as completed on the TAR. Interview with PSW staff #110, #112, #120, #121 and #122 verified that, in general, at times a treatment may have been applied; however, due to time constraints may not have been signed for on the TAR. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the residents responses to interventions are documented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, 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 the written policy to promoted 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-05-37-1" (revised date May 2016), identified the following: The Administrator and/or designate must notify Ministry of Health and Long Term Care by phone immediately of any alleged, suspected or witnessed abuse or neglect that has taken place in accordance with the Long Term Care Home Act and the reporting policy.

On an identified date in September 2016, resident #023 had a suspected altercation with resident #025. The incident as detailed in the progress notes suggested that there were reasonable grounds to suspect abuse to resident #025. The home did not notify the Director until three days after the incident. Interview with the Administrator confirmed that the incident was not reported to the Director as required. [s. 20. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

On an identified date in September 2016, at two different times, the DOC's office was left unlocked and unattended. The inspector observed on September 27, 2016, that the home stores controlled substances that are waiting to be destroyed and disposed of in a single locked drawer in a desk in the DOC's office. The DOC confirmed that when they are not in the office the door is to be closed and locked at all times to ensure the controlled substances are double-locked at all times. [s. 136. (2) 2.]

Issued on this 8th day of October, 2016

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

Original report signed by the inspector.