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
Feb 13, 2015	2015_250511_0001	T-000110-14	Resident Quality Inspection

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF HUMBER HEIGHTS
2245 Lawrence Avenue West ETOBICOKE ON M9P 3W3

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

ROBIN MACKIE (511), KATHLEEN MILLAR (527), KELLY HAYES (583)

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): January 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, and 19, 2015

The following mandatory reports #T-1145-14, T-1135-14, and #T-000200-14 were completed with this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with General Manager Assistant (GMA), Director of Care (DOC), Assistant Director of Care (ADOC), Director of Recreation, Director of Food Services, Director of Environmental Services, Registered Dietician (RD), Neighbourhood Coordinators, RAI Coordinator, Physiotherapist, PAL Kineslologist, registered staff including Registered Nurse (RN) and Registered Practical Nurse (RPN), Personal Support Worker (PSW), kitchen staff, recreation staff, housekeeping staff, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
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
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

29 WN(s)
7 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

On January 12, 2015, the home's Maglocks, a system which utilized a touch keypad and code to release the locking mechanism of doors, malfunctioned allowing residents access to stairways and the outside of the home. The home had six Resident Home Areas (RHAS's), three of which were considered by the home to be secured units, with 32 residents living on each RHA. The home's secured RHA's were described by the home as having residents with high cognitive impairment and potential elopement risks. These units were identified as: Lampton (first floor), Brule (second floor) and Alderwood (third floor). The GMA became aware of the potential safety risk at 0730 hours and posted signs on the doors leading to stairwells, at 0815 hours, that requested the staff to maintain extra vigilance and care at the doors. The home's plan, as stated by the GMA, was to have the assigned staff on duty supervise and ensure resident's did not have access to the stairwells.

A) At 1100 hours, the Ministry of Health Long Term Care (MOHLTC) Inspector observed unsupervised and unlocked doors leading to the stairwell on the Alderwood Unit. Two PSW's were observed to be in a resident's room with the door closed. They stated they were aware the doors to the stairwells were unsecured and unlocked but they could not watch the doors and provide care to the resident at the same time. The PSW's confirmed they had left the doors unsupervised when they went to provide assistance to a resident.

B) The Lampton unit was observed at 1150 hours to have two stairwells unsupervised and unlocked which allowed residents potential access to the stairwell and outside. The temperature outside was -1 degree Celsius and snowing.

C) The Brule unit was observed at 1150 hours to have one of the stairwells unsupervised and unlocked.

D) A second observation of the Alderwood unit, at 1150 hours, revealed the door to one stairwell to remain unsupervised and unlocked which allowed residents to access the stairs. Interview with the registered staff indicated a volunteer had been supervising the door but had left the door unsupervised when they went to porter residents to the dining room.

Interview with the GMA confirmed the home would call in extra staff and that the unsupervised and unlocked doors to the stairwells/outside posed a significant risk to the residents and did not ensure a safe and secure environment. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that if there is a malfunction in the locking mechanism of the home's secured doors the home will develop and enforce a contingency plan that provides for a safe and secure environment for its resident, to be implemented voluntarily.

WN #2: 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).

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

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

A) A review of the plan of care for resident #027 indicated they were at moderate nutrition risk and required a specified number of calories and a specified number of milliliters of fluid daily to meet their estimated nutritional needs. During the full assessment observation period in October 2014 resident #027's nutrition and hydration flow sheet assessment indicated the resident refused their lunch, seven out of twelve times and consumed less than the specified milliliters of fluid daily, eight out of twelve times. The nutritional risk screen - quarterly assessment, completed in October 2014 indicated resident #027 consumed greater than 75 percent of all meals and consumed 900 to 1400 milliliters of fluids daily. In an interview with the Registered Dietitian in January 2014 it was verified that the nutritional risk screen - quarterly assessment was conducted during the observation period in October 2014 and confirmed that the two assessments of resident #027 were not consistent and did not complement each other.

(B) A review of the plan of care for resident #029, completed in January 2015, indicated they received range of motion exercises facilitated by physiotherapy to relieve stiffness and to prevent contractures. The plan of care was updated in October 2014 after completion of resident #029's annual assessment. In an assessment by the Kinesiologist, completed in September 2014 resident #029 was discharged from the Program of Active Living (PAL) which included range of motion exercises. In an interview with the Physiotherapist and Kinesiologist in November 2014 it was verified that their department had not provided range of motion services during resident #029's annual assessment period in October 2014. The Kinesiologist and Physiotherapist confirmed there had not been collaboration with staff in the assessment of the resident so that their assessments were integrated, consistent and complemented each other. [s. 6. (4) (a)]

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

A review of the plan of care for resident #029, updated in October 2014, directed staff to complete a full body skin assessment at a minimum of weekly on the resident's bath day. An assessment completed by registered nursing staff in December 2014 indicated resident #029 was at a high risk for skin breakdown and an area of the resident's skin was currently red. A review of the personal care and observation and monitoring forms, section G. bath from December to January 2015, showed there were no documented skin assessments completed on resident #029's bath days. In an interview with resident #029 in January 2015 they shared they were not bathed two times per week as per their preference. A review of the clinical record, completed by the RAI Coordinator, confirmed

there were no skin assessments completed or documented as per the plan of care. [s. 6. (7)]

3. The licensee failed to ensure that the following were documented: 1. The provision of the care set out in the plan of care.

The plan of care, dated in December 2014 for resident #031, identified the resident required to be turned and repositioned. As a result of the resident's medical conditions and assessment, completed in December 2014, the resident was required to be turned and repositioned every two hours and staff were to document on the repositioning monitoring form in the PSW binder. The PSWs were interviewed and confirmed the resident required turning and repositioning and they were to document in the flow sheet in the PSW binder. When reviewing the resident's flow sheet for turning and repositioning there was inconsistencies in the documentation. [s. 6. (9) 1.]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs changed or care set out in the plan was no longer necessary; or (c) care set out in the plan had not been effective.

Resident #100 was capable of making decision related to their care needs. The resident's care had changed; was no longer necessary; or the care set out in the plan was not effective to meet the resident's needs.

A) The resident requested that volunteers were not to visit them in the week. The home discontinued the volunteers on August 2014.

B) The plan of care dated in December 2014 identified that no one was to enter resident #100's room before knocking and waiting for their reply, whether staff needed to see them or their roommate. Resident #100 was in a private room and had no roommate.

C) The plan of care dated in December 2014 identified that the resident was to receive ongoing visits from the Behavioural Support Ontario (BSO) for assessments; however in August 2014 the home had reassured the resident that they would cancel the BSO visits and would not initiate them again unless they had the resident's consent.

D) The home established a standard in January 2015 that staff were to respond to the resident's call bell within a specified time; however the expectations were not identified

on the plan of care.

The DOC, the Neighbourhood Coordinator, the registered staff and the PSWs confirmed the revisions to the plan of care were not made when the resident's care needs changed, when care set out in the plan was no longer necessary, or when care set out in the plan had not been effective. [s. 6. (10)]

5. The licensee failed to ensure that when a resident was reassessed and the plan of care reviewed and revised because care set out in the plan had not been effective, the licensee shall ensure that different approaches were considered in the revision of the plan of care.

Resident #015 had a number of falls in 2014 and 2015. A review of the resident's plan of care in October 2014 indicated the resident had a history of falls and interventions included a fall mat, lipped mattress and a high low bed. The resident had some of the falls from their bed and the other falls were noted to be from their wheelchair. Some of the falls from the wheelchair resulted in injury to the resident. The last fall in January 2015 resulted in a transfer to hospital for further assessment. Interview with the PAL (Program for Active Living) Kinesiologist, who was the lead for the Falls program, confirmed the home was aware in August 2014 that the wheelchair was not the right size and fit for the resident and may have contributed to the resident falls. Interview with the Kinesiologist confirmed the most recent plan of care contained a focus related to the ongoing falls but did not include different approaches/interventions to address the resident's continued risk of falling from their chair. [s. 6. (11) (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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, 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 where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

A) The home's policy, "Fall Prevention and Management" (LTC) dated February 2013 stated a resident who was at a high risk for falls or who frequently fell would be communicated to the Team. This could be done by using a 'falling leaf' or 'falling star' logo on the spine of the resident's chart as well as in the resident's room alongside their transfer logo. The policy also indicated the PAL Kinesiologist would be responsible for tracking all falls that occurred and would create a monthly report to be provided to management. Resident #015 had been identified as a risk for falls and observation of the resident's room and spine of the chart did not indicate a falling leaf or star. Interview with the registered staff confirmed they did not use a falling leaf or star program and there was nothing visible on the floor for resident #015 that would indicate they were at a risk for falls. Interview with the PAL Kinesiologist confirmed they were unaware of the 'falling leaf' or 'falling star' logo and this was not implemented in the home. The PAL Kinesiologist stated they tracked the falls monthly through a Risk Management Falls report. A report for October and November 2014 were provided and the PAL Kinesiologist indicated there were no monthly reports for September or December 2014. Interview with the DOC confirmed the licensee had not complied with the home's Falls Prevention and Management policy.

B) The home's policy and procedure, called "CON Standards Re: Delegation of Duties" #02-04, dated January 2013 was not complied with by the staff. The registered staff and the PSWs confirmed they applied medicated topicals that were ordered by the Physician for residents when they provided skin care after the resident bath. The PSWs were unaware that the registered staff were required by policy to observe them complete the task satisfactorily and sign off on a declaration that they had taught the PSW the task and were competent to perform the task.

The DOC and registered staff confirmed they did not comply with their home's policies and procedures related to the delegation of duties to an unregulated caregiver.(527) [s. 8. (1) (a),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 the home's Fall Prevention and Management plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #4: 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 was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps were 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 were addressed, including height and latch reliability.

Resident #032 was observed to have bed rails used on their bed system during the RQI. A review of the clinical records for resident #032 indicated the resident had the bed rails raised when the resident was in bed. An interview with the RPN indicated the bed rails were raised when the resident was in bed. A review of the home's Facility Entrapment Inspection Sheet, completed November 13-14, 2014, indicated resident #032's bed system had been assessed and identified with potential zones of entrapment. Interview with the DOC confirmed the resident had not been assessed, nor steps taken to prevent resident entrapment in accordance with evidence-based practices and if there were none, in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (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 to ensure that where bed rails are used, (a) the residents are 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; (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, to be implemented voluntarily.

WN #5: 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, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

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 each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A) A review of the December 2014 Minimum Data Set (MDS) Full Assessment, for resident #032, indicated they were frequently incontinent of their bladder. Further review could not confirm an assessment was completed that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. Interview with the DOC confirmed the home did not ensure resident #032 received an assessment, using a clinically appropriate assessment instrument that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

B) A review of the December 2014 Minimum Data Set (MDS) Full Assessment, for resident #033, indicated they were frequently incontinent of the bladder. Further review could not confirm an assessment was completed that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. Interview with the DOC confirmed the home did not ensure resident #032

received an assessment, that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.(511)

C) The MDS assessment for resident #011, during October and November 2014, identified no change in their urinary incontinence from one quarter to the next quarterly MDS assessment; however the Resident Assessment Protocol (RAP) from November 2014 identified that the resident's frequency of urinary incontinence had increased and the resident's incontinence product changed. There was no "Admission & Quarterly Bowel and Bladder Assessment" completed as directed in the home's Continence policy, #04-29 dated January 2013. The registered staff and the Resident Assessment Instrument (RAI) Coordinator confirmed the resident's urinary incontinence had increased in frequency, which required a change in product, and there was no assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. (527)

D) A review of the plan of care for resident #029 showed they had a cognitive performance score of one, were able to make their needs and ideas known and were incontinent of bowel and bladder. In an interview with resident #029, on a day in January 2015, they shared they had requested on multiple occasions to be toileted when they had an urge to have a bowel movement but were directed to use their incontinent product. The plan of care directed staff to provide total assistance with continence care in bed by two staff members. In an interview with non-registered staff it was confirmed the resident was directed to have bladder and bowel movements in bed. Resident #029 was changed from frequently incontinent to incontinent in October 2014. A review of the MDS quarterly bowel and bladder assessment form, completed in July 2014 and October 2014, showed no change. During a review of the Continence policy 04-29, January 2013 it was identified a full continence assessment included using the a) RAI MDS admissions and quarterly bowel and bladder assessment form b) a detailed three day voiding and bowel elimination record of all continent and incontinent episodes c) resident and multidisciplinary discussion to create a plan of action and individualized care plan. In an interview with the RAI Coordinator, on January 12, 2015, it was confirmed that resident #029's continence needs changed in October 2014 and there was no assessment by the home that used a clinically appropriate assessment instrument that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.(583) [s. 51. (2) (a)]

2. The licensee has failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based

on the assessment.

Resident #032 was determined to be frequently incontinent daily, with some control present of their bladder, as documented in the December 2014 MDS assessment (continence in the last 14 day). According to the clinical record, the resident had a CPS of two, was able to direct staff when they had to go to the toilet, had anger towards the night staff when they tried to hurry them for toileting, and requested they give them more time. A review of the resident's most recent plan of care did not identify an individualized plan for toileting of the resident. Interview with the PSW, that provided care to resident #032 on the day shift, stated the resident was toileted based on the home's schedule for toileting all residents, which was after breakfast and before lunch. The PSW stated that when they toileted the resident at these times the resident would void on the toilet but had often already been incontinent in their brief. Interview with the RPN confirmed resident #032 was toileted on a home schedule, which included after breakfast and before lunch and not on an individualized plan of care to promote and manage bowel and bladder continence based on an assessment. [s. 51. (2) (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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #6: 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: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the dining and snack service times were reviewed by the Residents' Council.

In an interview with the most recent president of Residents' Council on January 15, 2015 it was shared that the Residents' Council did not review the meal and snack times in 2014. In an interview with the Residents' Council assistant and the Director of Food Service it was confirmed that dining and snack service times were not reviewed by the Residents' Council. [s. 73. (1) 2.]

2. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements: 4. Monitoring of all residents during meals.

On observation on Alderwood Unit, at 1100 hours, two residents were observed to be sitting unsupervised in front of their plate of food and drink. The two residents were

identified as having some level of cognitive impairment and remained unsupervised for greater than 15 minutes until being brought to the attention of the PSW's by the MOHLTC Inspector. Two PSW's interviewed stated the home's expectation was that the residents were not to be left unattended during their meal. Interview with the RPN on the floor confirmed the home did not ensure the residents were monitored during their meal. [s. 73. (1) 4.]

3. The licensee failed to ensure that course by course service was provided for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

During an observation of the lunch service on the Lampton unit on January 5, 2015 the dessert course was not served until all residents in the dining room received their main entree. Lunch service began at 1200 hours and at 1225 hours greater than 75 percent of the residents in the dining room had finished their main entree. Dessert service began at 1250 hours at which time four residents had left the dining room prior to being offered dessert. In an interview with the Director of Food Service on January 9, 2014 it was confirmed that the residents were not served course by course as dessert was not provided to residents when they finished their main entree. [s. 73. (1) 8.]

4. The licensee failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

During an observation of lunch service on January 5, 2015, on the Lampton unit, four residents that required full feeding assistance were served their meal when staff were not present to feed them. Resident #503 had a bowl of soup placed at their table setting for greater than 30 minutes and a dessert for greater than 10 minutes with no staff present to feed the resident. Resident #017 had a bowl of soup placed at their table setting for greater than 10 minutes with no staff present to feed the resident. Resident #502 had a main entrée placed at their table setting for greater than 10 minutes with no staff present to feed the resident. Resident #501 had a dessert placed at their table setting for greater than 10 minutes with no staff present to feed the resident. In an interview with the registered nursing staff at 1230 hours, and non-registered nursing staff at 1250 hours, it was verified that residents #017, #501, #502, #503 required total feeding assistance. A review of the diet binder located at the serving table also confirmed the residents required total feeding assistance. In an interview with the registered nursing staff on January 5, 2015 it was confirmed residents who required full feeding assistance were served lunch when staff were not available to provide assistance. In an interview with

the Director of Food Service on January 9, 2015 it was confirmed that the expectation was that residents who required assistance were not to be served until staff were available to feed the resident. [s. 73. (2) (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 residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance, to be implemented voluntarily.

WN #7: 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 hazardous substances were labeled properly and kept inaccessible to residents at all times.

A) On January 7, 2015 on the Alderwood unit, the Spa room door was noted to be propped open with a door wedge. On further inspection a container labeled Arjo Disinfectant Cleanser 1V was accessible to the residents. This disinfectant's Workplace Hazardous Materials Information System (WHMIS) label identified the product as poisonous and corrosive. Interview with the RPN on duty confirmed the substance was hazardous to the residents and the Spa door was to be kept locked. (511)

B) On January 5, 2015 the Spa room on the Brule secured unit, where cognitively impaired residents reside, was unlocked and open. A container of Virex Disinfectant solution was sitting on the shelf when the MOHLTC Inspector entered the room. The Workplace Hazardous Materials Information System (WHMIS) label identified the solution as a hazardous substance. The housekeeper and the PSWs confirmed the disinfectant should not have been left in an unlocked room that was accessible to residents.(527) [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 hazardous substances are labeled properly and kept inaccessible to residents at all times, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the following rights of residents were fully respected and promoted: 8. Every resident had the right to be afforded privacy in treatment and in caring for his or her personal needs.

On a day in January 2015 at 1210 hours resident #031 was sitting at the dining room table awaiting lunch. The LTC Inspector observed the RPN completing a nursing treatment while the resident was sitting at the dining room table. The RPN did not ask the resident if they would prefer to have their treatment in a private location. The RPN and DOC confirmed the expectation was to offer privacy when providing care and treatment to a resident. [s. 3. (1) 8.]

2. The licensee failed to ensure every resident had his or her choices respected.

In an interview with resident #029 on two separate days in January 2015, with the RAI Coordinator present for observation, resident #029 stated a) they were not routinely dressed in their personal clothing as per their preference, b) they ate meals in bed but their preference on most occasions was to eat in the dining room and c) they had bladder and bowel movements in their incontinence product but their preference was to be toileted. A review of the plan of care indicated resident #029 had a cognitive performance scale score of one and was able to make their needs and ideas known. The plan of care did not indicate that resident #029 was not to be dressed in their personal clothing or that they ate meals in their room. The plan of care did direct staff to provide incontinence care in bed. During an interview with resident #029 on January 13, 2015 they shared they used the call bell and requested to be toileted for bowel movement and were directed by staff to use their incontinence product. In an interview with the RAI Coordinator on a day in January 2015 it was confirmed that resident #029 was changed from frequently incontinent to incontinent in October 2014. Resident #029 was observed in bed on multiple observation days in January 2015 between the hours of 0930 hours and 1400 hours wearing a hospital gown. A review of the repositioning record documents indicated resident #029 spent the day in bed on identified days in January 2015. In an interview with resident #029 on a day in January 2015, with the RAI Coordinator present for observation, resident #029 shared they were not given the choice of a) how to dress b) where to eat meals and c) where to toilet. In an interview with the RAI Coordinator on a day in January 2015 it was confirmed that resident #029's rights of choice were not promoted or respected. [s. 3. (1) 19.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rules were complied with: 1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, i. kept closed and locked.

On January 12, 2015 at 1000 hours it was observed that the doors leading to stairways on all three floors were not locked. Interview with the General Manager Assistant (GMA) confirmed the home's Maglock system, which was used to lock and secure the doors, had stopped working at 0730 hours. Interview with the Director of Environmental Services confirmed the doors leading to stairways and the outside of the home were not locked from 0730 hours to approximately 1900 hours on January 12, 2015. [s. 9. (1) 1.]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's, furnishings and equipment were kept clean and sanitary.

On January 5, 9 and 14, 2015 the Ministry of Health Long Term Care (MOHLTC) Inspector toured the home and the following were observed:

A) In the Spa rooms on the first, second and third floors of the home, the light brown wooden cabinets and small dark brown cabinets were not clean.

B) Wall paper had brown stains, along with bluish carpet stains in the hallways, on all the resident units.

C) There was a soiled and unclean bed pan and commode container on the floor of the Spa room.

D) The Spa room floor was stained in multiple places on the Weston unit.

E) The resident weigh scales in the Spa rooms were unclean and rusty.

F) The Spa room on the Brule unit, which contained the Parker bath tub had toilet paper ripped in pieces in the tub and toilet paper on the shelf beside the bath tub had brown stains.

G) The Hairdressing Salon had hairdressing equipment which was unclean and visibly dirty. The hairdresser stated that the salon had not been cleaned since early December 2014.

The General Manager Assistant (GMA) and the Director of Environmental Services toured the home with the LTC Inspector on January 14, 2015 and confirmed the resident areas were not clean and sanitary. [s. 15. (2) (a)]

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

On January 5, 9 and 14, 2015 the following items and areas were observed by the MOHLTC Inspector throughout the home.

A) The walls had areas of damage on the drywall throughout the home, in resident rooms and in the activity rooms on the six resident units.

B) The tiles were cracked or broken in all Spa rooms on each resident unit.

C) The Diverter plate in the shower areas were loose.

D) The bath tub on the Islington unit had several large chips in the plastic.

E) The privacy curtains in the six Spa room were off a number of the hooks and when pulled across, they did not provide 100% coverage for resident privacy.

F) The carpets throughout the resident units were stained and in some places ripped causing a trip hazard for residents. The wall paper was ripped in a number of places throughout the units.

[redacted] RM

[redacted] RM

The GMA and the Director of Environmental Services toured the home with the LTC Inspector on January 14, 2015 and confirmed the home needs repairs to ensure it is in safe condition for residents. [s. 15. (2) (c)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Resident #100 had complained to the home on a day in 2014 that they heard staff speaking about them in a derogatory way. On another specifed day in 2014 the resident had complained to the home that they had sustained an injury when they were being rushed to the washroom by staff. The resident called the Police because they felt they were being physically abused. On another specified day in 2014 the home was notified by the resident that a PSW was abusive to them. The resident informed the home that the PSW was not listening to them and became argumentative. On another specified day in 2014 the resident informed the home that the PSW had poured water on their chest and during the same week poured the urinal in their groin area. The resident also informed the home that they didn't feel safe.

When the MOHLTC Inspector interviewed resident #100 in January 2015 the resident notified the inspector of the allegations of verbal and physical abuse on the specified dates as above in 2014. The Neighbourhood Coordinator confirmed that they were aware of the abuse allegations. The registered staff and PSWs confirmed the abuse allegations the resident had made regarding their care and stated the resident complained frequently. A review of the home's Critical Incident log identified that no critical incidents were documented and no mandatory reporting to the Director was completed. The GMA and DOC confirmed they had not reported the allegations of abuse to the Director. [s. 24. (1)]

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:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of the following with respect to the resident: 18. Special treatments and interventions.

A) Resident #028 was observed to have contractures that were documented to cause them difficulty with their ADL's and bed mobility. Interview with the RPN and a PSW in January 2015, who provided care to the resident, stated the resident may have received a medical treatment in the last month to help with the contractures. The RPN and PSW could not confirm if the medical treatment was completed, on what day the medical treatment was provided and what side effects or interventions were required after the treatment. Interview with the Physiotherapist indicated they were unaware if the resident received the medical treatment. A review of the clinical record revealed a Consent for the medical treatment, signed by the POA, on file. The DOC confirmed there were no interdisciplinary assessments documented in the plan of care for the resident's special treatment and interventions related to the prescribed medical treatment.(511)

B) Resident #011 was observed with a contracture. The resident did not have a splint and during a 14 day period in 2015 the resident did not receive range of motion exercises. When reviewing the resident's clinical record there were no interdisciplinary assessments noted for the resident's contracture. When the registered staff, Physiotherapist (PT) and Kinesiologist were interviewed, they confirmed the resident did not have a splint and there was no range of motion exercises conducted. The registered staff, PT and Kinesiologist confirmed there were no interdisciplinary assessments completed for this resident since 2011.(527) [s. 26. (3) 18.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied: 4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #003 was observed to be in a tilt wheelchair, in the reclined position, with both legs elevated on foot rests. Review of the clinical record identified the resident's medical condition prevented the resident from rising from the wheelchair and the tilt chair was used for repositioning purposes and comfort measures. The resident's cognitive status prevented the resident from consenting to the use of the PASD and there was no consent from the substitute decision-maker for the resident on file. Interview with the RAI Coordinator confirmed the home's consent form for use of PASD's was not completed. [s. 33. (4) 4.]

WN #14: 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 residents were bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths.

In an interview with resident #029, on a day in January 2015, with the RAI Coordinator present for observation, resident #029 shared it was their preference to receive a shower two times per week but had not received showers and was not being offered a choice. A review of the care plan and personal care profile indicated resident #029 had a Cognitive Performance Scale(CPS) score of one, was able to make their needs and ideas known, and was to receive showers two times per week with two staff members to provide total assistance. A review of the the personal care observation and monitoring form section G, bath, from December to January 2015, indicated resident #029 received one bed bath on a specific day in January 2015. A review of the repositioning record documentation from December to January 2015 indicated resident #029 was in bed during scheduled bath times. In an interview with the registered nursing staff on a day in January 2015, it was confirmed that resident #029 was not bathed at a minimum of twice per week by a method of his preference. [s. 33. (1)]

WN #15: 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 the resident was dressed appropriately, suitable for the time of day and in accordance with their preferences.

Resident #029 was observed in bed, wearing hospital clothing, on several days in January during day time hours. A review of the care plan updated in October 2014 indicated resident #029 had a CPS score of one, required extensive to total assistance with dressing, could make their needs an ideas known and was to be asked what they wanted to wear. In an interview with resident #029 on a day in January 2014, with the RAI coordinator present for observation, resident #029 shared it was their preference to wear their own clothing during the day and they had not been given the choice to be dressed. In an interview with the RAI Coordinator if was confirmed that the plan of care from September 1 to January 13, 2015 did not indicate why resident #029 should be clothed during the day in hospital clothing and that resident #029 was not dressed in accordance with their preference. [s. 40.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of the clinical record for resident #015 identified they had several falls since September 2014. Interview with the RAI Coordinator confirmed each of the falls required a post falls assessment to be completed within 24 hours of the fall. The RAI Coordinator located some post falls assessments for the falls and confirmed six post falls assessment's were not completed using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

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

Resident #011 was identified as having persistent redness on an area of their skin and after the assessment by the Physician, the resident was ordered a topical ointment to be applied throughout the day, re-positioning every two hours and toileting more frequently. The registered staff on the day and evening shift identified they were to complete a weekly assessment using the Wound Assessment Tool. A review of the resident's clinical record indicated there was no weekly wound assessment using the clinically appropriate assessment instrument. The registered staff and the RAI Coordinator confirmed there was no weekly assessment conducted using the clinically appropriate assessment tool. [s. 50. (2) (b) (i)]

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 a response was provided in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Residents' Council meeting minutes and "The Village of Humber Heights Resident's Council Concern/Comment Form" indicated the licensee responded to Resident's Council advise 37 days after the August 21, 2014 meeting and 15 days after the October 15, 2014 meeting. In an interview with the Resident's Council assistant, on January 15, 2015 it was confirmed that the licensee did not respond in writing within 10 days of receiving the Resident's Council concerns or recommendations. [s. 57. (2)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident received on-site physiotherapy service on an individualized basis or in a group setting based on his/her assessed care needs.

Resident #011 had a hemiparesis related to their medical history. The MOH LTC Inspector observed the resident with a contracture. The resident did not have a splint in place and when the health record was reviewed, there were no assessments by Physiotherapy or Kinesiology. The DOC confirmed the resident was not a candidate for a specific medical treatment, to address the contracture, based on the Physician's assessment. The resident did not receive any active or passive range of motion exercises. The Physiotherapist and Kinesiologist confirmed the resident was not assessed in the past year to determine what their care needs were. [s. 59. (a)]

WN #20: 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,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the menu cycle was reviewed by the Residents' Council.

In an interview with the most recent president of Residents' Council on January 15, 2015 it was shared that the Residents' Council had not reviewed any of the cycle menus. In an interview with the Residents' Council assistant and the Director of Food Service it was confirmed that the menu cycles for spring/summer and fall/winter 2014/2015 were not reviewed by the Residents' Council. [s. 71. (1) (f)]

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff received retraining annually relating to the following:
A) The Residents' Bill of Rights,
B) The home's policy to promote zero tolerance of abuse and neglect of residents,
C) The duty to make mandatory reports under section 24, and
D) The whistle-blowing protections.

A Review of the home's policy titled Prevention of Abuse in Long Term Care, policy #04-06 and dated January 2015 identified that all team members would receive annual training on topics including, but not limited to the Residents' Bill of Rights; the policy to promote zero tolerance of abuse and neglect of residents; power imbalances; the serious nature of abuse; mandatory reporting; and whistleblowing.

Resident #100 had informed the home of four incidents were they alleged verbal or physical abuse in 2014. None of these allegations of abuse were immediately reported to the Director under Section 24 of the Act, which required a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff had occurred or may occur to immediately report the suspicion and the information upon which it is based to the Director.
Interviews with the Neighbourhood Coordinator, the DOC and the GMA confirmed the alleged abuse incidents, of resident #100, were immediately reported to the Director as per Section 24 and the home's policy. A record review revealed that 5% of all staff had not received training in mandatory reporting in 2014. The DOC and GMA confirmed that not all staff had completed their mandatory training. [s. 76. (4)]

WN #22: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that they sought advice of Residents' Council in developing and carrying out the satisfaction survey.

A review of the 2014 Residents' Council meeting minutes was done and indicated the licensee did not seek Residents' Council's advice in the development and carrying out of the satisfaction survey. In an interview with the Residents' Council assistant it was confirmed that the licensee did not seek out the Residents' Council advice in the developing and carrying out of the satisfaction survey. [s. 85. (3)]

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

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

The home's annual program evaluation was reviewed and there was no evaluation to determine the effectiveness of the policy to promote zero tolerance of abuse and neglect of residents and what changes and improvements were required to prevent further occurrences. The home was issued non-compliance on July 16, 2014 as a result of their Prevention of Abuse in Long Term Care policy, revised November 2013, not being in accordance with the Act. The home was requested to prepare a written plan of correction for achieving compliance to ensure their policy was in compliance. Review of the home's annual program evaluation for 2013, which was completed on February 20, 2014, identified that there was no evaluation of the home's policy. In the section of the Annual Program Evaluation called Prevention of Abuse, the only documentation included was: "There has been no incidence of abuse reported in 2013". Interview with the DOC confirmed that the Licensee was addressing the policy non-compliance and any suggestions made by individual home's would be provided to corporate for the annual policy review. [s. 99. (b)]

WN #24: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with the conditions to which the Licence was subject.

The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN), under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument -Minimum Data Set) system.
Each resident's care and service needs shall be reassessed using the MDS 2.0 Quarterly

or Full Assessment by the interdisciplinary team within 92 days of the ARD of the previous assessment and will ensure that RAI-MDS tools are used correctly to produce an accurate assessment of the Health Care Service Provider's (HSP) residents (RAI-MDS Data) – 8.1(c)(ii)
Any significant change in a resident's condition, either decline or improvement, shall be reassessed along with RAPs by the interdisciplinary care team using the MDS Full Assessment by the 14th day following the determination that a significant change in status has occurred.
Criteria for determining a significant change in status is identified in the Resident Assessment Instrument (RAI) MDS 2.0 and RAPs Canadian Version User's Manual, Second Edition, March 2005, pp 3-7, 3-8, 3-9. A "significant change" is defined as a major change in the resident's health status that:
• Is not self-limiting
• Impacts on more than one area of the resident's health status; and
• Required interdisciplinary review and/or revision of the care plan.

The home did not meet the criteria for determining a significant change in the status of the following resident and did not use the RAI-MDS tool correctly to produce an accurate assessment of the Health Care Service Provider's (HSP) residents (RAI-MDS Data) – 8.1(c)(ii):

An MDS review of the most recent 2014 quarterly, under Section I (Disease Diagnoses) and I2 (Infections), identified resident #003 with a specific diagnoses. There was no RAP (Resident Assessment Protocol), progress note or care plan update to address the concern of this diagnoses.
Interview with the RAI Coordinator confirmed resident #003 had the same diagnosis 2010 and had not had this disease diagnoses in the past two years. The RAI Coordinator stated the training and practice of the home's RAI coordinators were to carry over the original diagnosis in 2010 and other infections (e.g Urinary track infections) from year to year and quarter to quarter on all residents.
In consultation with the Clinical Specialist, Home and Continuing Care Canadian Institute for Health Information (CIHI) it was confirmed, as outlined in the RAI Manual in the intent for Section I (Disease Diagnoses) and I2 (Infections), the licensee would only include conditions that drive the current care plan. They would not include conditions that have been resolved or no longer affect the resident's functioning or care plan. Interview with the DOC confirmed that for resident #003, after the disease diagnoses in 2010 had resolved and after treatment and symptoms subsided, the assessor should not have captured the same disease diagnoses of 2010 on subsequent assessments and in doing

so, the licensee did not use the RAI-MDS tool correctly to produce an accurate assessment of the resident. [s. 101. (4)]

WN #25: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): Subject to subsection (3.1), 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 the resident's health condition.

A review of the clinical records for resident #301 confirmed the resident was able to weight bear, walk with their walker short distances and transfer with one person assistance prior to a fall on December 14, 2013. The resident was transferred to hospital on December 14, 2013 and returned later the same day with a diagnosis of a fracture. On return to the home, resident #301 was unable to weight bear for 6-8 weeks and required the use of a mechanical lift for transfer. The Director was notified on January 8, 2014, 24 days after the resident's fall, as identified on the Ministry of Health and Long Term Care Critical Incident Report. Interview with the DOC confirmed the fall resulted in an injury to the resident for which the resident was taken to the hospital and that resulted in a significant change in the resident's health condition. The DOC confirmed the home had not reported to the Director as required. [s. 107. (3.1) (b)]

WN #26: 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. (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:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated 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 eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: 6. That the resident's condition was reassessed and the effectiveness of the restraining evaluated 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 eight hours, and at any other time when necessary based on the resident's condition or circumstances.

A review of the clinical records for resident #003 indicated the resident had a consent for a restraint for bed rails, signed by the POA in 2012, that were to be applied when the resident was in bed. Observation of the resident's bed system confirmed the type and position of the bed rails were changed and a fall mat was placed at the side of the bed. Interview with a PSW confirmed the rails were placed in the raised position when the resident was in bed. A physiotherapy assessment confirmed the resident was unable to use the bed rails as a PASD as they were unable to grasp the rails by their hands due to to their physical and medical condition. A review of the multidisciplinary annual care conference in 2012 stated the restraint consent for the bed rails was signed at the request of the family. There were no further clinical records that indicated an assessment or reassessment of the effectiveness of the bed rails as a restraint, or if the change in size and location of the bed rails reduced its retraining effect, was completed since 2012. Interview with the RAI Coordinator indicated the resident's condition or circumstances had changed over the past few years and confirmed a reassessment of the effectiveness of the bed rails had not been completed. [s. 110. (2) 6.]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

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

On a day in January 2015, at 1200 and 1625 hours, the MOH LTC Inspector observed the medication cart to be unlocked on the Weston unit. On both occasions the RPNs had left the medication cart unattended, unlocked and out of visual range. The Administration of Medications policy #05-03 dated May 2014 directs registered staff to "never leave an unlocked Medication Cart unattended". The RPNs and the DOC confirmed the expectation was to lock the medication cart when unattended and not within visual range of the registered staff. [s. 130. 1.]

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a member of the registered nursing staff permitted a staff member who was not otherwise permitted to administer a drug to a resident to administer a topical, if, (a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; (b) the member of the registered nursing staff who permitted the administration was satisfied that the staff member could safely administer the topical; and (c) the staff member who administered the topical does so under the supervision of the member of the registered nursing staff.

Resident #011 required a prescribed, medicated topical ointment for an area of redness to their skin. The registered staff interviewed stated that the PSWs applied medicated topical ointment to the resident when they were bathed twice per week or when they provided skin care. The resident confirmed the staff member who helped them to the bathroom puts on their ointment. The PSWs confirmed they applied the resident's ointment, prescribed by the Physician, when they provided their bath and skin care. The PSWs confirmed they apply medicated ointments to other residents as directed by the registered staff. The PSWs confirmed the registered staff tell them what cream the resident required and how to apply it. The PSWs confirmed the registered staff don't observe them perform the task, and they are not aware of a declaration that must be signed by the team member who demonstrated the task to ensure they are competent to perform the skill. [s. 131. (4)]

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

A) On two separate days in January 2015, at 1230 and 1700 hours on the Weston, Brule, Alderwood and Islington units, the PSWs and registered staff were observed by the MOH LTC Inspector to not wash or sanitize their hands in between assisting residents with their meals.

B) On two separate days in January 2015, at 1230 and 1700 hours on the Weston and Brule units, the registered staff were observed by the LTC Inspector to not wash or sanitize their hands before or after contact with administering medications to residents in the dining room.

The PSWs, registered staff and the DOC confirmed the expectation was for staff to wash or sanitize their hands before and after contact with residents when providing care and treatment. [s. 229. (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

Issued on this 27th day of February, 2015

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

Original report signed by the inspector.