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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 6, 2018	2018_708548_0001	008228-17	Resident Quality Inspection

Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

Garry J. Armstrong Home
200 Island Lodge Road OTTAWA ON K1N 5M2

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

RUZICA SUBOTIC-HOWELL (548), JESSICA LAPENSEE (133), LINDA HARKINS (126), LISA KLUKE (547), MICHELLE EDWARDS (655), SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 15,16,17,18,19, 22,23,24,25 and 29, 2018.

During the course of the inspection, the inspector(s) toured resident care areas and non-residential areas, reviewed residents' health care records, observed medication administration, resident activities and staff to resident interaction, reviewed policies related to: infection prevention and control, skin and wound and medication. Documentation of menus and internal incident and investigation, employee files, bed maintenance records, email correspondence and, Family and Resident Council meeting minutes were reviewed.

Concurrently these critical incident inspections were conducted. Critical Incident Report (CIR) related to:
Log: 029433-17- Alleged abuse
Log: 029419-17- Fall incident
Log: 000769-18- Alleged neglect

Follow up inspection:
Log: 021177-17- related to Bed maintenance

Complaint logs were also conducted concurrently related to:
Alleged neglect: 016886-17
Resident Bill of Rights: 029181-17

During the course of the inspection, the inspector(s) spoke with Residents, Substitute Decision Makers, Administrator, Program Manager for Resident Care (#101) and Program Manager for Personal Care (#120), Manager of Recreation and Volunteer Services, Registered Nurses, Registered Practical Nurses, RAI Coordinator, Food Services Attendant, Personal Support Workers, Resident Council Chairperson, Family Council Chairperson, Lead for the Prevention of Abuse, Neglect and Retaliation, Lead for Infection Prevention and Control, Facility Supervisor, Registered Dietitian, Food Services Supervisor and Activity Coordinator.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
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
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 90. (2)	CO #001	2017_625133_0013	133

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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care for resident #016 includes alternatives to restraining that were considered, and tried, but have not been effective in addressing the risk.

On identified dates in January 2018, Inspector #178 observed resident #016 in a wheelchair with a lap belt in use.

During an interview with Inspector #178 on January 23, 2018, PSW #122 who works part-time, indicated that resident #016 uses the physical device as a restraint, whenever the resident is in a wheelchair and, the resident cannot remove the restraint. PSW #122 indicated that the purpose of the lap belt is to keep the resident from falling.

During an interview with Inspector #178 on January 23, 2018, PSW #127 who works full time, indicated that resident #016 uses a seat belt while in a wheelchair. PSW #127 indicated that the lap belt is used to prevent the resident from getting out of the chair and falling.

Review of resident #016's current plan of care indicated that the resident uses a lap belt when up in a wheelchair to reduce the risk of falls. However, resident #016's plan of care included no documentation of alternatives to restraining that were considered, and tried, but found to be ineffective in addressing the risk of falling or injury.

During an interview with Inspector #178 on January 26, 2018, the Program Manager of

Personal Care (PMoPC) #120 indicated that alternatives to the lap belt that were attempted and found to be ineffective, were not listed on resident #016's restraint plan of care. [s. 31. (2) 2.]

2. The licensee has failed to ensure that the restraint plan of care for resident #016 includes an order by the physician or the registered nurse in the extended class.

On identified dates in January 2018, Inspector #178 observed resident #016 in a wheelchair with a lap belt in use. During interviews with Inspector #178 on January 23, 2018, PSW #122 and PSW #127, both indicated that resident #016 uses a lap belt restraint for safety while in a wheelchair, and that the resident is unable to release the lap belt.

On January 23, 2018, Inspector #178 reviewed resident #016's health record with RN #106. No order for the lap belt restraint from a physician or a registered nurse in the extended class could be found.

On January 24, 2018, the Program Manager for Resident Care (PMoRC) #101 indicated that she had looked at resident #016's health record, and a physician's order for the use of the lap belt restraint was not present in the resident's record. [s. 31. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the restraint plans of care for resident #016 and resident #034 include alternatives to restraining that were considered, and tried, but have not been effective in addressing the risk, to be implemented voluntarily.

WN #2: 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).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or 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 based on the resident's condition or circumstances.

On three separate occasions Inspector #178 observed resident #034 sitting in a wheelchair with a lap belt in use.

During an interview with inspector #178 on January 26, 2018, PSW #145, who works full time days, indicated that resident #034 uses a lap belt restraint whenever the resident is in a wheelchair, and the resident cannot remove the restraint. PSW #145 indicated that the purpose of the lap belt is to keep the resident from falling out of a wheelchair.

Review of resident #034’s current plan of care indicated that the resident uses a lap belt when up in the tilt wheelchair, as per the Power of Attorney (POA)’s request to promote safety.

During an interview with Inspector #178 on January 26, 2018, RN #141 who works regular part time days on resident #034’s unit, indicated that she was unaware that a lap belt restraint was being used for resident #034. RN #141 indicated that she believed the resident's lap belt restraint had been discontinued approximately a year ago. RN #141 indicated that she sees the resident during the shift, but because the resident usually has a table top in place while in a wheelchair, RN #141 would not necessarily see that the resident has a lap belt restraint in use. RN #141 indicated that the need to assess a resident while a restraint is in use would normally appear on the resident medication administration record (MAR), where registered staff would initial each shift, indicating they had assessed the resident’s use of the restraint during the shift. Inspector #178 and RN #141 reviewed resident #034’s MAR, and no entry was present for registered staff to document that they had monitored the resident for use of a lap belt at least every eight hours. [s. 110. (2) 6.]

2. The licensee has failed to ensure that the documentation includes consent for the use of the physical device to restrain.

On two identified dates, Inspector #178 observed resident #016 in the wheelchair with a

lap belt in use.

Review of resident #016's current plan of care indicated that the resident uses a lap belt when up in a wheelchair to reduce the risk of falls.

During interviews with Inspector #178 on January 23, 2018, PSW #122 and PSW #127,both indicated that resident #016 uses a lap belt restraint for safety while in a wheelchair, and that the resident is unable to release the lap belt.

During an interview with inspector #178 on January 23, 2018, RN #106 indicated that it is her belief that the family of resident #016 requested that the resident use a lap belt while in a wheelchair, to prevent risk of injury. Inspector #178 reviewed resident #016's health record with RN #106, and no consent for the lap belt restraint was found.

On January 24, 2018, the PMoRC #101 indicated to inspector #178, that she had looked at resident #016's health record, and that a consent for the use of the lap belt restraint was not present in the resident's record. [s. 110. (7) 4.]

3. The licensee has failed to ensure that the documentation included the person who applied the device and the time of application.

On three identified dates, Inspector #178 observed resident #034 sitting in a wheelchair with a lap belt applied.

During an interview with inspector #178 on January 26, 2018, PSW #145, who works full time days, indicated that resident #034 uses a lap belt restraint whenever the resident is in a wheelchair, and the resident cannot remove the restraint. PSW #145 indicated that she documents the application and removal of the lap belt and the hourly monitoring of the resident in the PSW binder flow sheets. Inspector #178 reviewed resident #034's flow sheets with PSW #145. The flow sheet which PSW #145 indicated that she is initialing for resident #034's use of the lap belt, is actually a restraint monitoring form for the use of resident #034's long side rails while in bed, and does not contain any information regarding application or removal of the lap belt restraint, or monitoring of the resident while the lap belt is in use. [s. 110. (7) 5.]

4. The licensee has failed to ensure that the documentation of the use of resident #016's lap belt includes all assessment, reassessment and monitoring, including the resident's response.

During an interview with Inspector #178 on January 24, 2018, RN #106 indicated that registered nursing staff assesses resident #016 and evaluates the effect of the resident's restraint at least every eight hours while the lap belt is in use. However, RN #106 indicated that she does not necessarily document these assessments.

A review of resident #016's health record produced no documentation of registered nursing staff's assessment and evaluation of the effect of the lap belt restraint at least every eight hours. [s. 110. (7) 6.]

5. The licensee has failed to ensure that the documentation included all assessment, reassessment and monitoring, including the resident's response.

During an interview with inspector #178 on January 26, 2018, PSW #145, who works full time days, indicated that resident #034 uses a lap belt restraint when up in a wheelchair, and the resident is monitored at least hourly when the lap belt is in use. PSW #145 indicated that she documents the hourly monitoring of the resident in the PSW binder flow sheets. Inspector #178 reviewed resident #034's flow sheets with PSW #145. The flow sheet which PSW #145 indicated that she is initialing for resident #034's use of the lap belt, is actually a restraint monitoring form for the use of resident #034's long side rails while in bed, and does not contain any information regarding monitoring of the resident while the lap belt is in use. [s. 110. (7) 6.]

6. The licensee has failed to ensure that the documentation for resident #034's lap belt restraint included every release of the device and repositioning.

During an interview with inspector #178 on January 26, 2018, PSW #145, who works full time days, indicated that resident #034 uses a lap belt restraint when up in a wheelchair, the lap belt is removed and, the resident repositioned at least every two hours. PSW #145 indicated that she documents the removal of the lap belt and repositioning of the resident in the PSW flow sheets. Inspector #178 reviewed resident #034's flow sheets with PSW #145. The flow sheet which PSW #145 indicated that she is initialing for resident #034's use of the lap belt, is actually a restraint monitoring form for the use of resident #034's long side rails while in bed, and does not contain any information regarding release of the lap belt and repositioning of the resident while the lap belt is in use. [s. 110. (7) 7.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following with regards to use of restraints: -resident #034's condition has been reassessed and the effectiveness of the lap belt restraint evaluated by a physician or 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 based on the resident's condition or circumstances

-the documentation of the use of resident #034's lap belt includes the person who applied the device and the time of application, all assessment, reassessment and monitoring, including the resident's response, and every release of the device and repositioning

-the documentation of the use of resident #016's lap belt includes consent for the use of the lap belt, all assessment, reassessment and monitoring, including the resident's response, to be implemented voluntarily.

WN #3: 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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that proper techniques were used to assist the residents with eating, including safe positioning of residents who require assistance.

The following observations were made by Inspector #547 regarding improper feeding techniques utilized with residents that required feeding assistance during this inspection:

On an identified date, resident #047 was observed being fed at the beginning of the main meal by RPN #131. RPN #131 was standing to the resident's left side. RPN #131 who was then standing, indicated to the resident to continue to eat the meal on their own. Resident #047 was observed to be very drowsy at this meal service. PSW #130 then came to assist the resident, and was observed to kneel next to the resident to offer the resident feeding assistance. Resident #047's plan of care indicated the resident required to be spoon fed entirely the meals by a staff member.

On an identified date, resident #046 was observed being fed a hot beverage by a PSW #130 who was standing to the resident's left side. PSW #130 was observed to be cleaning up tables near the end of the resident's meal. PSW #130 stopped at resident #046's table to assist the resident to drink a hot beverage by placing the cup to the resident's mouth and tilting the cup in an upward motion. PSW #130 was talking to another resident family member also seated at this table, not paying attention to resident #046 drinking the hot beverage. Resident #046 began to cough and spew the hot beverage fluid, spilling the fluid on the front of the resident's clothing. PSW #130 then looked at the resident, and tilted the hot beverage cup back away from the resident's mouth and resident #046 continued coughing. PSW #130 stopped assisting the resident and brought the resident out of the dining room to change the resident's clothes. Resident #046's plan of care indicated the resident was independent to eat and drink, but required encouragement at mealtime.

On January 24, 2018, resident #045 was observed being fed the main meal by PSW #116 who was standing to the resident's right side. PSW #116 was observed to stop at resident #045's table to provide the resident sips of fluid by use of adaptive cup. PSW #116 assisted many other residents in the dining room, and did not use proper feeding techniques while assisting resident #045 with the meal and fluids. Resident #045's plan of care indicated the resident required one person physical assistance to complete feeding the resident. Resident #045 is also identified in the plan of care to have high nutritional risk for safe chewing and swallowing and choking risk related to swallowing and chewing difficulties.

On January 24, 2018 the Food Services Manager indicated to Inspector #547 that staff who provide assistance to residents requiring feeding assistance, are to be seated next to the residents, facing the resident for close observation as part of the proper feeding techniques. The Food Services Manager indicated that she would need to review proper feeding techniques with nursing staff.

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As such, nursing staff utilized improper feeding techniques with residents that required feeding assistance. [s. 73. (1) 10.]

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 proper techniques are used to assist residents with eating, including safe positioning, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a good state of repair.

This finding of non-compliance specifically relates to the state of repair of seven identified doors.

As per O. Reg. 79/10, s. 9 (1) 2, all doors leading to non-residential areas must be kept closed and locked when not being supervised by staff to restrict unsupervised access to those areas by residents.

On January 15, 2018, Inspector #547 observed that four doors leading into non-

residential areas appeared to be closed and locked, however, the doors could be pushed open. On January 23, 2018, Inspector #133 observed the same in that while the doors appeared to be closed and locked, they were in fact not fully closed and latched into place. Inspector #133 was able to push each door (identified below) open, as Inspector #547 had done the week before.

The doors of concern were as follows: brief storage room #718, brief storage room #618, housekeeping room #632, housekeeping room #432 and spa room #440.

Further related to housekeeping room #632 and #432 – Inspector #547 and Inspector #133 observed that the rooms contained a variety of accessible undiluted cleaning products on the storage shelves, including products capable of causing toxic effects. These products were as follows: Two containers of Wood Wyant "Redi Pro" multipurpose cleaner, two bottles of Wood Wyant "Oxy Pur" urine remover, one bottle of Wood Wyant " Vert-2-Go" neutral cleaner, two bottles of Sealed Air Diversey Care "Defoamer" and a spray can of Ecolab "Asepticare" aerosol disinfectant. These products were also found in housekeeping room #432, with exception of Wood Wyant "Vert-2-Go". In addition, one bottle of Wood Wyant "Total Cleaner and Polish" was found in housekeeping room #432.

On January 24, 2018, Inspector #133 met with the home's Facility Supervisor (FS, #132) to discuss the doors of concern. The FS indicated that the doors were steel and that some had a problem with the welds between the outer panel of the door and the main body of the door. The FS indicated that as a result of this problem, affected doors did not close and latch securely, despite the automatic door closure mechanism in place, as the doors were warped. The FS indicated that in 2017, all of the clean linen room doors were replaced as a result of this problem. The FS indicated that for 2018, all of the housekeeping room doors were scheduled to be replaced as a result of this problem.

On January 24, 2018, Inspector #133 and the FS walked through each care unit and observed doors leading into non-residential areas. Doors previously observed by Inspectors #547 and #133 to be unlatched were again observed to be unlatched. In addition, the FS and the Inspector found the same issue with the door leading to brief storage room #318 and the door leading to housekeeping room #332. Related to doors #718, #618, and #440, the FS indicated that it appeared that the automatic door closure mechanism in place required adjustment. Related to doors #632, #432, #318 and #332, the FS indicated that the doors required replacement as they were warped. The FS indicated he would put in a work order for all of the doors.

Further related to housekeeping room #332 – Inspector #133 observed that the room contained a variety of accessible undiluted cleaning products on the storage shelves, including products capable of causing toxic effects. In addition to the products that were found in housekeeping rooms #632 and #432, with the exception of Wood Wyant " Vert-2-Go" neutral cleaner, Inspector #133 also found one bottle of Lawrasons' "Insta Gel" lemon scented deodorizer.

On January 25, 2018, the Inspector observed that there was now a sign on the door for housekeeping room #432, directing "please pull door shut when leaving". While the door appeared to be closed, the Inspector was able to push the door open as it was not latched securely into place. The Inspector met the home's Administrator shortly thereafter, and informed the Administrator that the door had again been found unsecured. The Administrator indicated that she had also found the door unsecured, earlier that day. The Administrator indicated additional measures would be put into place to ensure all doors of concern remained secured when not supervised by staff until such time as the doors could be replaced and/or the closing mechanisms on the doors could be repaired.

The licensee has failed to ensure that the identified doors are maintained in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with the requirement that the home be maintained in a good state of repair, with specific reference to the identified doors leading to non-residential areas such as utility rooms and housekeeping rooms. The plan is to ensure that the condition of the doors, and the door closure mechanism in place on all such doors, is such that the doors close and latch securely into place when the doors are allowed to close under their own weight, in order to restrict access to the areas to all residents. The plan is to outline measures that will be taken to ensure that such doors are manually closed and latched securely into place, until such time as the door closure mechanisms can be repaired, or the doors replaced, in order to ensure resident safety. The plan is, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system (the system) is available in every area accessible by residents.

Related to the staff bathroom on each of the seven care units:

On January 15, 2018, Inspector #547 observed that while the staff bathroom door on 4th, 5th, 6th and 7th floors was locked, the key for the door was either in the lock (4th floor and 7th floor), or hung on the door handle. In this way, the identified staff bathrooms were accessible by any resident able to use a key. Inspector #547 observed that the system was not available in these areas accessible by residents.

On January 23, 2018, Inspector #133 observed that while the staff bathroom door on floors 2, 3, 4, 5 and 7 was locked, they key for the door was either in the lock (2nd floor) or hung on the door handle. Registered Nurse (RN) #135, on the 2nd floor, indicated to Inspector #133 that the key should not have been in the bathroom door lock or on the bathroom door handle. RN #135 removed the key and indicated it would be stored within the nurses' station.

On January 24, 2018, Inspector #133 observed that while the staff bathroom door on floors 7, 6, 5, 4 and 3 was locked, the key for the door was either in the lock (7th floor) or hung on the door handle.

Further related to the staff bathroom on the 4th and 5th floors, it was observed on January 23rd and 24th, 2017, that there was a spray can of Ecolab "Asepticare" aerosol disinfectant on the respective counters, which is a product capable of producing a toxic effect.

On January 24, 2018, Registered Practical Nurse #107, on the 7th floor, indicated that the staff bathroom key is always kept on the door handle if not in the lock. Registered Nurse (RN) #106, on the 6th floor, indicated that the staff bathroom key is always kept on the door handle to facilitate staff access to the bathroom. RN #106 indicated that the key is kept on the handle of the staff bathroom door on all units, with possible exception of the secured units (2nd and 3rd). RN #136, in the 5th floor, indicated that the staff bathroom key is always kept on the door handle and has always been, even on the secured units (2nd and 3rd). RN #102, on the 4th floor, indicated that the staff bathroom key is always kept on the door handle to facilitate staff access to the bathroom. Personal Support Worker #130, on the 3rd floor, indicated that the staff bathroom key is always kept on the door handle to facilitate staff access to the bathroom.

Related to the photocopy room (#547) on the 5th floor:

On January 15, 2018, Inspector #547 observed that the door to photocopy room #547 was closed but not locked. The room contained a photocopier and a table. The Inspector observed that the system was not available in the room, which was accessible by residents.

On January 23rd and 24th, 2018, Inspector #133 observed that the door to photocopy room #547 was closed but not locked. The Inspector observed that the door was equipped with a manual lock, and there was an access card reader on the wall next to the door.

On January 24, 2018, RN #133 and Inspector #133 observed the photocopier room door together. RN #133 confirmed that there was no key that would lock the door manually, and that while the access card reader appeared to detect his access card, it did not serve to lock the door. RN #133 indicated that the photocopy room door was always unlocked, to allow staff ready access to the photocopier.

The licensee has failed to ensure that the resident-staff communication and response system is available in the staff bathroom on the care units and in photocopy room #547. [s. 17. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance With the requirement that the communication and response system (the system) be available in every area accessible by residents, with specific reference to staff bathrooms on the care units and to photocopy room #547. The plan is to provide for the installation of the system in the identified areas should the areas remain accessible by residents. The plan is to provide for measures to ensure resident safety until such time as the system is available in the identified areas. The plan is, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006 received individualized personal care, including hygiene care and grooming on a daily basis.

Resident #006 was admitted to the home on an identified date with several medical diagnoses. Resident #006 was observed on the following days to be soiled with food matter and facial hair unshaven to the resident's chin area.

On an identified date in January 2018, resident #006 was observed at approximately 1500 hours by Inspector #547 to have dried food matter noted on the side of the resident's mouth and chin, as well as on the resident's clothes. On three separate occasions on three separate days in January 2018, the resident's face was also observed to have facial hair not removed or unshaven.

Inspector #547 interviewed PSW #149 who indicated that staff perform the resident's personal hygiene and grooming, completely.

Inspector #547 reviewed resident #006's health care records on an identified date in January 2018, that documented in the resident's current plan of care that the resident required total assistance for personal hygiene and grooming care; to remain clean and neat. The resident further required complete feeding assistance of one staff member to be fed all meals. The resident's care plan regarding grooming further indicated the resident requires shaving.

The home's Program Manager of Personal Care (PMoPC) #120 that is in charge of Personal Support Workers (PSW's) in the home indicated to Inspector #547 on January 24, 2018 that the resident should be kept clean and tidy at all times, and that it was not acceptable for the resident to have food debris left on the resident after meals or facial hair not removed. [s. 32.]

2. The licensee has failed to ensure that resident #011 receive individualized personal care, including hygiene care and grooming on a daily basis related to shaving facial hair.

Resident #011 was admitted to the home on identified date with several medical diagnoses. The resident's current plan of care for resident #011 indicated that the resident requires assistance for shaving facial hair on a regular basis.

On an identified date in January 2018 resident #011 indicated to Inspector #547 that assistance is required for the removal of hair from the resident's face. The resident indicated that staff do not always offer their assistance.

On three separate dates in January 2018 Inspector #547 observed the resident's face to have long facial hair that were unshaven.

On January 23, 2018 Inspector #547 interviewed PSW #124 who indicated that she was responsible for resident #011's personal care that day and the previous day shift. PSW #124 indicated that she did not offer to assist the resident to shave and that she did not realize the resident required assistance to shave. The PSW #124 explained that the resident seems to always have longish facial hair. PSW #112 and #128 also working on the resident's floor further indicated to inspector #547 that the resident does not refuse care and assistance for shaving.

On January 24, 2018 the PMoPC #120 indicated that this situation was not acceptable as resident #011 rarely refused personal care and that the plan of care identified that the resident required assistance for shaving. [s. 32.]

3. The licensee failed to ensure that resident #048 received individualized personal care on a daily basis.

On an identified date, the Director under the Long-term Care Homes Act (LTCHA), 2007, was informed of an incident which occurred on a specified date where resident #048 was unable to self-perform a prescribed medical intervention, as scheduled.

Inspector #655 reviewed the health care record belonging to resident #048. In the resident's health care record the Medication Administration Record (MAR) indicated that resident #048's medical diagnosis requires a self-performed prescribed medical intervention at specified times, each day.

Inspector #655 reviewed resident #048's care plan that was in place at the time of the incident, as described above. According to the care plan, resident #048 was to be assisted with morning care at a scheduled time in the morning. The care plan also indicated that at that time, resident #048 required the assistance of staff for transfers.

According to a family member of resident #048, resident #048 is normally assisted with morning care at a specified time. The routine is personalized as such so that the resident is able to access and self-perform a prescribed medical intervention at a specified time. The family member of resident #048 indicated to Inspector #655 that resident #048 is otherwise unable to perform the medical intervention. The family member of resident #048 indicated to Inspector #655 that if the specified times are not adhered to, it impacts the resident's health.

During an interview with the family member of resident #048, they indicated to Inspector #655 that on a specified date, resident #048 was not assisted with morning care until approximately two hours later than usual, having delayed the resident's ability to self-perform the medical intervention at the required time. The family member of resident #048 further indicated to Inspector #655 that when the PSW arrived, the resident was found to be having a negative outcome due to its delay. During an interview, resident #048 indicated the same.

During an interview on January 29, 2018, PSW #148 indicated to Inspector #655 that resident #048's morning care routine is personalized in order to meet the resident's needs. According to PSW #148, resident #048 is normally - and, on the specified date, was expected to be, assisted with morning care between a specific time period, noting that resident #048 self-performs the specified medical intervention at a specified time related to the resident's current medical diagnosis. PSW #148 recalled that on an identified date, a staff member (the same staff member assigned to resident #048's care) had called in, and was unable to work the shift. PSW #148 further recalled that at that time, they were informed that a replacement staff member had been identified and would arrive to the unit "shortly".

During the same interview, PSW #148 further recalled having responded to the call bell of resident #048 at a specific time on the identified date. PSW #148 indicated to Inspector #655 that at that time, the resident was informed that a the scheduled staff member was unable to work the shift, and the resident was assured that a replacement would assist the resident as soon as possible. During the interview, PSW #148 indicated that, at that time, they did not expect that the replacement would not arrive until two

hours later; and as such, continued with a resident assignment on another wing located on resident #048's floor. PSW #148 indicated to Inspector #655 that as a result, resident #048 was not assisted with morning care until after the replacement PSW had arrived.

During an interview, RN #117 also indicated to inspector #655 that on the identified date, the unit was short-staffed until a replacement PSW was found. According to RN #117 , on the specific date, the replacement PSW arrived at the home approximately two hours into the shift; and upon arrival, resident #048 received assistance.

The licensee failed to ensure that resident #048 received individualized personal care on a specified date, when the resident was not assisted with morning care at a specified time, delaying the resident's ability to self-administer a medical intervention at a specified time. [s. 32.]

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 #006, #011 and #048 receive individualized personal care on a daily basis, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Findings/Faits saillants :

1. 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.

As per O.Reg 79/10 s. 50 (2) (b) (iv) The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

Resident #041 was admitted to the home with pre-existing alteration in skin integrity; with a history of non-compliance in the management of nutrition. The Program Manager of Resident Care #101 described the resident's pressure ulcers to be chronic and unhealable.

The resident's #041 treatment plan includes an interdisciplinary approach for the management and care of the pressure ulcer/wound. The resident was seen by the outside consultant on an identified date and the pressure ulcer was described a specific stage.

The PMoRC #101 indicated the Skin and Wound Program specifies that weekly assessments are clinically indicated for pressure ulcers/ wounds and are to be recorded on a tool -'Altered Skin Integrity Tool, 355.29B'.

Review of the tool, 'Altered Skin Integrity Tool, 355.29B', it is indicated that pressure ulcer(s) are to be documented at least weekly, this would include wound description, pain, referrals and treatments. The Licensee's policy 'Skin and Wound Care: Skin Integrity', policy # 355.29, Revision Date: February 2017 supports the recording of registered nursing staff assessment of the wound state on the 'Altered Skin Integrity Tool, 355.29B' form.

The PMoRC #101 indicated that pressure ulcer/wound status assessment would be conducted on a weekly basis and more if necessary for the alteration of skin integrity such; as pressure ulcers, stasis ulcers and skin tears.

The Manager provided to Inspector #548 all completed wound assessments for resident #041. One completed assessment was provided for a specified period of time on a tool titled- 'Wound Assessment Tool'.

The licensee failed to ensure weekly reassessment of a resident exhibiting altered skin integrity is documented. [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 documentation of weekly reassessment of resident's #041 altered skin integrity, to be implemented voluntarily.

WN #8: 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 has failed to ensure that drugs are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies.

On January 15, 2018, Inspector #547 observed a basket filled with prescription creams and ointments, unsupervised in the sixth floor nursing station. The basket sat on the top of the shredding box, under a small sign marked "Creams".

On January 16, 2018, Inspector #547 observed a container of prescription cream, on the shelf beside the bed in the room for resident #004.

On January 17, 2018, Inspector #547 observed a container of prescription cream, on a

shelf in the room of resident #009.

On January 19, 2018, at approximately 1120h, Inspector #178 observed a container of prescription cream on the shelving unit in the room of resident #009.

On January 19, 2018, at 1125h, Inspector #178 observed six prescription creams, labeled with residents names, stored in a basket in the sixth floor nursing station.

On January 19, 2018, at approximately noon, Inspector #178 observed a container of prescription cream in the room of resident #004, on a shelf beside the resident's bed.

On January 19, 2018, RPN #125, indicated to Inspector #178 that on the sixth floor, the prescription creams are usually stored in the locked medication room, which is only accessible to registered staff. However, RPN #125 indicated that in the mornings the prescription creams are kept in the sixth floor nursing station to make them more accessible to the nursing staff, and then returned to the medication room in the afternoon. RPN #125 also indicated that prescription creams should not be kept in residents' rooms unless the resident has a physician's order to do so, and ensured that the prescription cream was removed from resident #004's room.

On January 22, 2018, RN #117 accompanied Inspector #178 to the room of resident #009, where the container of prescription cream had remained on a shelving unit. RN #117 indicated that prescription creams should be stored in the medication cart or medication room, and removed the cream from the resident's room.

During an interview with inspector #178 on January 22, 2018, the Program Manager of Resident Care #101 indicated that prescription creams should be stored in the locked medication room or the medication cart, and not stored in the unit nursing stations. Further, the Program Manager of Resident Care indicated that prescription creams should not be left in resident rooms, unless those residents have a physician's order to self-apply the medicated cream.

In conclusion, the licensee has failed to ensure that drugs are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies. [s. 129. (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 all areas where prescription creams and ointments are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Findings/Faits saillants :

1. The licensee failed to ensure that resident #043 is offered a minimum of, (a) three meals daily.

Log: 000769-18

The Director under the Long-term Care Homes Act (LTCHA), 2007 was informed on a identified date of alleged neglect of resident #043.

On an identified date resident #043 returned to the home from hospital. The resident requires assistance with Activities of Daily Living including feeding assistance.

On the following morning, charge RN #117 provided report on the resident's current health status to the staff members present. PSW #140 and PSW #137 indicated that they were present at the time of report. PSW #140 was assigned to provide care to resident #043.

The resident was seen by RN #117, at approximately 0930 hours and twice by RPN #146 for the administration of medications at specified times. Both registered nursing staff indicated when interviewed that the resident was "sleepy" with no apparent distress or change in health status.

At approximately 1400 hours RN #117 was informed by PSW #137 that the resident had not been provided breakfast and lunch meals. The RN immediately sought out PSW #140, the resident's primary care giver. PSW #140 confirmed that he had failed to provide breakfast and lunch to the resident; as he understood the resident was still away in hospital.

During an interview with RN #117 she indicated that the resident was assessed with no negative outcome and was offered a meal. [s. 71. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance offer three meals per day to resident #043, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device is undertaken on a monthly basis.

During an interview with inspector #178 on January 26, 2018, the Program Manager of Personal Care (PMoPC) #120, who is the lead for the home's restraint program, indicated that a monthly analysis of the restraining of residents by use of a physical device is not undertaken consistently throughout the home. The PMoPC #120 indicated that this analysis is being done monthly on some units by the nurse and the other staff, but it is his belief that it is not done consistently on all units throughout the home. Further, Manager #120 indicated that a monthly analysis of restraining of residents by use of a physical device is not undertaken at a home level by either of the two Program Managers of Resident/Personal Care. [s. 113. (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that written policies and protocols are developed for the medication management system to ensure the accurate administration of self-administered drugs.

On an identified date the Director under the Long-term Care Homes Act (LTCHA), 2007, was informed of an incident which occurred on a specified date where resident #048 was unable to self-perform a prescribed medical intervention as scheduled.

According to resident #048 and a family member of resident #048, on an identified date, resident #048 had not been assisted out of bed as scheduled, delaying the self-performance of a medical intervention by one hour.

Inspector #655 reviewed the health care record belonging to resident #048. In the resident's health care record, it indicated that resident #048 medical diagnosis requires specific prescribed medical interventions at specified times, each day.

Inspector #655 reviewed the Medication Administration Record (MAR) belonging to resident #048 for an identified month. On the MAR it was indicated that resident #048 was to perform the self- administration of a medical intervention at specified times during the day. There was a note 'self' that was written on the MAR. There were otherwise no entries made by any staff members on the identified date on the MAR related to the specific medical intervention the resident was responsible for. In addition, no documentation to demonstrate that the resident's compliance or ability to adhere with the medical intervention schedule had been monitored at any time by the registered nursing staff.

Inspector #655 reviewed the policy titled "Medication System: Resident Self-Administration – Long Term Care" (last review January 17, 2017). In the policy it indicates that when a resident is responsible to self-administer a medical intervention, it must be ensured that the resident understands the need for monitoring and documentation of the use of the prescription. In addition, it is indicated that the resident's compliance to the prescription schedule is to be monitored. There was no direction within the policy as to how the monitoring and documentation of the prescribed medical intervention is be completed, in order to ensure accurate administration.

During an interview on January 25, 2018, RN #117 indicated to Inspector #655 that resident #048 self-performs the administration (the majority of the time) of a specific prescription. RN #117 indicated to Inspector #655 that one prescription in particular is time sensitive and must be administered as specified. She added, that each day the resident requires assistance (from staff) to access the prescription, so that the resident is able to self-perform this action.

During the same interview, RN #117 indicated to Inspector #655 that on an identified date, resident #048 was not assisted by staff until a replacement PSW arrived approximately two hours after the start of the day shift, delaying the resident's self-administration of a specified medical prescription at the scheduled time. RN #117 was unable to recall the exact time at which resident #048 had performed the above-noted medical intervention on that specified date and was unable to produce any documentation to demonstrate that the resident's self-administration had been monitored or recorded that day. At the same time, RN #117 was unable to speak to a process

whereby registered nursing staff monitor or record the self-administration of any medical intervention on a daily basis. According to RN #117, resident #048 is supplied the prescription in packaging, once a week. Each time the new packaging is provided, the registered nursing staff would take note if there are any remaining items in the packaging to assess the resident's compliance or ability to adhere with the medical intervention schedule. This process was not documented.

During an interview on January 29, 2018, Program Manager of Resident Care (PMoRC) #101 indicated to Inspector #655 that the above-noted policy was the only policy related to self-administration of prescribed medical interventions in use in the home. At the same time, PMoRC #101 indicated to Inspector #655 that self-performance of medical interventions are identified in the MAR, though staff are not expected to document each time that the resident completes the intervention in the MAR, as per schedule. According to PMoRC #101, monitoring of the resident's compliance, or ability to adhere, to the medical intervention schedule is done on a weekly basis, when the resident's packaging is replaced.

While a process was in place to ensure that a resident who self-performs a medical intervention (prescription, had used a one week's supply of a prescribed medical intervention, there was no process in place whereby the resident's compliance, or ability to adhere, to the daily medication schedule was being monitored or documented.

That is, on a specified date, there was no process in place to ensure that resident #048 was able to access the medical intervention as scheduled, in order to adhere to the prescribed schedule.

The licensee failed to ensure that written policies and protocols are developed for the medication management system to ensure the accurate administration of of prescribed medical interventions. [s. 114. (2)]

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 7th day of February, 2018

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

Original report signed by the inspector.