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

Division de la responsabilisation et de la performance du système de santé
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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
Jul 23, 2015	2015_267528_0016	H-002770-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD OAKVILLE ON L6M 3L1

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

CREEK WAY VILLAGE
5200 Corporate Drive BURLINGTON ON L7L 7G7

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

CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LEAH CURLE (585)

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): June 23, 24, 25, 29 and July 6, 7, 2015

This inspection was done concurrently with Critical Incident Inspection Log #'s: H-002046-15 and H-001859-15

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DOC), Managers of Resident Care, Administration Assistants, Life Enrichment Supervisor, Minimum Data Set Resident Assessment Protocols (RAI MDS) Coordinator, Supervisor of Nutrition Services, Registered Dietician (RD), Cook, Maintenance Supervisor, Maintenance Operator, Physiotherapist (PT), Occupational Therapist (OT), Laundry Supervisor, laundry staff, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), dietary aides, residents and families.

The inspectors also toured the home, observed the provision of care and services, reviewed documents, including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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, the resident was assessed in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices to minimize risk to the resident.

A. Throughout the course of the inspection one three quarter and one quarter bed rail were observed raised when resident #14 was in bed. Registered staff and PSW's stated that the resident used the bed rails daily. Review of the plan of care did not include a formalized assessment of the bed rails and this was confirmed by the registered staff. (581)

B. In May 2015, a bed rail assessment identified that bed rails were not recommended for resident #11. However, during the course of the inspection the resident was observed to be in bed with one bed rail in the raised position. Review of the plan of care did not include an assessment of the bed rail use. Interview with direct care staff confirmed that the resident used the bed rails daily. Interview with registered staff confirmed that a formalized bed rail assessment was not completed in accordance with prevailing practices, to determine the use of bed rails. (528)

C. Throughout the course of the inspection one three quarter bed rail were observed to be raised for resident #12. Registered staff and PSWs stated that the resident used the bed rail daily. Review of the plan of care did not include a formalized assessment of the bed rail and this was confirmed by registered staff. (585) [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. (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).

Findings/Faits saillants :

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

The plan of care for resident #42 identified that they were to receive nectar thick fluids. During lunch service on an unidentified day in July 2015, a PSW added two heaping spoons of thickener to a hot drink, and then immediately provided it to the resident. The resident began drinking the fluid, which was less than nectar thick consistency as it had yet to sit long enough to thicken. The staff who prepared the drink was not aware what fluid consistency the resident required. Another PSW stated the resident required honey thick consistency, and proceeded to add a third spoonful of thickener to the drink. The initial PSW who prepared the beverage identified on the diet kardex that the resident actually required nectar thick consistency, and the resident was to only receive one level tablespoon of thickener. Registered staff confirmed the resident was to receive nectar thick fluids. [s. 6. (7)]

2. The licensee failed to ensure that the resident's plan of care was reviewed and revised at least every six months and at any other time when the resident’s care needs changed or care set out in the plan was no longer necessary.

In June 2015, resident #41 was observed receiving total assistance from staff with eating at a lunch and supper meal. Two PSWs and family reported in interviews that the resident required total assistance with eating, for at least one month. Flow sheets from June 2015, indicated the resident regularly required total assistance; however, the plan of care identified that they required limited/extensive assistance. Registered staff confirmed the resident's plan of care was not revised when the resident's care needs changed. [s. 6. (10) (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:
i. the care set out in the plan of care is provided to the resident as specified in the plan
ii. the resident's plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan is no longer necessary., to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. The home's policy, " Requirements for the Use of the Restraints/PASDs, #19-02-04", date July 2014, indicated that when a resident was being considered for the use of a Restraint/PASD, the registered staff were to complete a Restraint/PASD Alternative Assessment in Point Click Care (PCC). Following this assessment, if all alternatives tried were ineffective, the Restraint/PASD Consent and Physcians order form would be completed as well as the Restraint/PASD Assessment in PCC.

On two days during the course of the inspection, resident #61 was observed sitting in a

wheelchair which was in the tilted position. PSW and RPN staff stated they were in the tilt wheelchair for positioning and to assist them with activities of daily living. Review of the plan of care for resident #61 indicated that a PASD assessment was completed in the progress notes but was not documented on the Restraint/PASD Alternative Assessment nor on the Restraint/PASD Assessment. The Restraint/PASD Consent and Physicians order sheet was also not completed as per the home's policy and this was confirmed by the DOC.

B. The home's policy, " Requirements for the Use of the Restraints/PASDs, #19-02-04", date July 2014, indicated that when a resident was being considered for the use of a Restraint/PASD, the registered staff were to complete a Restraint/PASD Alternative Assessment in PCC. Following this assessment, if all alternatives tried were ineffective, the Restraint/PASD Consent and Physcians order form would be completed.

On two days during the course of the inspection, resident #62 was observed sitting in a tilt wheelchair in a tilted position. Review of the written plan of care indicated that they were positioned in a tilt wheelchair for comfort, to increase sitting tolerance and were tilted as needed for positioning. The plan of care revealed that a Restraint/PASD Assessment was completed but not the Restraint/PASD Alternative Assessment nor the Restraint/PASD Consent and Physicians Order Sheet as required by the home's policy. This was confirmed by the registered staff. (581)

C. The home's procedure, "Lost and Found, Procedure #15-02-02-11", effective April 2011, directed staff to complete a "Missing Article Resident Report" form when an article of clothing was missing.

During the course of the inspection, resident #16 reported to have a sweater. A regular laundry staff reported that the home's expectation was to complete a missing item form whenever missing clothing was reported. The staff stated they were aware of the missing sweater for approximately two weeks, and reported they did not complete a missing item form. The Environmental Supervisor confirmed a report form should have been completed. (585) [s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: 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 Personal Assistance Services Device (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:

1. Alternatives to the use of a PASD had been considered, and tried where appropriate.
2. The use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASD's that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario.
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.

A. During the course of the inspection, resident #14's bed was observed with one three quarter and one quarter bed rail raised. Direct care staff and the resident confirmed that the bed rails were raised when in bed and were used for bed mobility and positioning. Review of the clinical record indicated there was no assessment completed to determine the reason for the use of the bed rail, nor any documented consent or approvals for its use. The Resident Manager of Care confirmed that the resident's bed rails were not assessed to determine if they were being used as a PASD nor did they have documented consent or approval for the bed rails in place.

B. On two days in July 2015, resident #60 was observed sitting in a wheelchair which was in the tilted position. RPN and PSW staff stated they were in the tilt wheelchair for positioning and to assist them with activities of daily living. Review of the clinical record did not include a documented assessment for the use of the tilt wheelchair as a PASD, nor any documented consent or approvals for its use. The registered staff confirmed that the tilt wheelchair was not assessed as a PASD nor did they have documented consent or approval for its use. (581)

C. During the course of the inspection, resident #12's bed was observed with one three quarter rail raised. One PSW reported the rail was used for safety, and another reported the rail was used for mobility. Registered staff stated the rail had no use for the resident. The resident reported they were not sure why the rail was on their bed, but it made them feel safe. Review of the clinical record did not include an assessment to determine the

reason for the use of the bed rail, nor any documented consent or approvals for its use. The registered staff confirmed that the resident's bed rail was not assessed to determine if it was being used as a PASD nor did they have documented consent or approval for the bed rail in place. (585)

D. In June 2015, resident #11 was observed in bed with one bed rail in the raised position. Review of the plan of care did not include consent for the use of the bed rail by the substitute decision maker (SDM). Interview with registered staff confirmed that the resident used the bed rail daily; however, consent was not obtained. [s. 33. (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 use of a Personal Assistance Services Device (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 had been considered, and tried where appropriate.
2. The use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASD's that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario.
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, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all foods in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

A. On June 23, 2015, during lunch in the Escarpment View dining room, fluid was observed running from a portion of puree broccoli served to a resident. Another resident's puree pot pie and potato appeared thin, pooling in divided sections on the plate.

B. On June 29, 2015, during lunch in the Orchard Park dining room, a pureed meal, served on a divided plate, was provided to a resident. Mashed potatoes in one section of the plate had dry, browned potato crisp marks around the edge of the plate.

C. On June 29, 2015, during supper in the Orchard Park dining room, a pureed meal, served on a divided plate, was provided to a resident. Mashed potatoes in one section of the plate had dry, browned crisp pieces stuck on the rim of the section. A pureed meal served on a divided plate was requested and sampled. Confetti mashed potato contained dry chunks around the rim, and was dry to taste. A film was noted on top of the puree salmon, which clumped together when sampled with a spoon. Fluid was observed running out of the puree mixed vegetable serving. Food service workers reported hot puree items were plated, heated, and held in the rethermalization unit to maintain temperature prior to meal service, and should be smooth and free of clumps or crisped edges. The Food Service Manager (FSM) confirmed puree items should be smooth and moist, and not have crisped, dry edges, film forms, or fluid separation. [s. 72. (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 to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #6: 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. (6) Every licensee of a long-term care home shall ensure that the following are done:
1. The further training needed by the persons mentioned in subsection (1) is assessed regularly in accordance with the requirements provided for in the regulations. 2007, c. 8, s. 76. (6).
2. The further training needs identified by the assessments are addressed in accordance with the requirements provided for in the regulations. 2007, c. 8, s. 76. (6).

Findings/Faits saillants :

1. The licensee filed to ensure that further training needs identified by the assessments were addressed in accordance with the requirements provided for in the regulations.

Review of the home's education records for 2014 identified that all staff who applied PASDs or monitored residents with PASDs, did not receive training in the application, use and potential dangers of PASDs, as outlined in O. Reg 221(1)(6).

i. In 2014 Legislated Annual Training, including but not limited to Restraints and PASDs, was received by 72 percent (%) of PSWs and 70.73% of registered staff.
ii. Additional Restraint Roll Out in 2014 was provided for 86% of PSWs and 80.49% of registered staff.
iii. The DOC confirmed that all staff required in the regulations did not receive PASD training. [s. 76. (6) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that further training needs identified by the assessments are addressed in accordance with the requirements provided for in the regulations, to be implemented voluntarily.

WN #7: 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).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

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

A. The staff did not participate in the implementation of the infection prevention and control program's policy related to hand hygiene.

The home's policy IPC 03-03-02: Hand Hygiene outlined four moments of hand hygiene, and directed staff to complete hand hygiene using an alcohol-based hand run or soap and water. The four moments for hand hygiene included before initial resident environment contact, before aseptic procedure, after body fluid exposure risk, and after resident or environment contact.

In June 2015, a registered practical nurse (RPN) was observed administering medication in and around the dining room during lunch service on an unidentified home area. From 1140 to 1220 hours, the staff were noted to handle medications, feed residents medications crushed in applesauce, assist residents to dining tables, move residents' assistive aids, and handle medication cart. At no time during the observation was the registered practical nurse observed completing hand hygiene. Interview with registered staff confirmed hand hygiene should be completed between residents when administering medications, as outlined in the policy. [s. 229. (4)]

2. The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if none, in accordance with prevailing practices.

Provincial Infectious Diseases Advisory Committee (PIDAC), Best Practices for Surveillance of Health Care-Associated Infections In Patient and Resident Populations, Third Edition, dated July 2014, recommends Long Term Care Homes have a surveillance System to monitor and analyze infections, including but not limited to, the documentation of new symptoms of infection every shift.

In March 2015, resident #19 began displaying symptoms of possible upper respiratory infection, including but not limited to, deep cough and abnormal breath sounds during assessment. The resident than began treatment for a respiratory infection. Review of clinical documentation revealed that staff were not consistently monitoring symptoms of infection on every shift. Interview with registered staff confirmed that staff were not documenting symptoms every shift. [s. 229. (5) (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 the staff participate in the implementation of the infection prevention and control program, 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

In June 2015, a shift change medication monitoring sheet was observed in a public hallway, in a mail basket outside of a Director of Resident Care's office for approximately 30 minutes. The sheet contained personal health information, including names of residents and their prescribed medications. The Administrator confirmed the document contained personal health information, and was not kept confidential. [s. 3. (1) 11. iv.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

On June 23 and 25, 2015, a resident-staff communication and response system was not observed on the outdoor terrace area on the main floor outside of the pub. A staff member was interviewed and demonstrated that a call bell, part of the communication and response system, was present; however, behind an dense evergreen tree. The staff confirmed residents or anyone unfamiliar with the area would not be able to easily see or use the call bell. [s. 17. (1) (a)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee filed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy "Prevention, Reporting and Elimination of Abuse and Neglect, #01-05-03", last revised September 2014, stated "Any person who has reasonable grounds to suspect abuse or neglect of a resident shall immediately report the suspicion and the information upon which it is based to the Director...or can be done by reporting the suspected abuse or neglect to the home's Administrator or designate who will immediately notify the MOHLTC"

In February 2015, the family of resident #80 brought forward allegations that the resident was mistreated by staff. Review of the homes investigation notes confirmed that the Ministry of Health and Long Term Care (MOHLTC) was not notified until 24 hours after becoming aware of the allegations. Interview with the Manager of Resident Care identified that due to miscommunication between registered staff, the incident was not reported immediately, as required by policy. [s. 20. (1)]

WN #11: 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: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. During the course of the inspection, several residents identified that at times, hot foods were served cold.

On June 29, 2015, during lunch in the Orchard Park dining room, residents reported that the broccoli was cold. Broccoli was probed and minced broccoli was recorded at 55 degrees Celsius.

On June 29, 2015, during supper in Orchard Park dining room, residents reported that meat and vegetables were cold. Food items were probed and recorded as follows: regular chicken, 53 degrees Celsius; regular peas, 48 degrees Celsius; regular salmon loaf, 47 degrees Celsius.

The home's procedure, "Safe Food Handling, Procedure # 10-04-03", last reviewed August 2011, stated "hot foods can be served to residents between 60 to 70 degrees Celcius." The Food Service Manager (FSM) confirmed that the home's expectations was that hot food be served between 60 to 70 degrees Celsius to ensure palatability for the residents. [s. 73. (1) 6.]

WN #12: 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 did not ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

In June 2015, housekeeping room NW205 was observed to have a key still in the lock, staff was not present at the time. The key opened the door to the room, allowing access to residents on the unit. The room was noted to have hazardous substances including, three bottles of disinfectant cleaner and one bottle of virucide cleaner. There were three residents wandering the hallways at the time of the observation. Housekeeping staff was located on the unit and confirmed they had accidentally left the key in the lock, and the door should be locked at all times. [s. 91.]

Issued on this 23rd day of July, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2015_267528_0016
Log No. / Registre no:	H-002770-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 23, 2015
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF HALTON 1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1
LTC Home / Foyer de SLD :	CREEK WAY VILLAGE 5200 Corporate Drive, BURLINGTON, ON, L7L-7G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patti Coates

To THE REGIONAL MUNICIPALITY OF HALTON, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must ensure that all residents who use bed rails, including but not limited to, resident #11, #12, #14, are assessed for the use of the bed rails in accordance with evidenced based practices and, if there are none, in accordance with prevailing practices.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices to minimize risk to the resident.

A. Throughout the course of the inspection one three quarter and one quarter bed rail were observed raised when resident #14 was in bed. Registered staff and PSW's stated that the resident used the bed rails daily. Review of the plan of care did not include a formalized assessment of the bed rails and this was confirmed by the registered staff. (581)

B. In May 2015, a bed rail assessment identified that bed rails were not recommended for resident #11. However, during the course of the inspection the resident was observed to be in bed with one bed rail in the raised position. Review of the plan of care did not include an assessment of the bed rail use. Interview with direct care staff confirmed that the resident used the bed rails daily. Interview with registered staff confirmed that a formalized bed rail assessment was not completed in accordance with prevailing practices, to determine the use of bed rails. (528)

C. Throughout the course of the inspection one three quarter bed rail were observed to be raised for resident #12. Registered staff and PSWs stated that the resident used the bed rail daily. Review of the plan of care did not include a formalized assessment of the bed rail and this was confirmed by registered staff. (585) (585)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23rd day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cynthia DiTomasso

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