Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 23, 2016	2016_431527_0012	019877-16	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

KATHLEEN MILLAR (527), DARIA TRZOS (561), NATASHA JONES (591)

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): July 6, 7, 8, 11, 12, 13, 14, 18, 19, 20, 21 and 22, 2016

The following Critical Incidents and Complaints were inspected concurrently with the Resident Quality Inspection (RQI).

The Critical Incidents included:
Log #032930-15 - alleged staff to resident abuse
Log #001963-16 - fall with injury
Log #010134-16 - alleged volunteer to resident abuse
Log #020339-16 - alleged staff to resident abuse
Log #020340-16 - alleged staff to resident abuse
Log #020502-16 - alleged resident neglect

The Complaints included:
Log #026917-15 - resident fall and transfer to hospital
Log #004051-16 - concerns regarding resident care

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Administrator, the Director of Resident Care (DRC), the Assistant Director of Resident Care (ADRC)/Wound and Skin Care Lead, the Behavioural Support Leader (BSL), the physicians', the Physiotherapist, the Falls Lead, the Resident Assessment Instrument (RAI) Coordinator, the Activities Manager, the Recreation Facilitator, the Pharmacist, the Food Service Manager, the Food Service Supervisor, the Housekeeping Manager, the Social Worker, the Restorative Care staff, the Accounting Manager, Maintenance staff, the registered staff and the personal support workers (PSWs)

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **13 WN(s)**
- **9 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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).

Findings/Faits saillants :

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

Resident #007 returned from the hospital in June, 2016. The progress note on a specific date in June, 2016 indicated the resident was assessed by the Speech Language Pathologist (SLP) and they documented that the resident should continue with their specific diet. The health records were reviewed and indicated that the resident was on a different diet and there were no changes made to the diet before or after admission from the hospital.

Interview with the Registered Dietitian (RD) #125 indicated that they were not aware that the resident was assessed by the SLP. They also indicated that the SLP usually reviews the resident's current diet and if any changes were made they would write an order, contact the doctor, and the nurses would then make a referral to them. The resident's health records indicated that there was no referral made to the RD after the resident was assessed by the SLP.

The RD confirmed that the registered staff should have referred the resident to the RD after the SLP assessment was completed. The Assistant Director of Resident Care (ADRC) and the Resident Assessment Instrument (RAI) Coordinator confirmed that the registered staff should have made a referral to the RD as the assessment conducted by the SLP was not consistent with the resident’s diet specified in the resident's plan of care prior to hospitalization. [s. 6. (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 to ensure that staff and others involved in the different aspects of care of residents', collaborate with each other in their assessments of residents, and their assessments are integrated and consistent with, and complement each other. In addition, to ensure residents' are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the residents' care needs change or care set out in the plan is no longer necessary., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 failed to ensure that when advised by the Family Council 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.

The Family Council advised the home of concerns based on their meeting minutes from September, 2015 and March, 2016. The concerns were not responded to in writing within ten days of the home being advised. The President of the Family Council and the Administrator confirmed that if they don't get the response right away at the Family Council meeting, then a written letter of response was provided in preparation for the next Family Council meeting. The home did not respond in writing within ten days of receiving the Family Council advice related to concerns or recommendations. [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 to ensure that when the Family Council advises 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., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) A review of the home's policy called "Mechanical Lifts and Resident Transfers", number NUR-GM-01, and revised in June, 2016 stated "two staff are required at all times when a mechanical device is used to transfer and/or lift a resident. Residents are never to be left alone in a lift or sling that is attached to any type of lift" and "Annually staff will receive training and education with respect to the use of mechanical lifts; staff are required to demonstrate to the home trainers the safe use of mechanical lifts".

In July, 2016, the Director of Resident Care (DRC) reported to the Long Term Care (LTC) inspector that a critical incident occurred where PSW #159 had left resident #050 in a compromised position for approximately one hour, at the end of their shift, and a

report had been submitted to the Director. The incident was confirmed in written statements by staff involved, and included in the home's investigation notes. PSW #160 also confirmed the incident during an interview with the LTC Inspector #591.

The DRC was interviewed and confirmed that PSW #159 did not comply with the home's above mentioned policy and also confirmed that not all staff had received training in 2015 related to the use of mechanical lifts for resident transfers as per the same policy. (591)

B) The home's policy called "Medication Disposal", policy number 5.8, and revised July, 2014, indicated that medications designated for disposal were compromised of expired drugs, drugs with illegible labels, drugs that were discontinued, drugs that were held or refused, drugs for a deceased resident, or drugs for a discharged resident. (561)

i) In July, 2016, in the medication room on one of the home areas, the LTC Inspector found a medication that did not have a clear label; was previously removed and only few letters of the first name were visible; it appeared as if the wrong label was placed on the box. The ADRC indicated that perhaps the wrong label was placed on the medication and staff removed it. The registered staff #103 was not aware why this specific medication was sitting in the cabinet. The ADRC indicated that this medication should have been disposed of if not used, especially when it was unclear who it was prescribed for and when. (561)

ii) In July, 2016, on another home area,the LTC Inspector found medications that were supposed to be disposed of, but were sitting in the medication cart in the first drawer:

- The specific medication belonged to resident #051. The RPN # 120 indicated that this medication was ordered earlier in July, 2016, for specific period of time and should have been disposed of five days later.
- There was another specific medication, which belonged to resident #047. The RPN #120 indicated that three tablets were sent by pharmacy in a cap; two were administered and one remained. The pharmacy sent these medications in pouches. The remaining one tablet in an ampoule should have been disposed of on a specific date in July, 2016.

The ADRC confirmed that these medications should have been disposed of on the dates that were identified by the registered staff. (561)

C) The home's policy called "Medication Disposal – Controlled Substance/LTCH's", policy number 5.8.1, and revised July, 2014, indicated that the home used a Controlled

Substance Destruction log to be completed at the time the drug was witnessed being placed in the double-locked location designated for controlled drugs awaiting disposal for risk management reasons. The Controlled Substance Destruction log was reviewed for 2016 and found that in February, 2016, two medications were not signed by two registered staff and the quantity was not documented. The medications were recorded. The ADRC confirmed that the staff did not follow the home's policy. (561)

D) The home's policy called "Administering Routine Medications", policy number 4.2, and revised November, 2015, indicated that each individual medication was to be initialled as administered on the Medication Administration Record/Treatment Administration Record (MAR/TAR), in the correct boxes upon administration and before administering the next resident's medication(s).

The medication administration by registered staff #117 was observed in July, 2016 at a specific time of the day The LTC Inspector observed that the registered staff did not always sign the medication upon administration and before administering the next resident's medications. When interviewed, the registered staff #117 indicated that there wasn't always time to document immediately after medications were administered and confirmed that they were signed after the entire medication pass.

The ADRC confirmed that the staff member was not following the home's policy and the College of Nurses Practice Standard. (561)

E) The home's policy called "Post Fall Protocol", number CNS-00-07-13, and revised June, 2016, stated "if head injury possible or fall was unwitnessed, begin Head Injury Routine, see policy #30-04-03".

A review of the policy called "Head Injury Routine – GM", number 60-05-07, and was issued January, 2016, stated " the procedure is to be carried out by the registered staff when a head injury is apparent or suspected including for all unwitnessed falls; monitor and record vital signs i.e.. Blood pressure, temperature, pulse and respirations, pupils and hand grips every fifteen (15) minutes for the first hour; if stable monitor and record hourly signs for the next three (3) hours; if signs remain stable, monitor and record every four hours for the remaining twenty-four hours".

A review of a document called "Documentation process for falls" stated "If unwitnessed you must do HIR; next shift must be aware to continue to monitor and do follow-up progress notes".

The resident's health record was reviewed and the documentation did not include any "Head Injury Routine (HIR)" assessments related to the unwitnessed fall mentioned above for resident #001. A review of a progress note called, "Fall Note", documented by RPN #136 on a specific date in June, 2016, confirmed that the resident had fallen when they went to administer their medication, the resident was questioned and denied that they had hit their head. Furthermore, the health record review revealed RPN #136 completed the following documentation on a different date in June, 2016 related to the fall sustained by resident #001; a "Post Fall Head to Toe Assessment", "Fall Incident Report", "Head to Toe skin assessment", and a "Fall Note".

RPN #102 was interviewed and confirmed that a "Head Injury Routine (HIR)" should be completed for unwitnessed resident falls and confirmed after a review of resident #001's health record, that a HIR assessment had not been completed. The DRC confirmed that RPN #136 did not comply with the home's policies related post-fall assessments. [s. 8. (1) (b)]

Additional Required Actions:

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

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 failed to ensure that all hazardous substances were kept inaccessible to residents at all times.

In July, 2016, during the initial tour of the home the following hazardous substances were found in an unlocked cabinet in the tub/shower rooms:

- On a specific home area a disinfectant cleaner/tub cleaner was found in the bottom cabinet that was unlocked. The RPN #102 indicated that the disinfectant should have been locked in the cabinet.
- On another home area an LD 2000 liquid detergent was found in an unlocked bottom cabinet. PSW #101 and RPN #100 were not sure whether the cabinet should have been locked since the doors to the shower and tub rooms were always locked.

The interview with the DRC confirmed that these hazardous substances should have been locked at all times. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #5: 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: 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. 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.

A) The home's skin and wound care program was inspected and there was no 2015 annual program evaluation in accordance with evidence-based practices, or in accordance with prevailing practices. There was no documentation related to the date of the evaluation, the names of the persons who participated in the evaluation, there was no summary of the changes made, and there was no date that those changes were implemented. The ADRC was interviewed and confirmed that the home did not conduct the annual evaluation of the skin and wound care program in 2015. [s. 30. (1) 1.]

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

A) Resident #041 was identified as having altered skin integrity. The physician ordered treatment to occur every three days, and staff were to document the treatment in the treatment administration record (TAR). The TAR for March, April, May, and June, 2016, were reviewed and identified that the treatment on a specific date in March, April and May, 2016 were not documented by the registered staff. The RPN#120 confirmed that they were expected to document all treatments for the resident in the TAR and this was not done consistently. The ADRC/Wound Care Nurse confirmed that with each treatment the registered staff were expected to sign the TAR as completed. The home did not ensure that resident #041's skin care interventions were documented. (527)

B) Resident #013 had altered skin integrity. The physician's ordered specific treatment for the resident, which was to occur three times weekly and whenever necessary. The TAR was reviewed and indicated that on specific dates in April and May, 2016, the treatment was not documented as completed. The ADRC/Wound Care Nurse confirmed that with each treatment the registered staff were expected to sign the TAR as completed. (561)

C) Resident #007 returned from the hospital in June, 2016. The skin assessment on the Treatment Record: Weekly Assessment Summary (skin care), dated June, 2016, indicated the resident had altered skin integrity in specific areas of their body. The resident's health records were reviewed and no other documentation was found as to what actions were taken. The ADRC/Wound Care Nurse was interviewed and indicated that through their internal investigation they had found that the registered staff who had assessed the resident on a specific date in June, 2016, made an error with the skin assessment. Furthermore, the ADRC/Wound Care Nurse stated that on the next shift the registered staff did not document their re-assessment of the skin and in fact the altered

skin integrity was no longer present. The home failed to ensure that the assessment of the resident’s altered skin integrity was correctly documented and that the re-assessment was documented by the second registered staff. (561)

D) In July, 2016, the Director of Resident Care (DRC) reported to the LTC inspector that a critical incident occurred where PSW #159 had left resident #050 in a compromised position at the end of their shift on a specific date in July, 2016, and a report had been submitted to the Director. The incident was confirmed in written statements by staff involved, and included in the home's investigation notes. PSW #160 also confirmed the incident during an interview with the LTC Inspector #591. The resident's health record was reviewed and revealed that there was no documentation of the incident.

A review of the home’s investigation notes confirmed that RPN #161 and RPN #109 were both present at the time of the incident. RPN #109, who worked that day, was made aware of the incident by PSW #162 and assisted the PSW to toilet the resident, but did not document the incident. RPN #161, who was the on-coming nurse was also made aware of the incident, and did not document it.

The DRC was interviewed and confirmed that it was the home’s expectation that the above mentioned incident, related assessments and resident #050’s responses to the interventions should have been documented in the resident’s health record by the registered staff. [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 a) to 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. 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. 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. 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; and b) to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During the course of the inspection, resident #036 was interviewed, they stated that they received a shower twice weekly, would prefer to have a tub bath, they were not offered a choice, and did not know that they had a choice. A review of resident #036's most recent written plan of care, last revised in June, 2016, did not indicate their preference of a shower or a tub bath. The "Nursing Admission Assessment" form, dated June, 2014 for resident #36 was reviewed and indicated their level of assistance required for bathing; however, the form did not indicate the resident's preference for bathing.

RPN #117 was interviewed and stated that residents who requested to have a tub bath were given one; however, all but one resident on the unit received showers only. They further confirmed that resident #036's choice of bathing was not included in their written plan of care. PSW's #119 and #128 were interviewed and indicated that residents were given a shower twice weekly and as needed; however, if a resident requested a tub bath, they were accommodated. The DRC was interviewed and they stated that it was the home's expectation that residents were offered a choice on admission and their preference added to their written plan of care. The RAI coordinator confirmed that the "Nursing Admission Assessment" form did not include resident preference for bathing. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents' are bathed, at a minimum, twice a week by the method of their choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the residents' hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

In July, 2016, the Director of Resident Care (DRC) reported to the LTC inspector that a critical incident occurred where PSW #159 had left resident #050 in a compromised position at the end of their shift in July, 2016, and a report had been submitted to the Director. The incident was confirmed in written statements by staff involved, and included in the home's investigation notes. PSW #160 also confirmed the incident during an interview with the LTC Inspector #591.

Resident #050 was interviewed and could not recall the incident due to their cognitive impairment. PSW #159 was not available for interview at the time of the inspection. PSW #160 was interviewed and confirmed that they had been working on the evening shift on the day of the above mentioned incident. PSW #160 stated that it was shift change when PSW #159 notified them that they were unable to find assistance to transfer the resident onto the toilet as requested. PSW #160 informed them that they would assist the resident to the toilet with their partner. PSW #160 stated that it was not until after attending report and an in-service that they were informed that the resident had been found by their partner, PSW #162 in their room in a compromised position, and calling out. PSW #160 stated that PSW #159 had not informed them that they had left resident #050 in the compromised position for approximately one hour. There was no harm to resident #050

A review of the home's investigation notes confirmed that PSW #159 admitted in a written statement that they had left resident #050 in a compromised position and was to be toileted by the oncoming staff, and that they did so without the assistance of a second staff member because no one was available. PSW #162 gave a written statement, which indicated that they found the resident in their room in a compromised position, and notified RPN #109 who assisted them to toilet the resident. A review of a document dated July, 2016, indicated that PSW #159 was disciplined.

The DRC was interviewed and confirmed that PSW #159 performed an unsafe transfer of resident #050. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcer, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Resident #013 had ongoing altered skin integrity. The progress notes indicated that in June, 2016, the registered staff documented that the resident's skin treatment was changed and the area was getting worse.

The health care records were reviewed and indicated that there was no follow up documentation as to what actions were taken.The ADRC/Wound & Skin Care Nurse was interviewed and confirmed that the doctor was not notified about the worsening state of the resident's skin condition, and no new treatment was prescribed. The ADRC/Wound & Skin Care Nurse indicated that the registered staff should have notified the doctor to reassess the resident. The licensee failed to ensure that the resident received immediate treatment to promote healing and prevent infection. [s. 50. (2) (b) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcer, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required., to be implemented voluntarily.

WN #9: 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).

Findings/Faits saillants :

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

RPN #123 was interviewed and identified that they were a part time staff member, and confirmed that they had not received training on falls prevention and management in 2015. The RPN further indicated that they had not received falls training since they were hired.

A review of a document called "Surge – Course completion – OANHSS Falls Prevention and Management Training", from January, 2015 to December, 2015, indicated 4.7% of direct care staff had not completed training. The DRC was interviewed and confirmed that not all direct care staff had completed falls prevention and management training in 2015. [s. 221. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that direct care staff are provided training in falls prevention and management, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, 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 when the Residents' Council advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee did not respond to the Residents' Council in writing within 10 days.

The Residents' Council advised the home of concerns and/or suggestions based on their meeting minutes from September, and November, 2015, and June, 2016. The concerns and/or suggestions were not responded to in writing within ten days of the home being advised. The Residents' Council and the Administrator confirmed that if they were not provided with the response right away at the Residents' Council meeting, then a written letter of response was provided at the next meeting. The home did not respond in writing within ten days of receiving the Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration programs included, (e) a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter, and (ii) body mass index and height upon admission and annually thereafter.

The LTC Inspectors identified during stage one of the Resident Quality Inspection (RQI) that many residents in the home had no annual heights completed in their clinical records. The home's policy called "Weight Change - Dietary", number Diet-GM-01-07, and revised May, 2016 directed staff to ensure admission and annual heights of individual residents were recorded. The "Current Weights and Vitals" report was reviewed and it identified the following:

- thirty two (32) residents had no heights documented since 2014;
- seventeen (17) residents had no heights documented since 2013;
- fourteen (14) residents had no heights documented since 2012;
- five (5) residents had no heights documented since 2011;
- four (4) residents had no heights documented since 2010; and
- three (3) residents had no heights documented on admission or annually thereafter.

The RPNs #109 and #112 identified that they were expected to complete annual heights on residents and document in Point Click Care (PCC). The DRC and ADRC confirmed that staff were expected to complete annual heights on all residents and document in PCC. The home did not ensure that all residents had their heights completed and documented annually in their clinical records. [s. 68. (2) (e) (ii)]

WN #12: 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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, procedures were implemented for (b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices: (i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs.

In July, 2016, during the initial tour of the home, the LTC Inspector observed on a specific unit in the shower room, a sit to stand mechanical lift that had a dirty base. The lift was also observed several weeks later in July, 2016 and the base of the lift continued to be dirty. The PSW #114 indicated that it was the responsibility of the evening staff on the weekend to clean the lifts. The lifts were to be cleaned every Sunday and the PSW responsible for cleaning the lifts was to sign the schedule once the equipment was cleaned. The cleaning schedule was provided to the LTC Inspector and it identified that the PSWs did not sign that the mechanical lifts or any other equipment were cleaned for the month of July 2016.The DRC was interviewed and indicated that the cleaning of lifts was part of the PSWs job description, there was a schedule on each floor for cleaning the lifts, and the PSWs were expected to sign off on the sheet when the mechanical lifts and other resident equipment was cleaned. [s. 87. (2) (b)]

WN #13: 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 drugs were stored in an area or a medication cart, i. that was used exclusively for drugs and drug-related supplies, and iv. that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

A) On a specific date in July, 2016 on an identified home area, the LTC Inspector found resident jewellery and money in the narcotic bin in the medication cart along with the controlled substances. The RPN #120 confirmed that these items should not be stored in the narcotic bin. The ADRC was interviewed and also confirmed the same.

B) On another specific date in July, 2016, the LTC Inspector observed the medication room on an identified home area and there were several medications found expired in the cabinet where the home stored government stock:

- one bottle of medication, which expired in April 2016; and
- there was another bottle of medication, which expired in June, 2016.

The ADRC was interviewed and confirmed that these medications should have been disposed of when expired. [s. 129. (1) (a)]

Issued on this 28th day of September, 2016

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

Original report signed by the inspector.