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
Jun 5, 2015	2015_275536_0009	H-002313-15	Resident Quality Inspection

Licensee/Titulaire de permis

HOLLAND CHRISTIAN HOMES INC
7900 MCLAUGHLIN ROAD SOUTH BRAMPTON ON L6Y 5A7

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

GRACE MANOR
45 Kingknoll Drive BRAMPTON ON L6Y 5P2

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

CATHIE ROBITAILLE (536), DARIA TRZOS (561), KATHLEEN MILLAR (527), MICHELLE WARRENER (107)

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): April 23, 24, 27, 28, 29, 30, May 1, 4, 5, 6, 7, 8, 2015.

During this Resident Quality Inspection(RQI), Complaint Inspections H-001059-14,H-001109-14, H-002390-15 and Critical Incident System (CIS)Inspections H-002008-15,H-002127-15 and H-002244-15 were conducted concurrently. There were findings of non-compliance in both the Complaints and CIS inspections.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s)spoke with residents, family members, Dietary staff, Food Service Manager, Registered Dietitian (RD), Personal Support Workers (PSW), Social Worker, Registered Nurses (RN) and Registered Practical Nurses (RPN), Resource Nurse, Resident Assessment Instrument(RAI)Co-Ordinator, Activation Manager, Human Resources staff, Maintenance Staff, housekeeping staff, Assistant Director of Resident Care (ADRC), Director of Resident Care(DRC) and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed meal services, observed the provision of care and services provided on all home areas,interviewed staff, residents and families, and reviewed relevant documents including, health care records, investigation reports, training records, meeting minutes, menus, health care records and relevant policies and procedures.

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
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **32 WN(s)**
- **18 VPC(s)**
- **8 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 49. (1)	CO #001	2014_301561_0015	536
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2014_205129_0010	536

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that infection prevention and control program included, (b) measures to prevent the transmission of infections.

A) The shower rooms in three of three areas surveyed contained communal personal care items.

i) Identifed floor shower room:
- an unlabeled straight razor
- an unlabeled brush with hair in it sitting on top of the paper towel dispenser in the washroom area
- several unlabeled hair brushes with hair in them stored in the file folder on the wall
- unlabeled stick deodorant (one men's stick and one women's stick)
- unlabeled opened bottles of petroleum jelly
- unlabeled pair of soiled nail clippers (with nails in them)
- unlabeled comb with hair in it sitting on the counter in the shower room

ii) Identified shower room:
- two bottles of unlabeled opened "infazinc" cream
- an unlabeled roll on deodorant on the top of the paper towel dispenser in the washroom
- cupboard contained unlabeled zinc and petroleum jelly bottles
- a resident's labeled HC 1% cream
- men's stick deodorant
- disposable razor (looks used) stored with the nail clippers (1 pair) in k-basin with nail clippings in the bottom and a dirty nail file (all unlabeled)
- a large container of zinaderm cream (unlabeled)

iii) Identified shower room:
- cupboard - soiled disposable razor (had hair and build up on it)
- unlabeled petroleum jelly and zinc creams

- unlabeled stick deodorant
- k-basin with unlabeled hair brush and a tube of toothpaste - basin had hair and fingernail clippings in the bottom

iv) Identified shower room:
- communal jars of zinc oxide and vaseline identified in the cupboard along with an unlabeled large pair of toe nail clippers, and several unlabeled hair brushes.
- Toilet area (located in between shower and bath room): A raised toilet seat was identified on the floor and had brown stains and hair stuck to the seat (107)

B) The fabric backs on the shower chairs in the shower areas on all floors were stained and appeared significantly soiled (brown or green when fabric was supposed to be white). During interview on on an identified date in 2015, a PSW stated the fabric was laundered but not sure how frequently. On an identified date in 2015, the Assistant Director of Resident Care(ADRC) confirmed that the backs of the shower chairs were significantly stained and did not appear clean. (107)

C) During interview on an identified date in 2015, a PSW confirmed that an electric razor stored on an idenfied floor in the clean utility room in the care caddy cart was used on multiple residents.(107)

D) During interview on an identified date in 2015, a Personal Support Worker (PSW) on the identified floor stated that residents should have their own nail clippers stored in the cupboard of the washroom in their rooms or in the clean utility room. No clippers were found in the cupboards in the washrooms in identified rooms, and no individual clippers were found in the clean utility or soiled utility rooms. A unlabeled soiled pair of nail clippers was found in the care caddy in the clean utility room, and in the cupboard in the shower room on identified dates in 2015. (107)

E) A soiled unlabeled pair of nail clippers, an unlabeled roll on deodorant, and an unlabeled used tube of toothpaste were found in the care caddy in an identified floor clean utility room on an identified date in 2015.(107)

F) Not all items in shared resident rooms were labeled or stored in a manner that would prevent the spread of infection. In an identified room, three unlabeled toothbrushes were stored in a toothbrush holder in the shared washroom and an unlabeled soiled hair brush was stored on the counter of the shared washroom, and an unlabeled denture cup was stored on the counter; in an identified room four unlabeled toothbrushes were stored in a

toothbrush holder and there was an unlabeled comb and denture cup; and in another identified room they had labeled k-basins filled with unlabeled toothbrushes inside, unlabeled brushes on the counters, and unlabeled jars of zinc cream was on the counter. (107, 561, 536)

G) During interview on an identified date in 2015, the Infection Prevention and Control (IP&C) Lead confirmed that multiple personal use items were unlabeled and stored in the tub rooms, used by staff, and that the individual care caddies for personal items were no longer in use. The IP&C Lead confirmed that education related to use of personal items between residents was not included in the home's infection prevention and control education or policies for staff providing care. (107)

H) On an identified date and time, the clean utility room on an identified unit contained an unlabeled white hair brush, soiled with a large amount of hair, stored on the care cart used for residents. Staff stated they were not sure who the comb belonged to.(107)

I) During the initial tour of the home on an identified date in 2015, the LTC Inspector observed in the shower room on an identified floor the following:

- communal containers of zinc oxide and vaseline,
- there was one large pair of toe nail clippers,
- there were several hair brushes with hair in them
- a raised toilet seat was identified on the floor in an identified shared bathroom, which had brown stains underneath it and along the sides, and hair stuck to the seat in several areas.

The PSW's interviewed and confirmed that the zinc ozide, vaseline, toe nail clippers, hair brushes, and raised toilet seat were shared among residents when they should be individualized for residents and labeled accordingly. As a result, the home did not ensure that measures were taken to prevent the transmission of infections.(527)

J) On an identified date in 2015 the registered staff were administering pain medication subcutaneously to resident #021. The registered staff did not perform hand hygiene before or after the medication administration and continued to administer other medications to other residents on the unit without performing hand hygiene. When the registered staff was interviewed, they confirmed they were expected to perform hand hygiene before and after medication administration. The registered staff at the home did not ensure that measures were taken to prevent the transmission of infections by

performing hand hygiene before aseptic procedures and pre and post resident care. (527) [s. 86. (2) (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 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, (a) the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

A) During interview on an identified date in 2015, the Director of Resident Care (DRC) confirmed that when bed rails were used, the home had not completed an assessment of the bed systems or of the residents in relation to the safety risks with the use of bed rails, to minimize risk to residents. The DRC stated that the Physiotherapist was supposed to start assessing the residents in relation to the need for bed rails, commencing April 28, 2015.

B) The home's policy, "Entrapment Zones - Resident Beds" when received had not been implemented and the policy did not contain a policy number or date of implementation. The policy was implemented during this inspection. The Director of Resident Care (DRC)

confirmed the policy was just implemented.

C) Numerous residents in the home were using bed rails; however, the DRC and Assistant Director of Resident Care (ADRC) confirmed a system was not currently in place to identify which residents were using the rails, if the bed rails limited the residents' freedom of movement and for what purpose the bed rails were being used. Staff on all three floors identified that most residents were using bed rails at night (a variety of sizes - 3/4, 1/2 and 1/4 rails, in various combinations). The DRC, ADRC and Resident Assessment Instrument (RAI)-Coordinator confirmed that unless the bed rails were identified as a restraint, they were not included on the resident's plan of care, an assessment was not completed, and direction for staff was not provided in relation to the use of bed rails. Staff were using the bed rails without direction or an assessment of safety. The home's policy, "Use of Personal Assistive Service Device 30.06.03GA", dated as reviewed on April 22, 2014, identified bed rails used for turning or repositioning, positioning during sleep, and for getting out of bed as examples of PASDs, and stated that the care plan must clearly indicate the purpose of a PASD and PASDs must be included in the residents' plans of care.

D) The previous Resident Quality Inspection (RQI), November 2014, identified that the bed systems and residents had not been assessed in relation to bed entrapment; or safety risks, with the use of bed rails since the home opened. The home had not taken action to assess the bed systems, or residents requiring bed rails between the previous RQI report issued in November 2014 and April 2015. [s. 15. (1) (a)]

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 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, (a) could be easily seen, accessed and used by resident, staff and visitors at all times. Not all call bells were available or functioning when pressed/pulled by the inspectors.

A) When the bedside call bells were pressed, the resident to staff communication system were not activated, including the light on the call bell panel inside the room and the light in the hallway. The staff confirmed, they were not notified by their pagers when the bell was pressed. Some of the rooms did not have a bedside call bell, in addition to a bed alarm system in identified rooms. In one room the bell was not fully plugged into the wall and the system did not function as a result.

B) The bedside call bells were not working in the identified rooms. Staff stated the last audit of the call bell systems was completed August 2014. A schedule was not in place, other than annually, to ensure that all of the call bells were in good working order or could be activated by residents and staff.

C) The washroom call bells were very hard to pull, and some did not activate or the cord broke off prior to activating the call bell communication system in identified rooms.

D) A resident in an identified room, was unable to pull the call bell for assistance when required. Maintenance was informed and the bell was adjusted.

E) A resident in an identified room was unable to call for assistance when required, as the call bell system was very difficult to pull. The resident was on the toilet and unable to call for staff assistance. Maintenance has since adjusted to switch to be more sensitive.

F) Maintenance staff confirmed the call bells in the washrooms were very difficult to activate, and some cords broke off prior to activating the system. He stated the home was now in the process of replacing or adjusting the washroom call bell systems.

G) Call bell cords were squished in between the grab bar and metal plate on the grab bars or looped through extended tracks in washrooms. The location of the string and positioning along with the cords being very difficult to activate, would prevent many residents from activating the washroom call bell systems. The LTC Inspectors were unable to activate many of the bells when in a seated position in the washrooms. [s. 17. (1) (a)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times.

A) On an identified date and time, the tub room on an identified floor was found unlocked with the door propped open and the room was unattended by staff. A bottle of Per Diem disinfectant was accessible in the unlocked cupboard (bottle says avoid contact with skin and eyes), along with a spray bottle of an unknown substance - hand writing "tub and shower chair cleaner". In the tub room on the counter, there were two 3 Litre containers of Disinfectant Cleanser IV with poison and corrosive WHMIS symbols on the label, and a 4 Litre jug of Disinfectant Cleaner IV in the unlocked cupboard of the tub room. The Long Term Care (LTC) Inspector informed the Personal Support Worker (PSW) doing the snack cart, who just happened to walk by as inspector leaving the shower room at 1052 hours. The PSW confirmed, the door was supposed to be closed and inaccessible to residents. (107)

B) On an identified date and time, the shower room on an identified floor was found unlocked and unattended with the door ajar. The same chemicals were accessible as noted on an identified date2015. A PSW entered the room while the LTC Inspector was in the shower room and the door was then locked upon leaving the room. (107)

C) On an identified date and time, the shower room on an identified floor was found unlocked and unattended with the door ajar. The same chemicals were accessible as noted on an identified date in 2015. The door did not automatically close. The door was locked prior to the inspector leaving the area and the Registered Nurse (RN) sent a

requisition for maintenance to look at the door to the shower room. (107)

D) On an identified date and time, the shower room on an identified floor was found unlocked and unattended with the door ajar. The same chemicals were accessible as noted on an identified date in 2015. The door did not automatically close. The door was closed and locked by the inspector and staff were notified.(107)

E) During the initial tour of the home on an identified unit, the LTC Inspector observed in the Activity room that the cupboard under the sink was unlocked and stocked with activity supplies and sanitizing cleaner called "Diverso/BXA". The sanitizing cleaner had a Class D Workplace Hazardous Materials Information System (WHMIS) logo, which identified that the sanitizing cleaner was poisonous and infectious material. There were seven residents sitting in the Activity room unsupervised waiting for activities to begin, and the residents' had access to the hazardous material. The Activities staff member, charge nurse and Personal Support Worker (PSW) confirmed the cupboard door was unlocked and the hazardous material was accessible to residents.(527)

F) On an identified date and time, the "Resident Care Supplies" room on an identified floor was left unlocked and unattended by staff. An unlocked treatment cart was stored in the room and contained a bottle of iodine solution. The room also contained a bottle of hydrogen peroxide and bottles of hand sanitizer. The labels identified the items were hazardous if ingested. The first floor was a secure home area with residents that had cognitive impairment and wandered. (527) [s. 91.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to

the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer’s instructions.

Instructions provided to the home on the "Use & Care of Wheelchair Hip Belts" directed staff to allow just enough space for two fingers to fit between the hip belt and the person's body, at any one point along the belt.

A) On an identified date and time, resident #001 was observed with a very loose seatbelt (down to the resident's knees) while sitting in the dining room. The RN confirmed the seatbelt was too loose, and that the resident was unable to undo the seatbelt. The seatbelt was then tightened.

B) On an identified date and time, resident #002 was observed with a very loose seatbelt (more than 2 fists). The resident was unable to undo the seatbelt (the seatbelt was a prohibited device that required an external device to unlock). During interview with the resident's family, they stated that the resident's seatbelt was frequently loose. The resident was at risk for falling.

C) On an identified date and time, resident #002 was observed sitting in the hallway with a loose seatbelt. The space between the belt and the resident was more than two fists. Staff confirmed the belt was too loose.

D) On an identified date and time, resident #003 was observed with a very loose seatbelt with the belt fully extended. Registered staff was reluctant to tighten the belt when identified by the inspector as a safety risk. Registered staff confirmed the resident was unable to undo the seatbelt independently and that the resident was at risk for falling.

E) On an identified date and time, resident #007 had their seatbelt almost fully extended and it was hanging loose at about knee level of the resident. The registered staff confirmed the resident was unable to independently release the seatbelt. The registered staff stated the wheelchair was not their permanent wheelchair and confirmed the seatbelt was too loose. The belt was then tightened.

F) On an identified date and time, resident #007 was sitting in the hallway with a loose seat belt. The seatbelt was half way down the resident's thighs and the inspector could put two fists under the belt. The registered staff confirmed the belt was too loose and tightened the belt.

G) On an identified date and time, resident #051 was sitting in a wheelchair with both of their hands beneath the seatbelt. The Registered staff confirmed the belt was too loose for safety and tightened the belt. [s. 110. (1) 1.]

2. The licensee has failed to ensure that resident #002; #003 and #007 were released from the physical device and repositioned at least once every two hours.

A) A review was completed, of an identified month in 2015 Point of Care (POC) restraint monitoring flow sheet, which refers to resident #002's restraint application; release; repositioning; and re-application. Between identified dates in 2015, there were forty eight different times that the range between checking on the resident and repositioning or releasing the seatbelt, ranged from 3 hours(hrs) to 13 hrs. This was confirmed on May 5, 2015, by the Resident Instrument Instrument (RAI) Co-Ordinator.

B) A review was completed, of an identified month in 2015 POC restraint monitoring flow sheet, which refers to resident #003's restraint application; release; repositioning, and re-application. Between identified dates in 2015, there were fifty separate times that the range between checking on the resident and repositioning or releasing the seatbelt, ranged from 3 hrs to 11 hrs. This was confirmed on May 5, 2015, by the DRC.

C) A review was completed, of the identified months in 2015 POC restraint monitoring flow sheet, which refers to resident #007's restraint application; release; repositioning and re-application. Between identified dates in 2015, there were seven separate times that the range between checking on the resident and repositioning or releasing the seatbelt, ranged from 3hrs to 10 hrs. Between identified dates in 2015, there were nine separate times were the range was from 3 hrs to 8 hrs. This was confirmed on May 7, 2015, by the DRC. [s. 110. (2) 4.]

3. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented: 1. The circumstances precipitating the application of the physical device. 2. What alternatives were considered and why those alternatives were inappropriate. 3. The person who made the order, what device was ordered, and any instructions relating to the order. 4. Consent. 5. The person who applied the device and the time of application. 6. All assessment, reassessment and monitoring, including the resident's response. 7. Every release of the device and all repositioning. 8. The removal or discontinuance of the

device, including time of removal or discontinuance and the post-restraining care.

Resident #046 had an order for a identified type of seatbelt and a tilt wheelchair between an identified date in 2014 and 2015. The identified seat belt was discontinued with an order for it to be replaced with a regular seatbelt on an identified date in 2015. Documentation did not reflect a re-assessment of the resident in relation to the type of restraint, did not indicate the reason the restraint had been discontinued, the resident's response to the new seatbelt, and consent for changing the restraining device. During interview on an identified date in 2015, the registered staff stated the resident was able to undo the seatbelt with crayons (resident liked to colour) and the restraint had been ineffective. Documentation did not reflect the information provided by the registered staff. [s. 110. (7)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, (a) drugs were stored in an area or a medication cart, (i) that was used exclusively for drugs and drug-related supplies, (ii) was secure and

locked and (iv) that complies with manufacturer's instructions for the storage of the drugs.

A) On April 29, 2015, at 1045 and 1100 hours, a bottle of prescription cream was sitting on the bedside table of resident #005. The Personal Support Worker (PSW) providing care for the resident confirmed they forgot to put the cream away after using it. (107)

B) On an identified date in 2015, on an identified floor, a basket of prescription creams was being kept in the care carts stored in the clean utility room on the first floor. The clean utility room was not an area that was used for drugs or drug related supplies. The Assistant Director of Resident Care (ADRC) confirmed the prescription creams were required to be stored in the medication cart or in the medication room and were not to be stored in the clean utility room. The creams were returned to the medication cart.(107)

C) On an identified date and time, on an identified unit, a large bottle of prescription hydrocortisone 1% cream was left on the counter by the television in resident #049's room. The room was empty and staff did not return while the inspector was in the room. (107)

D) On an identified date and time, on an identified unit, the same bottle of prescription hydrocortisone 1% cream for resident #049 was left sitting on top of the cart that held resident charts. Staff were not in the immediate area and the door to the nursing station was left ajar. The nursing station was not an area that was locked and staff confirmed the creams were to be kept in the medication cart.(107)

E) On an identified date and time, on an identified unit, the registered staff left the medication cart unlocked and unattended outside of an identified room while giving medications to a resident in their room. The LTC Inspector was able to open the cart without being seen by the staff member. (107)

F) On an identified date and time during an observation of the medication pass, it was observed that the medication cart was left unattended in the lounge area with pre-poured medications sitting on top of the medication cart. The registered staff was observed going in to the medication room behind the nursing station to get a pulse oximeter. Residents and one volunteer member were present in the lounge area. The registered staff indicated that residents would not have taken any medications from the medication cart and certainly not the volunteer. The home did not ensure that the drugs were stored in a secured and locked medication cart while it was left unattended. (561)

G) During the review of the process of drug destruction with the Director of Resident Care (DRC) on May 7, 2015, the government stock medications were observed and the LTC inspector identified six bottles of Aromatic Cascara, laxative stimulant for occasional constipation that had an expiry date of February 2015. There was also one bottle of the Novasen-enteric coated ASA, 325 mg that had an expiry date of March 2015. The DRC confirmed that the expired medications should have been disposed of. (561) [s. 129. (1) (a)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee failed to ensure that prohibited devices provided for in the regulations were not used on a resident, (a) to restrain the resident. In reference to O.Reg. 79/10, s. 112.3, "For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home: 3. Any device with locks that can only be released by a separate device, such as a key or magnet.

A) On an identified date and time in 2015, resident #002 was observed wearing a prohibited device (a seat belt that required a pen device to unlock). When prompted by the LTC Inspector, the resident was unable to undo the seat belt independently and staff confirmed a separate device was required to unlock the seat belt. The staff confirmed they were unaware that this type of seat belt was a prohibited device under the LTCHA regulations, despite the home's policy, "Reassessment of Restraints 30-06-03E", dated June 17, 2008, and reviewed June 18, 2013, that stated, "Types of restraint that cannot be used: Device that cannot be released by staff, vests or jackets, four point extremity restraint, device that requires another device to release the lock." Staff replaced the seat belt with a regular seat belt (easily removed). Registered staff confirmed a plan was not in place to ensure the resident's safety until the appropriate replacement seat belt was available.

B) Resident #047 had a physician's order for a seat belt that required a pen device or external device to unlock. The order was changed on an identified date in 2015 to a regular seat belt; however, on an identified date in 2015, the registered staff stated the regular seat belt had not been effective as the resident was able to extend the seat belt and slide out of the chair routinely. The resident had a fall on an identified date in 2015, and during interview, registered staff stated interventions were not revised to ensure the resident's safety.

C) Resident #046 had a physician's order for a seat belt that required a pen or external device to unlock it between identified dates in 2014 and 2015. The device was changed to a regular seat belt on an identified date in 2015. [s. 35. (a)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that direct care staff were provided training in falls prevention and management.

A)The home's training records related to Falls Prevention and Management were reviewed. It was identified that there were 70/120 or 62% of direct care providers trained in 2014. The attendance breakdown for training identified: 3/14 registered nurses, 18/30

registered practical nurses, and 49/76 PSWs trained on falls prevention and management in 2014.The Director of Resident Care (DRC) confirmed that 100% of staff are required to complete the Falls Prevention Management Training. An order was issued to the home last year. The plan was to be submitted to the Ministry by January 2015, with the compliance date of April 30, 2015. As part of the corrective action in the plan the home indicated the following: "A Multidisciplinary Team Approach for Falls Prevention on September 23rd Falls in Elderly presented by the Pharmacist. These in-services will be held on a quarterly basis, also reviewing of the falls policy". The DRC confirmed that only one in-service was held in September 2014, by the Pharmacist for staff. Only 19 staff members attended the training. The home failed to ensure that all direct care staff where provided training in falls prevention and management. (561) [s. 221. (1) 1.]

2. The licensee has failed to ensure that training shall be provided to all staff who provide direct care to residents: 2. Skin and wound care.

A) The home's training records for 2014, related to skin and wound care were reviewed. It was identified that there were 69/127 or 54% of direct care providers trained in 2014. The attendance breakdown for training identified: 1/14 registered nurses, 15/32 registered practical nurses, and 51/81 PSWs trained on skin and wound care in 2014. When the PSWs and registered staff were interviewed on May 7 and 8, 2015, the LTC Inspector identified that 2/5 interviewed had not received training in 2014. The DRC confirmed that not all of their direct care providers were trained in 2014. The home failed to ensure that all direct care staff where provided training in skin and wound care.(527) [s. 221. (1) 2.]

3. The licensee has failed to ensure that training related to continence care and bowel management to all staff who provide direct care to residents.

A) The home's training records for 2014, related to continence care and bowel management were reviewed. It was identified that there were 64/121 or 53% of direct care providers trained in 2014. The attendance breakdown for training identified: 3/14 registered nurses, 14/31 registered practical nurses, and 44/76 PSW's trained on continence care and bowel management in 2014. The Resident Assessment Instrument (RAI) Co-Ordinator confirmed on May 6, 2015, that not all of their direct care providers were trained in 2014. The home failed to ensure that all direct care staff where provided training in continence care and bowel management.(536) [s. 221. (1) 3.]

4. The licensee has failed to ensure that direct care staff where provided training related to minimizing of restraints on an annual basis.

A) The home's training records for 2014, related to minimizing of restraints were reviewed. It was identified that there were 75/120 or 62.5% of direct care staff trained in 2014. The attendance breakdown for training identified: 3/14 registered nurses, 19/30 registered practical nurses, and 53/76 PSW's trained on minimizing of restraints in 2014. The RAI Co-Ordinator confirmed on May 8, 2015, that not all direct care providers were trained in 2014. The home failed to ensure that all direct care staff where provided training in minimizing of restraints.(536) [s. 221. (1) 5.]

5. The licensee has failed to ensure that training had been provided for all staff who apply PASDs or who monitor residents with PASDs including: application of these PASDs, use of these PASDs, and potential dangers of these PASDs.

A) The staff confirmed education related to PASDs had not been provided to any staff at the home and was not included in the on-line modules for minimizing restraints. The RAI-Coordinator confirmed that education materials were in development; however, had not been implemented to date. The licensee has failed to ensure that training had been provided for all staff who apply PASDs or who monitor residents with PASDs including: application of these PASDs, use of these PASDs, and potential dangers of these PASDs. (107) [s. 221. (1) 6.]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: 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. (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 has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #046 so that their assessments were integrated, consistent with and complemented each other.

Progress notes on an identified date in 2015, identified the resident had skin issues with redness at resident's buttocks with breakdown of skin noted. On an identified date in 2015, the resident's Physician identified a reddened area on buttocks with evidence of skin breakdown - stage II. The home's "Treatment Record - weekly assessment summary - skin treatment not wound", completed on an identified date in 2015, identified the resident had an open skin tear on their buttocks.

The assessments were not consistent in relation to the type of skin breakdown the resident had on their buttock area pressure area or skin tear. An assessment of the size of the wound was not completed, and further assessment of the area was not completed until the treatment was discontinued on an identified date in 2015. The home's policies, "Skin Care and Wound Management General Policy 30-08-09B" and "Management of Skin Breakdown 30-08-19" stated ulcers and wounds would be followed weekly; however, clear direction related to assessment and documentation of skin tears was not provided for staff. [s. 6. (4) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

The plan of care for resident #003 required a seatbelt applied for safety while the resident was up in their wheelchair. On an identified date in 2015, on an identified floor, at an identified time, resident #003 was found sitting in their wheelchair outside the shower room without their seatbelt applied (was hanging on the side of their wheelchair). The area was unattended by staff. When the Personal Support worker (PSW) returned they confirmed the seatbelt had not been applied yet and stated they had just provided the resident a shower. The resident was at high risk for falling. [s. 6. (7)]

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

Resident #043 sustained a number of falls in 2015. After a fall in an identified month 2015, new interventions were put in place to prevent the resident from falling, including placement of the bed in the lowest position. The resident sustained another fall on an identified date in 2015, and the home made changes to resident's care. The Falls Prevention Followup/Recommendations note dated on an identified date in 2015, indicated the following: "Interventions reviewed with nursing staff. Resident struggles to get out of low bed with mat, and this may increase risk. Bed to be kept at knee height and mat no longer needed. Walker to be kept at bedside as resident would walk without it if they did not see it. Bed alarm to continue". The written plan of care was updated with the recommended changes. The progress notes following the falls prevention follow up were reviewed and indicated that staff continued to place the bed in the lowest position. The PSW and the registered staff confirmed that the resident's bed was always placed in the lowest position and not at knee height. The staff did not provide care to the resident as specified in the plan. The home did not ensure that the staff followed the care plan for this resident when new interventions were put in place. [s. 6. (7)]

4. 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.

During an observation of the medication pass on an identified date in 2015, the registered staff member confirmed that two residents, #001 and #053 were required to have crushed medications given in food. The written plans of care which the home refers to as the care plan were reviewed, and did not indicate that residents required to have their medications given in food. Resident #053's Medication Administration Record (MAR) and written plan of care did not indicate that the resident required medications crushed. The Director of Resident Care (DRC) confirmed that the plans of care for these residents' did not indicate that the residents' medications were to be given in their food.

The DRC confirmed that resident #053 did not require medications crushed. The home did not ensure that the residents' plans of care were followed. [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 and ensuring that the plan of care for residents provides clear direction for staff, that care is provided as per the care plan and collaboration occurs in the assessment of residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that 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, (b) is complied with.

A) The home's policy called "Skin Care and Wound Management General Policy, 30-08-09B", revised February 21, 2013, directs registered staff to complete a head to toe skin assessment upon admission, upon readmission, quarterly, when there was a change in the health status of the resident that affects skin integrity, or upon any sign of skin break down. There was no head to toe assessment completed when resident #050 was

admitted to the home or when the quarterly reviews were completed. Resident #050 had one head to toe assessment and that was when they returned from the hospital on an identified date in 2015. The clinical record was reviewed, and the only head to toe assessment found was on an identified date in 2015. The registered staff confirmed in an interview that they only do head to toe assessments on admission and when a resident returns from the hospital. The registered staff confirmed the resident had only one head to toe assessment, and it was completed when the resident was re-admitted in January 2015. The Director of Resident Care (DRC) and the registered staff confirmed, they did not use a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

B) The home's policy called "Skin Care Assessment - Braden Scale,30-08-14", revised November 28, 2012, directs registered staff to complete the Braden Scale on all residents on admission, quarterly and within 24 hours upon return from the hospital. The policy identified that the Braden Scale scores the level of risk for residents at risk for altered skin integrity, for residents who had skin integrity compromised, and for residents who exhibited skin breakdown and/or wounds. The clinical records for resident #005, #018 and #050 were reviewed and the LTC Inspector was unable to locate the Braden Scale risk assessment. The registered staff were interviewed and they identified they don't use the Braden Scale and were not aware that there was a policy that directed then to assess residents, using the Braden Scale. The DRC confirmed in an interview that they don't use the Braden Scale and it was discontinued.

C) The home's policy called "Management of Skin Breakdown, 30-08-19", revised November 28, 2012, directs staff that when a resident has a Stage 4 pressure ulcer they were to obtain a physician's order for an Enterostomal Therapy (ET) assessment and they were to fax the referral to the Community Care Access Centre (CCAC). Resident #050 had a Stage 4 pressure ulcer with undermining. In an identified month in 2015, there was no referral for an ET assessment. The resident had improved gradually and as of an identified date in 2015, the resident was assessed with a Stage 3 pressure ulcer with undermining. The registered staff interviewed were not aware of the policy for ET referral, and identified the home used to obtain physician orders for a dermatologist referral with the types of ulcers/wounds that resident #050 had. The DRC confirmed the home's policy for ET referral, and that they did not obtain ET referrals through the CCAC. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that a policy, procedure or protocol put in place was complied with.

A) The home's policy "Medication Administration, 30-10-01C", dated 12/02/2014, indicated the following: "DO NOT PRE-POUR MEDICATION FOR ADMINISTRATION LATER".

On an identified date in 2015, between the hours of 0715 and 0800 hours (hrs), during an observation of a medication pass, it was observed that two medication cups were sitting on top of the medication cart with crushed medications. The Registered Nurse (RN) reported, that the medications were pre-poured for two residents because they take them in their food at breakfast. The RN was not aware of the policy related to pre-pouring of medications, and indicated that it would have taken her until 1100 hours to complete the entire medication pass if she didn't pre-pour. The Director of Resident Care (DRC) confirmed, that as per the home's policy and Best Practice Guidelines for nurses, the pre-pouring of medications was not allowed. The RN did not follow the home's policy related to administration of medications.

B) The policy from Classic Care Pharmacy "Handling Hazardous Medications,7.12", revised July 2014, indicated the following:

"Classic Care Pharmacy will add the following precautions to the directions of oral solid Non-Cytotoxic Hazardous medication prescriptions: 'NON-CYTOTOXIC HAZARDOUS PRECAUTIONS REQUIRED: WEAR 1 PAIR OF NITRILE GLOVES. DO NOT CRUSH OR SPLIT TABLETS OR OPEN CAPSULES'".

i) The Electronic Medication Administration Record (E-MAR) for resident #053 indicated: "Anastrozole Tablet 1 MG, Give 1 tablet by mouth one time a day for Breast carcinoma NONCYTOTOXIC HAZARDOUS PRECAUTIONS REQUIRED: WEAR 1 PAIR OF NITRILE GLOVES. DO NOT CRUSH OR SPLIT TABLETS OR OPEN CAPSULES". The RN confirmed on an identified date in 2015, that she had crushed all morning medications for this resident #053.

ii) Resident #052 had a medication with a yellow sticker on the pouch indicating "WEAR 1 PAIR OF NITRILE GLOVES. DO NOT CRUSH OR SPLIT TABLETS OR OPEN CAPSULES". During the observation of the medication pass on an identified date and time in 2015, the RN that administered the medication to resident #052 did not wear any gloves. The DRC confirmed, that as per the pharmacy policy related to hazardous medications, the registered staff should have worn gloves that were provided to the staff and should have administered the medications whole as per label. The home has failed

to ensure that the registered staff followed the policy for handling of hazardous medications. [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 and ensuring that the licensee puts in place any plan, policy, protocol, procedure, strategy or system and that it is complied with (this VPC is issued for 8(1(b) skin and wound policy), to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Findings/Faits saillants :

1. The license has failed to ensure that a 24-hour admission care plan set out the planned care for the resident.

Resident #044 was admitted to the home on an identified date in 2015, sustained a fracture on an identified date in 2015, had surgery and passed away in the hospital on an identified date in 2015 . The resident was considered at high risk for falls at admission to the home. The home did identify the resident as high risk for falls in the 24 hour care plan. The registered staff and the PSW indicated that the resident had the bed in the lowest position and had safety checks every 30 minutes. The care plan and Kardex were reviewed and did not indicate that the resident had the bed in the lowest position. The 24 hour admission care plan did not set out the planned care for resident. The DRC confirmed that the interventions for high risk of falls should have been addressed in the 24 hour care plan. [s. 24. (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 and ensuring that the 24-hour admission care plan sets out the planned care for the resident, to be implemented voluntarily.

WN #12: 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:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #003 was based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene.

A dental assessment report, dated on an identified date in 2015, stated, "oral hygiene needs to improve. Food debris and plaque on implants." The resident's care plan and kardex, the documents that staff used to provide care to the resident, did not identify the resident had dental implants in addition to dentures or how to provide oral care for the dental implants. Both PSW and registered staff interviewed were unable to verify for the inspector if the resident had dental implants or only dentures. Two PSW staff that provided care for the resident were interviewed and stated they cleaned the resident's dentures and had the resident rinse their mouth with mouthwash prior to inserting the dentures in the morning. The staff were unaware that the resident had dental implants and confirmed that brushing the implants was not part of the morning care routine for the resident. On May 7, 2015, the Registered Nurse (RN) confirmed for the inspector that the resident still had the dental implants. [s. 26. (3) 12.]

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 and ensuring that the plan of care for residents is based on an interdisciplinary assessment, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to minimize the restraining of residents is done in accordance with the Act and the Regulations.

The homes policy "30-06-03A -Least Restraints-Use and Application" issued June 17, 2008, reviewed May 2, 2013, stated the following:

A) "The resident's need for a restraint will be reassessed by nursing staff (RN/RPN) every 12 hours and documented, on the resident's Medication Administration Record (MAR)." The LTC Inspector identified that the registered staff are documenting on the Electronic Medication Administration Record (EMAR) every 8 hours as per regulation 110 (2) 6; however, the policy is not up to date with the current legislation. This was confirmed by the Director of Resident Care(DRC) on May 6, 2015.

The homes policy "30-06-03C-Least Restraints-Alternatives to Using" issued June 17, 2008, reviewed October 2, 2013, replaces: 30-06-04D, stated the following:

B) "Each shift must refer to alternative to restraint initiated, and assess and evaluate

every 12 hours." The LTC inspector identified that the Registered staff are documenting on the Electronic Medication Administration Record (EMAR) every 8 hours as per regulation 110 (2) 6 however, the policy is not up to date with current legislation. This was confirmed by the DRC on May 6, 2015.

The homes policy "30-06-03F-Reassessment of Restraints" issued June 17, 2008, reviewed October 2, 2013, replaces: 30-06-04I, stated the following:

C) "The twelve(12)hour reassessment for the need of a restraint must be documented by the registered staff on the Medication Administration Record (MAR) of each individual resident requiring a restraint. Reassessment for the need of restraint is to be done daily at 0900 and 2100 hours. These time schedules are included on the MAR." The LTC Inspector identified that the registered staff are documenting on the Electronic Medication Administration Record (EMAR) every 8 hours as per regulation 110 (2) 6 however, the policy is not up to date with current legislation. This was confirmed by the DRC, on May 6, 2015.

The homes policy "30-06-03B-Restraint Form and Documentation" issued June 17, 2013, replaces: 30-06-04C, states the following:

D) The home presently completes electronic documentation in Point of Care (POC) for restraint monitoring, and this is completed by the Personal Support Workers (PSW's), not the registered staff and not on the hard copy Restraint Monitoring Record referred to in the policy. The DRC confirmed on May 6, 2015, that the entire policy does not reflect the homes current practice and is not up to date with current legislation.

The homes policy "30-06-03D-Least Restraints-Emergency Use" issued June 17, 2008, reviewed October 2, 3013, replaces: 30-06-04C, states the following:

E) "A Restraint Monitoring Record is initiated, completed and in use." The home presently completes electronic documentation in Point of Care (POC) for restraint monitoring, and this is completed by the PSW's. The Restraint Monitoring Record referred to in the policy is not electronic. The DRC confirmed on May 6, 2015, the policy is not up to date with current legislation.

The homes policy "30-06-03D-Least Restraints-Emergency Use" issued June 17, 2008, reviewed October 2, 3013, replaces: 30-06-04C, is not in accordance with Regulation 110 (3)(a) and(b)as it does not include the following:

E) Reg. 110 (3) (a) the resident is monitored or supervised on an ongoing basis and released from the physical device and repositioned when necessary based on the resident's condition or circumstances;

F) Reg. 110 (3) (b)the resident's condition is reassessed only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every 15 minutes, and at any other time when reassessment is necessary based on the resident's condition or circumstances.

This DRC confirmed on May 6, 2015 that the home's policies on restraints were not in accordance with the Act and the Regulations. [s. 29. (1) (a)]

2. The licensee has failed to ensure that the policy to minimize restraining of residents was complied with.

The homes policy "Least Restraint-Use and Application, 30-06-03A" issued: June 17, 2008, reviewed May 2, 2013, replaces: 30-06-04B, stated the following:

A) "Initiation of a Restraint: Consultation with Resident/Substitute Decision Maker (form) must be completed." At the time of the inspection the home had not implemented this form. This was confirmed by the Director of Resident Care (DRC) on May 6, 2015.

B) "Physician order for a restraint must be obtained in writing which includes: 1. Type of restraint; 2. Reason(s) for the restraint; 3. When restraint to be used; and 4) Length of time the resident is to be in the restraint including maximum length of time (i.e. 'one (1) hour while up in chair')." At the time of the inspection the home was not completing step 4 and physician was not writing an order including maximum length of time to be up in chair. This was confirmed by the DRC on May 6, 2015.

The homes policy "Least Restraints-Emergency Use, 30-06-03D" issued June 17, 2008, reviewed October 2, 3013, replaces: 30-06-04C, is not in accordance with this Act and the regulations in relation to the following:

C) "Contact the resident's Substitute Decision/maker and complete Consent with Resident/Substitute Decision Maker section of the Resident Assessment Form." At the time of the inspection, the home had not implemented this form. This was confirmed by the DRC, on May 6, 2015. [s. 29. (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 and ensuring that the written policy to minimize the restraining of the residents is done in accordance with the Act and the Regulations., to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must 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. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

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 the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The Nursing and Personal Support Services program did not include all relevant policies,

procedures, and protocols to provide for methods to reduce risk and monitor outcomes.

A) The program did not include a policy for the provision of oral care to residents without teeth or dentures. Not all staff providing care to residents were aware of the procedures for oral care to residents who did not have teeth or dentures.

B) The program did not include a policy for removing facial hair of women. The staff were not always clear on how to care for women with facial hair and many female residents were observed with long facial hair throughout this inspection. [s. 30. (1) 1.]

2. The licensee has 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.

A) Resident #050 returned from the hospital in an identified month in 2015, after having their fractured hip repaired. The skin assessments identified the resident had pressure ulcers. In an identified month in 2015, the staff identified the resident had Stage 3 pressure ulcers. In an identified month in 2015, the pressure ulcers had worsened. In an identified month in 2015, the resident's pressure ulcers had progressed to Stage 4, and in an identified month in 2015, they had improved and were assessed as Stage 3. The physician had ordered skin treatments in order to heal the wounds. The staff and clinical record identified there was gradual improvement to the resident's pressure ulcers.

B) When reviewing the Treatment Administration Record (TAR), the LTC Inspector identified that the resident's interventions were documented inconsistently as per the physician's orders. In an identified month in 2015, the resident's [redacted] dressings [redacted] were not documented on identified dates in 2015. The wound dressing for the [redacted] ulcer was not documented on the TAR on an identified date in 2015. The physician's order to monitor the resident's dressing [redacted] every shift was not documented on identified dates in 2015. In an identified month in 2015, the resident's dressing to [redacted] ulcers were not documented on an identified date in 2015. The [redacted] dressing was not documented in the TAR on an identified date in 2015, and the Cream to their dry skin areas was not documented on an identified date in 2015. The physician's order for monitoring the resident's [redacted] every shift was not documented on identified dates in 2015. In addition; in an identified month in 2015, the resident's interventions to heal [redacted] ulcers were not documented on identified dates in 2015. The dressings [redacted] were not documented on identified dates in 2015. The resident also had cream prescribed to their dry skin areas once per day, and

was not documented in the TAR on identified dates in 2015. The physician's order to monitor the dressing on the resident's coccyx area every shift was not documented in the TAR on identified dates in 2015.

C) The home's policy called "Skin Care Charting, 30-08-11",revised April 6, 2013. The policy directs registered staff to complete detailed charting on skin care weekly or more frequently if needed, and charting of treatments was on the TAR. Interviews with the registered staff confirmed the expectation of documenting all treatments ordered by the physician for the resident's skin and wound care on the TAR. When the documentation for the last three months was reviewed with registered staff, they were unsure why the treatments as per the physician's orders were not documented in the TAR. The DRC confirmed that staff were expected to document all skin and wound care treatments ordered by the physician in the TAR. The registered staff failed to ensure the physician's orders and interventions to heal the resident's pressure ulcers were documented consistently. [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 and ensuring that any action taken with respect to residents includes: assessments, reassessments, interventions and the residents response to interventions is documented, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents received oral care to maintain the integrity of their oral tissue, including mouth care in the morning and evening.

A) The plan of care for resident #005 identified the resident no longer wore their dentures and directed staff to use lemon swabs for oral care. During interview on an identified date in 2015, a Personal Support Worker (PSW)confirmed that the resident no longer wore their dentures however; stated, no other care besides the cleaning of dentures was done for oral care for the resident. During interview on an identified date in 2015, a PSW confirmed the lemon swabs were not used for oral care that day and stated the swabs were not available. The PSW was unable to find the swabs in the supplies room; care cart, or the resident's room. The resident was observed on identified dates in 2015 and their mouth did not appear clean. The home did not have a policy for the provision of oral care for residents who did not have teeth and did not wear dentures.

B) Oral care was not provided for resident #003 in relation to their dental implants. A dental assessment report, dated on an identified date in 2015, stated, "oral hygiene needs to improve. Food debris and plaque on implants." The resident's care plan and kardex, the documents that staff used to provide care to the resident, did not identify the resident had dental implants in addition to dentures or how to provide oral care for the dental implants. Two PSW staff that provided care for the resident were interviewed and stated they cleaned the resident's dentures and had the resident rinse their mouth with mouthwash prior to inserting the dentures in the morning. The staff were unaware that the resident had dental implants and confirmed that brushing the implants was not part of the morning care routine for the resident. On an identified date in 2015, the Registered Nurse (RN) confirmed for the LTC Inspector that the resident still had the dental implants. [s. 34. (1) (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 and ensuring that each resident receives oral care to maintain the integrity of their oral tissue, including mouth care in the morning and the evening, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids. O. Reg. 79/10, s. 37 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident received assistance, if required, to use personal aids, such as dentures.

On an identified date in 2015, staff providing care for resident #003 confirmed the resident was not assisted to insert their dentures for the breakfast meal. The Personal Support worker (PSW) stated they were going to insert the resident's dentures after the resident received their shower (closer to an identified time). The PSW providing care confirmed the resident was assisted with oatmeal and fluids but refused their toast and egg. The resident was at high nutritional risk due to weight loss. [s. 37. (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 and ensuring that each resident receives assistance if required, to use personal aids, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, (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.

A) Resident #050 was admitted to the home on an identified date in 2014, and in an identified month in 2014, the resident had a fall and suffered a fracture. The resident was transferred to the hospital and had surgery. The resident returned to the home on an identified date. The staff identified that the resident had a Stage 2 pressure ulcer on the and black spots on identified areas. By an identified month in 2014, the pressure ulcers had progressed to Stage 3. Then by an identified date in 2014, the pressure ulcers had worsened and were staged as Stage 4 with undermining.

B) The home's policy called "Skin Care and Wound Management General Policy, 30-08-09B" directs registered staff to complete a head to toe skin assessment upon admission, upon readmission, quarterly, when there was a change in the health status of the resident that affects skin integrity, or upon any sign of skin break down. There was no head to toe assessment completed when the resident was admitted to the home or when the quarterly reviews were completed. Resident #050 had one head to toe assessment, and that was when they returned from the hospital in an identified month in 2015. The

clinical record was reviewed and the only head to toe assessment found was for an identified date in 2015. The registered staff confirmed in an interview that they only do head to toe assessments on admission and when a resident returns from the hospital. The registered staff confirmed the resident had only one head to toe assessment, and it was completed when he was re-admitted on an identified date in 2015. The Director of Resident Care (DRC) and registered staff confirmed they did not use a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that resident #046, received immediate treatment and interventions to promote healing and prevent infection as required in relation to a skin tear or stage II open area.

The resident had a physician order to cleanse the open skin area with normal saline, apply a sterile non-stick dressing and change every three days between identified dates in 2015. Documentation on the resident's treatment records (TAR) for an identified month reflected the order was not signed as completed. The Registered Nurse on the unit stated the order was not implemented. [s. 50. (2) (b) (ii)]

3. The licensee has failed to ensure that resident #046 was assessed by a Registered Dietitian when there was a change in the resident's skin integrity.

Documentation in the resident's progress notes on an identified date in 2015, identified an area of skin breakdown. An order was written by the physician for a treatment starting on on an identified date in 2015; however, staff confirmed a referral to the Registered Dietitian was not completed in relation to the skin breakdown. Registered staff confirmed that residents were to be referred to the Dietitian for skin breakdown and the home's policies related to skin tears and skin breakdown, "Skin Care and Wound Management General Policy 30-08-09B" and "Skin Tears 30-08-21", directed staff to refer to the Registered Dietitian for all wounds, skin breakdown and skin tears. [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 and ensuring that the home uses a clinically appropriate assessment instrument specifically designed for the skin and wound assessment; as well as, treatments and interventions to promote healing and prevent infection and assessments and referrals are completed, to be implemented voluntarily.

WN #18: 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 ensure that 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.

During interview with members of the Residents' Council they confirmed that response to the meetings was not always provided within 10 days.

i) A response was provided April 9, 2015 for the meeting March 26, 2015.
ii) A response was provided January 12, 2015 for the meeting October 30, 2014.

The Administrator confirmed that response to concerns or recommendations voiced at Residents' Council meetings were not provided within 10 days. [s. 57. (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 and ensuring that the licensee responds in writing to the Residents' Council within 10 days, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Meeting minutes reflected a response was not provided within 10 days for the following meetings:

i) April 11, 2015 - a response was not included in the binder. Concerns were voiced by the Council related to: staffing changes, responses from staff, staff communication and knowledge of care routines, menus, staff name tags.

ii) February 7, 2015 - a response from the Administrator was provided March 31, 2015. Concerns were voiced by the Council related to: voicemails, carpets have stains and odours on second and third floor, staffing levels on weekends, staff not wearing name tags, missing clothing, humidity levels too low.

iii) November 22, 2014 - a response from the Administrator was provided January 12/15. Concerns were voiced by the Council related to: staff names being engraved on nursing board.

iv) Sept 20, 2014 - a response from the Administrator was provided October 20, 2014

v) June 14, 2014 - a response from the Administrator was provided July 2/14

vi) The April 11, 2015 Family Council meeting minutes reflected concerns related to the timeliness of the responses to the Family Council. The Administrator confirmed that there were delays in providing a response to concerns voiced at the Family Council meetings.

The Administrator confirmed that a response was not consistently provided within 10 days of receiving Family Council advice or concerns. [s. 60. (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 and ensuring that the licensee responds in writing to the Family Council within 10 days, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges;

2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee has failed to ensure that the admission package included the home's policy to promote zero tolerance of abuse and neglect of residents.

On April 28, 2015, the Administrator confirmed that the admission package had not been updated following the non-compliance issued in November 2014. [s. 78. (2) (c)]

2. The licensee has failed to ensure that the admission package included the an explanation of the duty to make mandatory reports related to incidents resulting in harm or risk of harm to a resident.

On April 28, 2015, the Administrator confirmed that the admission package had not been updated following the non-compliance issued in November 2014. [s. 78. (2) (d)]

3. The licensee has failed to ensure that the admission package included the home's policy on minimizing the restraining of the residents and how to obtain a copy of the policy.

On April 28, 2015, the Administrator confirmed that the admission package had not been updated following the non-compliance issued in November 2014. [s. 78. (2) (g)]

4. The licensee has failed to ensure that the admission package included an explanation of the protections afforded by section 26; in relation to, whistle-blowing protections related to retaliation.

On April 28, 2015, the Administrator confirmed that the admission package had not been updated following the non-compliance issued in November 2014. [s. 78. (2) (q)]

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 and ensuring the the information provided in the admission package complies with the requirements of the legislation, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)

(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that a copy of the long term care service accountability agreement(LSAA) was posted in a conspicuous and easily accessible location.

The Administrator confirmed on April 23, 2015, that the LSAA was in his office and not posted in a conspicuous and easily accessible location. [s. 79. (1)]

2. The licensee has failed to ensure that the Residents' Bill of Rights posted in both English and French.

On April 29, 2015, the Administrator confirmed that the Residents' Bill of Rights are not posted in French as the home has a Dutch population. [s. 79. (3) (a)]

3. The licensee has failed to ensure that the mission statement was posted and communicated.

On April 28, 2015, the Administrator confirmed that the mission statement was posted in the board room; however, it was not posted in a conspicuous and easily accessible location. [s. 79. (3) (b)]

4. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was posted and communicated.

On April 28, 2015, the Administrator confirmed that the policy to promote zero tolerance of abuse and neglect of residents, was not posted in a conspicuous and easily accessible location. [s. 79. (3) (c)]

5. The licensee has failed to ensure that the policy to minimize the restraining of the residents was posted and communicated, as well as information about how a copy of the policy can be obtained.

On April 28, 2015, the Administrator confirmed that the policy to minimize the restraining of residents and how to receive a copy of the policy was not posted. [s. 79. (3) (g)]

6. The licensee has failed to ensure that the name and telephone number of the licensee were posted and communicated.

On April 28, 2015, the Administrator confirmed that the name and telephone number of the licensee was not posted in a conspicuous and easily accessible location. [s. 79. (3) (h)]

7. The licensee has failed to ensure that the most recent minutes of the Family Council meetings; if any, with consent of the Council, were posted and communicated.

On April 29, 2015, the Social Worker confirmed that the Family Council meeting minutes were sent out to each family member on the Council however, they were not being posted and communicated with the consent of the Council. [s. 79. (3) (o)]

8. The licensee has failed to ensure that an explanation of whistle-blowing protections related to retaliation was posted and communicated.

On April 28, 2015, the Administrator confirmed that an explanation of whistle-blowing protections related to retaliation was not posted in a conspicuous and easily accessible location. [s. 79. (3) (p)]

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 and ensuring that all of the required information complies with the requirements of the legislation and is posted in a conspicuous and easily accessible location, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home developed and implemented a quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of the accommodation, care, services, programs and goods provided to residents of the home.

The Administrator confirmed on May 4, 2015, that a Quality Improvement Program was not currently in place. The Administrator confirmed the home was in the process of organizing a Quality Improvement Program for all departments. The home had not completed any of the required program evaluations or monitoring activities, and had not developed a plan for improvements within the home. [s. 84.]

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 and ensuring that the home develops and implements a quality improvement and utilization review system than monitors, analyzes, evaluates and improves the quality of the accommodations, care, services, programs and goods provided to residents of the long term care home, to be implemented voluntarily.

WN #23: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee sought the advice of the Family Council in developing and carrying out the satisfaction survey and in acting on its results.

The Administrator confirmed that the Family Council was not currently involved in developing the survey. The President of the Family Council also confirmed that the council was not involved in developing or carrying out the satisfaction or in acting on its results. [s. 85. (3)]

2. The licensee has failed to ensure that the licensee sought the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

The Administrator and members of the Residents' Council confirmed that the Residents' Council was not involved in developing and in carrying out and acting on the results of the satisfaction survey. [s. 85. (3)]

3. The licensee has failed to ensure that the licensee made available to the Residents' Council the results of the satisfaction survey.

The Administrator and members of the Residents' Council confirmed that the results of the satisfaction survey were not made available. [s. 85. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the licensee seeks the advice of both the Family Council and Residents' Council in developing and carrying out the satisfaction survey and acting on its results as well as, the results made available to the Councils., to be implemented voluntarily.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee did not ensure that procedures were developed for cleaning of the home, specifically flooring and common area furnishings.

A) During a tour of the home between April 23 and May 6, 2015, furnishings were observed to be soiled in appearance in the common areas of identified areas. Cushions and arm rests were surface stained and appeared soiled. The licensee did not have an established procedure for addressing when the furnishings would be cleaned, by whom and how. No schedule had been developed and housekeepers who were interviewed stated that furniture would be spot cleaned and deep cleaned as needed.

B) Flooring material in common lounges and hallways in identified home areas, were observed to be stained. The home's policy on "Deep Cleaning" (no policy number identified but dated May 14, 2014, reviewed April 28, 2015), stated the carpets would be steam cleaned; however, the policy did not indicate the frequency of cleaning or who was responsible for completing the task. Staff interviewed confirmed the carpets were spot cleaned or steam cleaned as needed but were not completed on a schedule. According to the information provided to the inspector on the "Job List" for the time period of October 2014 and April 2015, the first floor and 2 South carpets were not identified as being cleaned. The Housekeeping manager confirmed that the carpet cleaning was completed as needed. [s. 87. (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 and ensuring that procedures and schedules are developed for cleaning of the home, to be implemented voluntarily.

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
8. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the admission package included the Ministry's toll-free telephone number for making complaints about the home and its hours of service.

On April 28, 2015, the Administrator confirmed that the admission package did not include the Ministry's toll-free telephone number and its hours of service. [s. 224. (1) 8.]

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 and ensuring that the admission package complies with the requirements of the legislation, to be implemented voluntarily.

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act. O. Reg. 79/10, s. 225 (1).
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act. O. Reg. 79/10, s. 225 (1).
3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the most recent audited reconciliation report was posted and communicated.

On April 23, 2015, the Administrator confirmed all audited reconciliations were kept in the accounting office and were not posted in a conspicuous and easily accessible location. [s. 225. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the posting of information complies with the requirements of the legislation, to be implemented voluntarily.

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing.

On an identified date and time in 2015, resident #048 was observed sitting in a [redacted] terry cloth robe that opened at the front (nothing underneath). Staff were starting to porter residents to the dining area for the dinner meal. The resident was unable to state their preferred clothing, or if they were uncomfortable with their attire. The resident's plan of care stated they required extensive assistance with dressing, and were unable to dress independently. Staff confirmed the resident did not put themselves in the robe. The Personal Support Worker (PSW) providing care for the resident was unable to tell the LTC Inspector why the resident was in their robe prior to the dinner meal however; later stated, the resident was scheduled for a shower (earlier) but the shower was not provided due to running behind. The resident was not placed in appropriate clothing for the time of day when their shower was rescheduled. [s. 40.]

Aug 26/15

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002's had an individualized plan of care to promote and manage incontinence.

The plan of care for resident #002, which the home refers to as the care plan, dated an identified date in 2015, stated that resident #002 is routinely toileted with one staff and resident will sometimes ask to go to the bathroom and; is a heavy wetter. The kardex, which a Personal Support Worker (PSW) identified as the plan of care they follow, stated that resident #002 had a specific behaviour when wanting to be toileted. The kardex and the care plan, did not identify any specifics in regards to the toileting schedule, or routines for the resident. This was confirmed by the Personal Support Worker (PSW); as well as, the Resident Assessment Instrument(RAI)Co-Ordinator on April 30, 2015. [s. 51. (2) (b)]

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

**s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration; O. Reg. 79/10, s. 71 (1).**

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 the home's menu cycle, (a) was a minimum of 21 days in duration, including the snack menu.

The snack menu for residents receiving a pureed texture menu was for a one week rotation. The menu included puddings daily at afternoon snacks, and pureed canned fruit for the evening snack daily. A one week rotation would not provide a sufficient variety. [s. 71. (1) (a)]

2. A) The licensee has failed to ensure that the planned menu items were offered and available at each meal.

i) At the lunch meal on an identified floor on April 23, 2015, not all residents were offered milk as per the planned menu. The menu required offering 125 ml of milk to residents at the lunch meal. Two residents in the dining room received milk with their meal. Thickened milk was not offered to residents requiring thickened fluids. Many of the residents would not have been able to ask for milk. The Registered Dietitian confirmed that the residents were to be offered milk with meals unless the plan of care specified otherwise. The plans of care for the four residents requiring thickened fluids did not indicate the residents were not to receive milk (one was lactose restricted; however, lactose restricted milk was available in the home).

B) The licensee has failed to ensure that the planned menu items were offered and available at each snack.

i) The menu for the afternoon snack on April 29, 2015 (Week 1 Wednesday) stated oatmeal cookies. Residents requiring a regular texture were offered assorted cookies (no oatmeal cookies).

ii) The menu for the afternoon snack on May 4, 2015 (Week 2, Monday) stated 2 fig newtons for the regular texture menu. Staff providing the snacks confirmed that almond cookies were offered to residents requiring a regular textured menu. The menu also required assorted juices; however, drink crystals were offered and juice was not available on the snack cart.

iii) Residents requiring thickened beverages were not offered a variety of beverages on May 4, 2015; only thickened water. PSW staff stated that thickener was not available on the snack cart and they would have to ask the dietary staff to provide thickener if a resident refused the thickened water. The Food Service Supervisor stated that staff were to provide the labeled thickened water in addition to thickened juices. Thickened juices were not available on the snack cart. [s. 71. (4)]

WN #30: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the weekly menus were communicated to residents residing on the first floor.

Daily menus were posted; however, weekly menus were not posted and staff confirmed that the weekly menus were not routinely communicated to residents. The case where the daily menus were posted were locked and could not be opened by residents or families. [s. 73. (1) 1.]

WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee has failed to ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

A) The home's policy "Complaint Handling" issued 01/01/2012, reviewed 31/08/2014, does not contain an explanation O.Reg. 79/10, s. 101 (1) 1, 2 and 3:

101.(1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.
O. Reg. 79/10, s. 101 (1).

B) The home's policy "Complaint Handling" issued 01/01/2012, reviewed 31/08/2014, does not contain an explanation O.Reg. 79/10, s.101 (2) c, d, e and f:

101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

(2) The licensee shall ensure that a documented record is kept in the home that includes,

(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;

(d) the final resolution, if any;

(e) every date on which any response was provided to the complainant and a description of the response;

(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

C) The home's policy "Complaint Handling" issued 01/01/2012, reviewed 31/08/2014, does not contain an explanation O.Reg. 79/10. . 101 (3) a, b and c:

101.(1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

(3) The licensee shall ensure that,

(a) the documented record is reviewed and analyzed for trends at least quarterly;

(b) the results of the review and analysis are taken into account in determining what improvements are required in the home;

(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

D) The home's policy "Complaint Handling" issued 01/01/2012, reviewed 31/08/2014, does not contain an explanation O.Reg. 79/10, s.101 (4):

101.(1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

(4)Subsections (2) and (3) do not apply with respect to verbal complaints that the licensee is able to resolve within 24 hours of the complaint being received. O. Reg. 79/10, s. 101 (4).

E) The home's policy "Complaint Handling" issued 01/01/2012, reviewed 31/08/2014, does not contain an explanation O.Reg. 79/10, s.103 (1) and (2):

103.(1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1). [s. 100.]

WN #32: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in resident's condition followed by the report required under subsection (4).

A) Resident #043 had a fall on an identified date in 2015, sustained an injury and was taken to hospital. The home did not submit a written critical incident report until an identified date in 2015.

B) The home's policy "Critical Incident Reporting" with no issue date that was provided to the inspector by the DRC on May 4, 2015 indicated that "(3) the licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident..."

The report was submitted to the Director 17 days after the incident occurred. The licensee did not submit a report as required by the legislation, and did not follow their policy for reporting of an incident that caused an injury to the resident for which the resident was taken to a hospital. [s. 107. (3) 4.]

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

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Issued on this 2nd day of July, 2015

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

Original report signed by the inspector.

by Aug 26/15 - This report has been revised for the purpose of publication.

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) :	CATHIE ROBITAILLE (536), DARIA TRZOS (561), KATHLEEN MILLAR (527), MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2015_275536_0009
Log No. / Registre no:	H-002313-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 5, 2015
Licensee / Titulaire de permis :	HOLLAND CHRISTIAN HOMES INC 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7
LTC Home / Foyer de SLD :	GRACE MANOR 45 Kingknoll Drive, BRAMPTON, ON, L6Y-5P2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PETER DYKSTRA

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

To HOLLAND CHRISTIAN HOMES INC, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures the home's infection prevention and control program includes measures to prevent the transmission of infections. The plan shall include, but is not limited to:

1. Removal of all communal personal care items.
2. Education for all staff providing care on the correct use of personal care items and the correct process for the use of and cleaning/disinfection process for appropriate multi-use items.
3. The provision of adequate supplies and equipment for personal care and the development of appropriate policies for the cleaning and disinfection of appropriate multi-use personal care items.
4. Quality improvement activities, including monitoring and evaluating the infection control program, auditing of the correct use of personal care items, frequency of auditing, and person responsible for the auditing.

The plan shall be submitted electronically to Long Term Care Homes Inspector, Michelle Warrener, by June 30, 2015 to: Michelle.Warrener@ontario.ca. The plan is to be complied with by: June 30, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that infection prevention and control program included, (b) measures to prevent the transmission of infections.

A) The shower rooms in three of three areas surveyed contained communal

personal care items.

i) An identified shower room:
- an unlabeled straight razor
- an unlabeled brush with hair in it sitting on top of the paper towel dispenser in the washroom area.
- several unlabeled hair brushes with hair in them stored in the file folder on the wall
- unlabeled stick deodorant (one men's stick and one women's stick)
- unlabeled opened bottles of petroleum jelly
- unlabeled pair of soiled nail clippers (had nails in them)
- unlabeled comb with hair in it sitting on the counter in the shower room

ii) An identified shower room:
- two bottles of unlabeled opened "infazinc" cream
- an unlabeled roll on deodorant on the top of the paper towel dispenser in the washroom
- cupboard contained unlabeled zinc and petroleum jelly bottles
- a resident's labeled HC 1% cream
- men's stick deodorant
- disposable razor (looks used) stored with the nail clippers (1 pair) in k-basin with nail clippings in the bottom and a dirty nail file (all unlabeled)
- a large container of zinaderm cream (unlabeled)

iii) An identified shower room:
- cupboard - soiled disposable razor (had hair and build up on it)
- unlabeled petroleum jelly and zinc creams
- unlabeled stick deodorant
- k-basin with unlabeled hair brush and a tube of toothpaste - basin had hair and fingernail clippings in the bottom

iv) An identified shower room:
- communal jars of zinc oxide and vaseline identified in the cupboard along with an unlabeled large pair of toe nail clippers, and several unlabeled hair brushes.
- Toilet area (located in between shower and bath room): A raised toilet seat was identified on the floor and had brown stains and hair stuck to the seat (107)

B) The fabric backs on the shower chairs in the shower areas on all floors were stained and appeared significantly soiled (brown or green when fabric was

supposed to be white). During interview on an identified date in 2015, a PSW stated the fabric was laundered but not sure how frequently. On April 29, 2015, the Assistant Director of Resident Care(ADRC) confirmed that the backs of the shower chairs were significantly stained and did not appear clean. (107)

C) During interview on an identified date in 2015, a PSW confirmed that an electric razor stored in the first floor clean utility room in the care caddy cart was used on multiple residents.(107)

D) During interview on an identified date in 2015, a PSW on the first floor stated that residents should have their own nail clippers stored in the cupboard of the washroom in their rooms or in the clean utility room. No clippers were found in the cupboards in the washrooms for rooms 115, 117, 118, 119, 104, 106, 107 (shared room), 108 (shared room), 110, 111 (shared room), 113, 114 (shared room) and no individual clippers were found in the clean utility or soiled utility rooms. A unlabeled soiled pair of nail clippers was found in the care caddy in the clean utility room, and in the cupboard in the shower room on April 23 and April 29, 2015. (107)

E) A soiled unlabeled pair of nail clippers, an unlabeled roll on deodorant, and an unlabeled used tube of toothpaste were found in the care caddy in the first floor clean utility room on April 29, 2015.(107)

F) Not all items in shared resident rooms were labeled or stored in a manner that would prevent the spread of infection. In room 111 three unlabeled toothbrushes were stored in a toothbrush holder in the shared washroom and an unlabeled soiled hair brush was stored on the counter of the shared washroom and an unlabeled denture cup was stored on the counter; in room 311 four unlabeled toothbrushes were stored in a toothbrush holder and there was an unlabeled comb and denture cup; and in room 308 they had labeled k-basins filled with unlabeled toothbrushes inside, unlabeled brushes on the counters, and unlabeled jars of zinc cream was on the counter. (107, 561, 536)

G) During interview on an identified date in 2015, the Infection Prevention and Control (IP&C) Lead confirmed that multiple personal use items were unlabeled and stored in the tub rooms, used by staff, and that the individual care caddies for personal items were no longer in use. The IP&C Lead confirmed that education related to use of personal items between residents was not included in the home's infection prevention and control education or policies for staff

providing care. (107)

H) On an identified date and time in 2015, the clean utility room on the 2 South unit contained an unlabeled white hair brush, soiled with a large amount of hair, stored on the care cart used for residents. Staff stated they were not sure who the comb belonged to.(107)

I) During the initial tour of the home on April 23, 2015, the LTC Inspector observed in the shower room on 2 North and 3 South the following:

- communal containers of zinc oxide and vaseline,
- there was one large pair of toe nail clippers,
- there were several hair brushes with hair in them, and
- a raised toilet seat was identified on the floor in the 2 North bathroom, which had brown stains underneath it and along the sides, and hair stuck to the seat in several areas.

The PSW's interviewed and confirmed that the zinc ozide, vaseline, toe nail clippers, hair brushes, and raised toilet seat were shared among residents when they should be individualized for residents and labeled accordingly. As a result, the home did not ensure that measures were taken to prevent the transmission of infections.(527)

J) On an identified date in 2015 the registered staff were administering pain medication subcutaneously to resident # 021. The registered staff did not perform hand hygiene before or after the medication administration and continued to administer other medications to other residents on the unit without performing hand hygiene. When the registered staff was interviewed, they confirmed they were expected to perform hand hygiene before and after medication administration. The registered staff at the home did not ensure that measures were taken to prevent the transmission of infections by performing hand hygiene before aseptic procedures and pre and post resident care. (527) (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

Order # / Ordre no : 002

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

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 licensee shall prepare, submit, and implement a plan that ensures that when bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are non, in accordance with prevailing practices, to minimize risk to the resident. The plan shall include, but is not limited to:

1. The development and implementation of a policy related to bed rail safety, including the assessment of the bed system when bedrails are used, assessment of residents in relation to the need for bed rails, assessment of residents who require bed rails in relation to safety while the rails are applied. The policy should include the use of bed rails as PASDs and as restraints.
2. Education for all direct care staff related to bed rail safety, including the home's policy on bed rails, the risks related to the use of bed rails and the assessment process for the use of bed rails.
3. Quality improvement activities, including a system to monitor and evaluate the bed systems being used in the home and resident safety while bed rails are being used. The plan shall include a process for auditing, frequency of auditing, and person responsible for the auditing process.

The plan shall be submitted electronically to Long Term Care Homes Inspector, Michelle Warrener, by June 30, 2015 to: Michelle.Warrener@ontario.ca. The plan is to be complied with by: September 30, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used, (a) the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

A) During interview on an identified date in 2015, the Director of Resident Care (DORC) confirmed that when bed rails were used, the home had not completed an assessment of the bed systems or of the residents in relation to the safety risks with the use of bed rails, to minimize risk to residents. The DORC stated that the Physiotherapist was supposed to start assessing the residents in relation to the need for bed rails, commencing April 28, 2015.

B) The home's policy, "Entrapment Zones - Resident Beds" when received had not been implemented and the policy did not contain a policy number or date of

implementation. The policy was implemented during this inspection. The Director of Resident Care (DRC) confirmed the policy was just implemented.

C) Numerous residents in the home were using bed rails; however, the DRC and Assistant Director of Resident Care (ADRC) confirmed a system was not currently in place to identify which residents were using the rails, if the bed rails limited the residents' freedom of movement and for what purpose the bed rails were being used. Staff on all three floors identified that most residents were using bed rails at night (a variety of sizes - 3/4, 1/2 and 1/4 rails, in various combinations). The DRC, ADRC and Resident Assessment Instrument (RAI)-Coordinator confirmed that unless the bed rails were identified as a restraint, they were not included on the resident's plan of care, an assessment was not completed, and direction for staff was not provided in relation to the use of bed rails. Staff were using the bed rails without direction or an assessment of safety. The home's policy, "Use of Personal Assistive Service Device 30.06.03GA", dated as reviewed on April 22, 2014, identified bed rails used for turning or repositioning, positioning during sleep, and for getting out of bed as examples of PASDs, and stated that the care plan must clearly indicate the purpose of a PASD and PASDs must be included in the residents' plans of care.

D) The previous Resident Quality Inspection (RQI), November 2014, identified that the bed systems and residents had not been assessed in relation to bed entrapment; or safety risks, with the use of bed rails since the home opened. The home had not taken action to assess the bed systems, or residents requiring bed rails between the previous RQI report issued in November 2014 and April 2015. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times. The plan shall include, but is not limited to:

1. An audit of all areas of the home to ensure that the resident-staff communication and response system is working and can be easily seen, accessed and used by residents, staff and visitors
2. Quality improvement activities, including routine auditing of the resident-staff communication and response system, frequency of auditing and the person responsible for the auditing process.

The plan shall be submitted electronically to Long Term Care Homes Inspector, Michelle Warrener, by June 30, 2015 to: Michelle.Warrener@ontario.ca. The plan is to be complied with by: September 30, 2015.

Grounds / Motifs :

1. Previously issued as a VPC on November 14, 2014.

2. The licensee failed to ensure that the home was equipped with a resident staff communication and response system that, (a) could be easily seen, accessed and used by resident, staff and visitors at all times. Not all call bells were available or functioning when pressed/pulled by the inspectors.

A) When the bedside call bells were pressed, the resident to staff communication system were not activated, including the light on the call bell panel inside the room and the light in the hallway. The staff confirmed they were not notified by their pagers when the bell was pressed. Some of the rooms did not have a bedside call bell, in addition to a bed alarm system. In one room the bell was not fully plugged into the wall and the system did not function as a result (107S-2).

B) The bedside call bells were not working in identified rooms. Staff stated the last audit of the call bell systems was completed August 2014. A schedule was not in place, other than annually, to ensure that all of the call bells were in good working order or could be activated by residents and staff.

C) The washroom call bells were very hard to pull, and some did not activate or the cord broke off prior to activating the call bell communication system. Some examples were identified in rooms, in identified washroom/tub/shower room call bells in identified areas.

D) A resident in an identified room, was unable to pull the call bell for assistance when required. Maintenance was informed and the bell was adjusted.

E) A resident in an identified room was unable to call for assistance when required, as the call bell system was very difficult to pull. The resident was on the toilet and unable to call for staff assistance. Maintenance has since adjusted to switch to be more sensitive.

F) Maintenance staff confirmed, the call bells in the washrooms were very difficult to activate, and some cords broke off prior to activating the system. He stated the home was now in the process of replacing or adjusting the washroom call bell systems.

G) Call bell cords were squished in between the grab bar and metal plate on the grab bars or looped through extended tracks in washrooms. The location of the

string and positioning along with the cords being very difficult to activate, would prevent many residents from activating the washroom call bell systems. The LTC Inspectors were unable to activate many of the bells when in a seated position in the washrooms. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times. The plan shall include, but is not limited to:

1. Education for all staff in relation to the use of hazardous substances, the storage of hazardous substances, and the need to ensure all areas that contain hazardous substances are kept inaccessible to residents.
2. A review of all home areas to ensure that doors that are supposed to automatically close behind staff are in proper working order.
3. Quality improvement activities including monitoring, frequency of monitoring, and person responsible for the auditing.

The plan shall be submitted electronically to Long Term Care Homes Inspector, Michelle Warrener, by June 30, 2015 to: Michelle.Warrener@ontario.ca. The plan is to be complied with by: June 30, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that all hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times.

A) On an identified date and time in 2015, the "Storage Room" on an identified unit was left unlocked and unattended. A bottle of rubbing alcohol was stored in an unlocked cupboard and the door to the room was not locked. (107)

B) On an identified date and time in 2015, the tub room on an identified floor was found unlocked with the door propped open and the room was unattended by staff. A bottle of Per Diem disinfectant was accessible in the unlocked

cupboard, along with a spray bottle of an unknown substance - hand writing "tub and shower chair cleaner". In the tub room on the counter, there were two 3 Litre containers of Disinfectant Cleanser IV with poison and corrosive WHMIS symbols on the label, and a 4 Litre jug of Disinfectant Cleaner IV in the unlocked cupboard of the tub room. The LTC Inspector informed the PSW doing the snack cart, who just happened to walk by as inspector leaving the shower room at 1052 hours. The PSW confirmed, the door was supposed to be closed and inaccessible to residents. (107)

C) On an identified date and time in 2015, the shower room on an identified floor was found unlocked and unattended with the door ajar. The same chemicals were accessible as noted on April 27, 2015. A PSW entered the room while the LTC Inspector was in the shower room and the door was then locked upon leaving the room. (107)

D) On an identified date and time in 2015, the shower room on an identified floor was found unlocked and unattended with the door ajar. The same chemicals were accessible as noted on April 27, 2015. The door did not automatically close. The door was locked prior to the inspector leaving the area and the RN sent a requisition for maintenance to look at the door to the shower room. (107)

E) On an identified date and time in 2015, the shower room on an identified floor was found unlocked and unattended with the door ajar. The same chemicals were accessible as noted on April 27, 2015. The door did not automatically close. The door was closed and locked by the LTC Inspector and staff were notified.(107)

F) During the initial tour of the home on an identified unit, the LTC Inspector observed in the Activity room that the cupboard under the sink was unlocked and stocked with activity supplies and sanitizing cleaner called "Diverso/BXA". The sanitizing cleaner had a Class D Workplace Hazardous Materials Information System (WHMIS) logo, which identified that the sanitizing cleaner was poisonous and infectious material. There were seven residents sitting in the Activity room unsupervised waiting for activities to begin, and the residents' had access to the hazardous material. The Activities staff member, charge nurse and Personal Support Worker (PSW) confirmed the cupboard door was unlocked and the hazardous material was accessible to residents.(527)

G) On an identified date and time in 2015, the "Resident Care Supplies" room on

an identified floor was left unlocked and unattended by staff. An unlocked treatment cart was stored in the room and contained a bottle of iodine solution. The room also contained a bottle of hydrogen peroxide and bottles of hand sanitizer. The labels identified the items were hazardous if ingested. The first floor was a secure home area with residents that had cognitive impairment and wandered. (527)

(107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that staff apply physical devices (e.g. seat belts) in accordance with any manufacturer's instructions. The plan shall include, but is not limited to:

1. A review of all residents wearing a restraining device to ensure the appropriate application of all devices
2. Education on the correct application of restraining devices for all staff who apply restraining devices
3. Quality improvement activities, including an evaluation of the home's program on minimizing of restraining, auditing of all residents wearing physical devices to ensure the correct application of the devices, frequency of monitoring, and the designated person responsible for the monitoring activities

The plan shall be submitted electronically to Long Term Care Homes Inspector, Michelle Warrener, by June 30, 2015 to: Michelle.Warrener@ontario.ca. The plan is to be complied with by: June 30, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.

2. Instructions provided to the home on the "Use & Care of Wheelchair Hip Belts" directed staff to allow just enough space for two fingers to fit between the hip belt and the person's body, at any one point along the belt.

A) On an identified date and time in 2015, resident #001 was observed with a very loose seat belt (down to the resident's knees) while sitting in the dining room. The RN confirmed the seat belt was too loose, and that the resident was unable to undo the seat belt. The seat belt was then tightened.

B) On an identified date and time in 2015, resident #002 was observed with a very loose seat belt (more than 2 fists). The resident was unable to undo the seat belt (the seat belt was a prohibited device that required an external device to unlock). During interview with the resident's family, they stated that the resident's seat belt was frequently loose. The resident was at risk for falling.

C) On an identified date and time in 2015, resident #002 was observed sitting in the hallway with a loose seat belt. The space between the belt and the resident was more than two fists. Staff confirmed the belt was too loose.

D) On an identified date and time in 2015, resident #003 was observed with a very loose seat belt with the belt fully extended. Registered staff was reluctant to tighten the belt when identified by the inspector as a safety risk. Registered staff confirmed the resident was unable to undo the seat belt independently and that the resident was at risk for falling.

E) On an identified date and time in 2015, resident #007 had their seat belt almost fully extended and it was hanging loose at about knee level of the resident. The registered staff confirmed the resident was unable to independently release the seat belt. The registered staff stated the wheelchair was not their permanent wheelchair and confirmed the seat belt was too loose. The belt was then tightened.

F) On an identified date and time in 2015, resident #007 was sitting in the hallway with a loose seat belt. The seat belt was half way down the resident's thighs and the inspector could put two fists under the belt. The registered staff confirmed the belt was too loose and tightened the belt.

G) On an identified date and time in 2015, resident #051 was sitting in a

wheelchair with both of their hands beneath the seat belt. The Registered staff confirmed the belt was too loose for safety and tightened the belt. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies and that is secure and locked.

The plan shall include, but is not limited to:
1. Removal of drugs and medication creams being stored in alternate locations
2. Education for staff that handle medications and medicated creams on the correct storage of medications
3. Quality improvement activities, including an evaluation of the home's medication administration system, monitoring of the storage of medications and treatment creams, frequency of monitoring, and the person responsible for completing the monitoring activities.

The plan shall be submitted electronically to Long Term Care Homes Inspector, Michelle Warrener, by June 30, 2015 to: Michelle.Warrener@ontario.ca. The plan is to be complied with by: June 30, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that, (a) drugs were stored in an area or a medication cart, (i) that was used exclusively for drugs and drug-related supplies, (ii) was secure and locked and (iv) that complies with manufacturer's instructions for the storage of the drugs.

A) On an identified date and time in 2015, a bottle of prescription cream was sitting on the bedside table of resident #005. The Personal Support Worker (PSW) providing care for the resident confirmed they forgot to put the cream away after using it. (107)

B) On an identified date in 2015, on an identified floor, a basket of prescription creams was being kept in the care carts stored in the clean utility room on the first floor. The clean utility room was not an area that was used for drugs or drug related supplies. The Assistant Director of Resident Care (ADRC) confirmed the prescription creams were required to be stored in the medication cart or in the medication room and were not to be stored in the clean utility room. The creams were returned to the medication cart.(107)

C) On an identified date and time in 2015, on an identified unit, a large bottle of prescription hydrocortisone 1% cream was left on the counter by the television in resident #049's room. The room was empty and staff did not return while the inspector was in the room. (107)

D) On an identified date and time in 2015, on an identified unit, the same bottle of prescription hydrocortisone 1% cream for resident #049 was left sitting on top of the cart that held resident charts. Staff were not in the immediate area and the door to the nursing station was left ajar. The nursing station was not an area that was locked and staff confirmed the creams were to be kept in the medication cart.(107)

E) On an identified date and time in 2015, on an identified unit, the registered staff left the medication cart unlocked and unattended outside of room 114 while giving medications to a resident in their room. The LTC Inspector was able to open the cart without being seen by the staff member. (107)

F) On an identified date and time in 2015, during an observation of the medication pass, it was observed that the medication cart was left unattended in

the lounge area with pre-poured medications sitting on top of the medication cart. The registered staff was observed going in to the medication room behind the nursing station to get a pulse oximeter. Residents and one volunteer member were present in the lounge area. The registered staff indicated that residents would not have taken any medications from the medication cart and certainly not the volunteer. The home did not ensure that the drugs were stored in a secured and locked medication cart while it was left unattended. (561)

G) During the review of the process of drug destruction with the Director of Resident Care (DRC) on May 7, 2015, the government stock medications were observed and the LTC Inspector identified six bottles of Aromatic Cascara, laxative stimulant for occasional constipation that had an expiry date of February 2015. There was also one bottle of the Novasen-enteric coated ASA, 325 mg that had an expiry date of March 2015. The DRC confirmed that the expired medications should have been disposed of. (561)
(107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

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

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 35. Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that prohibited devices are not used in the Long Term Care home. The plan shall include, but is not limited to:

1. Removal of the prohibited devices for those residents who were wearing the prohibited devices
2. Re-assessment of the residents who were wearing the devices, including an assessment of alternative strategies, appropriate replacements, if required, to ensure the safety of the residents.
3. Quality improvement activities, including monitoring and evaluating the home's program for minimizing of restraining, monitoring of the restraining process, the frequency of monitoring, and the person responsible for the monitoring.

The plan shall be submitted electronically to Long Term Care Homes Inspector, Michelle Warrener, by June 15, 2015 to: Michelle.Warrener@ontario.ca. The plan is to be complied with by: June 15, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that prohibited devices provided for in the regulations were not used on a resident, (a) to restrain the resident. In reference to O.Reg. 79/10, s. 112.3, "For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home: 3. Any device with locks that can only be released by a separate device, such as a key or magnet.

A) On an identified date in 2015, at 1300 hours, resident #002 was observed wearing a prohibited device (a seat belt that required a pen device to unlock). When prompted by the LTC Inspector, the resident was unable to undo the seat belt independently and staff confirmed a separate device was required to unlock the seat belt. The staff confirmed they were unaware that this type of seat belt was a prohibited device under the LTCHA regulations, despite the home's policy, "Reassessment of Restraints 30-06-03E", dated June 17, 2008 and reviewed June 18, 2013, that stated, "Types of restraint that cannot be used: Device that cannot be released by staff, vests or jackets, four point extremity restraint, device that requires another device to release the lock." Staff replaced the seat belt with a regular seat belt (easily removed), which the resident's daughter stated had been very unsuccessful previously. Registered staff confirmed a plan was not in place to ensure the resident's safety until the appropriate replacement seat belt was available.

B) Resident #047 had a physician's order for a seat belt that required a pen device or external device to unlock. The order was changed on an identified date in 2015 to a regular seat belt; however, on an identified date in 2015, the registered staff stated the regular seat belt had not been effective as the resident was able to extend the seat belt and slide out of the chair routinely. The resident had a fall on an identified date in 2015, (slid out of the geri chair) and during interview, registered staff stated interventions were not revised to ensure the resident's safety.

C) Resident #046 had a physician's order for a seat belt that required a pen or external device to unlock it between identified dates in 2014 and 2015. The device was changed to a regular seat belt on an identified date in 2015. (107)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2015

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all staff who provide direct care to residents receive training in all areas identified in the legislation:

The plan is to include but not limited to:

A) A schedule of ongoing staff training to ensure that all staff who provide direct care to residents receive training annually.
B) Prepare in writing: the content of training sessions, schedules and evidence that staff have attended training sessions.
C) Training and retraining all staff at the home according to legislative requirements, specifically, s.76 (Training) and O.Reg 216 to 222 inclusive (Training and Orientation) including but not limited to the following areas:

1. Falls Prevention and Management.
2. Skin and wound Care.
3. Continence Care and Bowel Management.
4. Pain Management, including pain recognition of specific and no-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these devices.
6. For staff who apply PASD's, or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.
7. Any other areas provided for in the regulations.

The plan is to be submitted electronically to Long Term Care Homes Inspector, Cathie Robitaille by June 30, 2015 to: Cathie.Robitaille@ontario.ca. The plan is to be complied with by December 31, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure training and retraining of all staff at the home according to legislative requirements,

A) The home's training records related to Falls Prevention and Management were reviewed. It was identified that there were 70/120 or 62% of direct care providers trained in 2014. The attendance breakdown for training identified: 3/14 registered nurses, 18/30 registered practical nurses, and 49/76 PSWs

trained on falls prevention and management in 2014.The Director of Resident Care (DRC) confirmed that 100% of staff where required to complete the Falls Prevention Management Training. An order was issued to the home last year for s. 49 (1). The plan was to be submitted to the Ministry by January 2015, with the compliance date of April 30, 2015. As part of the corrective action in the plan the home indicated the following: "A Multidisciplinary Team Approach for Falls Prevention on September 23rd Falls in Elderly presented by the Pharmacist. These in-services will be held on a quarterly basis, also reviewing of the falls policy". The DRC confirmed that only one in-service was held in September 2014, by the Pharmacist for staff. Only 19 staff members attended the training. The home failed to ensure that all direct care staff where provided training in falls prevention and management. (561)

B) The home's training records for 2014, related to skin and wound care were reviewed. It was identified that there were 69/127 or 54% of direct care providers trained in 2014. The attendance breakdown for training identified: 1/14 registered nurses, 15/32 registered practical nurses, and 51/81 PSWs trained on skin and wound care in 2014. When the PSWs and registered staff were interviewed on May 7 and 8, 2015, the LTC Inspector identified that 2/5 interviewed had not received training in 2014. The DRC confirmed that not all of their direct care providers were trained in 2014. The home failed to ensure that all direct care staff where provided training in skin and wound care. (527)

C) The home's training records for 2014, related to continence care and bowel management were reviewed. It was identified that there were 64/121 or 53% of direct care providers trained in 2014. The attendance breakdown for training identified: 3/14 registered nurses, 14/31 registered practical nurses, and 44/76 PSW's trained on continence care and bowel management in 2014. The Resident Assessment Instrument (RAI) Co-Ordinator confirmed on May 6, 2015, that not all of their direct care providers were trained in 2014. The home failed to ensure that all direct care staff where provided training in continence care and bowel management. (536)

D) The home's training records for 2014, related to minimizing of restraints were reviewed. It was identified that there were 75/120 or 62.5% of direct care staff trained in 2014. The attendance breakdown for training identified: 3/14 registered nurses, 19/30 registered practical nurses, and 53/76 PSW's trained on minimizing of restraints in 2014. The RAI Co-Ordinator confirmed on May 8, 2015, that not all direct care providers were trained in 2014. The home failed to

ensure that all direct care staff where provided training in minimizing of restraints. (536)

E) Staff confirmed education related to PASDs had not been provided to any staff at the home and was not included in the on-line modules for minimizing restraints. The RAI-Coordinator confirmed that education materials were in development; however, had not been implemented to date. The licensee has failed to ensure that training had been provided for all staff who apply PASDs or who monitor residents with PASDs including: application of these PASDs, use of these PASDs, and potential dangers of these PASDs. (107)

(536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 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 5th day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cathie Robitaille

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