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
Nov 26, 2015; Feb 12, 2016	2015_246196_0016	029577-15	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

PINEWOOD COURT
2625 WALSH STREET EAST THUNDER BAY ON P7E 2E5

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

LAUREN TENHUNEN (196), JENNIFER LAURICELLA (542), JULIE KUORIKOSKI (621), KATHERINE BARCA (625)

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): November 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 2015

The Inspectors reviewed resident health care records, internal investigation reports, the home's policies and procedures, components of employee human resource files and training logs, and other documentation within the home, conducted a daily walk through of the resident care areas, observed staff to resident interactions and the delivery of care and services to the residents.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Pharmacist, Registered Dietitian (RD), Personal Support Workers (PSW), RAI Coordinator, Food Service Manager (FSM), Activation staff member, Mobility Facilitator, Dietary Aides (DA), Environmental Service Manager (ESM), Maintenance staff, Housekeeping staff, Residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
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
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

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

28 WN(s)
13 VPC(s)
5 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
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #901	2015_246196_0016	196

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A Critical Incident report was submitted to the Director in December 2014, for an incident of alleged staff to resident verbal abuse.

A review of the investigation notes from the home regarding the alleged verbal abuse indicated that PSW #154 used inappropriate language in the main dining room on a particular day in November 2014, in front of residents. Specifically, PSW #154 was witnessed to use multiple profane words loudly in the presence of a dining room full of residents during a meal service. [s. 3. (1) 1.]

2. The licensee failed to ensure that residents #007, #018, #020, #023, #031, #032 and #036 are cared for in a manner consistent with his or her needs.

On a particular day, during the inspection in November 2015, Inspectors #196 and #542 observed the following on one of the care units between 1129hrs through to 1150hrs:

A. Resident #020 was seated at the edge of their wheelchair seat, no seat belt fastened. The resident also had a device for falls prevention that was not attached properly. Inspector #542 informed RPN #100 that the resident was not attached properly to the

device for falls prevention and that they were seated at the very edge of the wheelchair seat. The RPN stated that this resident was always unclipping the device and proceeded to reattach the device and reposition the resident.

The current care plan indicated that resident #020 was a high risk for falls and required a falls prevention device and specialized seat belt as interventions.

B. Resident #023 was in a wheelchair and both of their feet were on the floor, and the resident was sliding down out of the chair and the falls prevention device was taut. The wheelchair was positioned upright with the back of the chair at 90 degrees. Inspector #542 and #196 immediately obtained staff as the resident was at imminent risk of sliding out of the chair and falling to the floor. PSW #101 and the RPN #100 proceeded to tilt the wheelchair backwards and repositioned the resident in the chair.

The current care plan was reviewed and identified resident #023 as being at high/medium risk for falls and interventions included a specialized wheelchair.

C. Resident #036 was seated in a wheelchair with an ill-fitting falls prevention device in place. Inspector #196 informed RPN #100 who indicated that there should be two finger widths of space between the resident and the device. RPN #100 re-affixed the falls prevention device at that time and then realized that it was not activated. The resident did not have any other seat belt in place.

The care plan was reviewed and identified that the resident was to a particular type of seat belt. In addition, a restraint device was listed and noted the resident to be at high risk for falls and a falls prevention device was to be used.

D. Resident #018 was seated in their wheel chair. The resident was sitting on the edge of the seat leaning forward in their chair. Inspector #542 immediately retrieved PSW #101 to show them that the resident was at imminent risk of falling out of their wheel chair. PSW #101 stated that they wanted to put a seat belt on the resident however they are not allowed to and that it would prevent them from falling out. The PSW #101 then proceeded to walk away without assisting the resident to a safer position in their wheel chair. Inspector then asked the PSW to come back to ensure that the resident was safe. The PSW returned and then attempted to have the resident sit back in their wheel chair.

The PSW then brought the resident to their room, tilted back the wheel chair slightly.

The current care plan indicated resident #018 was a high risk for falls and that they were to have a falls prevention device in place.

During the observations of the residents identified in A, B, C and D, staff walked past these residents and did not intervene until prompted by Inspectors #542 and #196.

E. Inspector #625 also observed three residents that did not have functioning fall prevention devices in place as per their care plans.

On a specific date during the inspection, Inspector #625 observed that the the fall prevention device for resident #031 was not functioning. Inspector #625 had overheard PSW #102 and #103 discuss that the fall prevention device for resident #031 was not working that morning when the PSW got resident up from bed.

The current care plan for resident #031 indicated that they were a high to medium risk for falls and required a fall prevention device as a falls prevention strategy.

On another day during the inspection, Inspector #625 heard resident #032 call out from their room. Inspector saw resident sitting at the edge of the bed on a small portion of the fall prevention device. The fall prevention device box was not visible and the fall prevention device was not sounding. RPN #104 confirmed that no fall prevention device box was present in resident's room nor on their bed.

The current care plan for resident #032 indicated that they were a high to medium risk for falls and required a fall prevention device as a falls prevention strategy.

On two other days, Inspector #625 observed that resident #007 did not have a fall prevention device on their bed. On another date during the inspection, Inspector observed resident to have a fall prevention device in place, however it did not did not activate when appropriate.

The current care plan for resident #007 indicated that they were a high risk for falls and required a fall prevention device on their bed and on chair.

The determination to issue an immediate order was based upon immediate risk of

serious injury, harm or impairment to residents receiving care in the home.

The scope was identified as a pattern.

The compliance history included: Inspection # 2014_246196_0017 dated September 21, 2014 Written Notification s.3.(1)8; Inspection # 2013_211106_0027 dated September 16, 2013 Compliance Order s.3.(1)3; Inspection # 2013_211106_0004 dated February 11, 2013 Voluntary Plan of Correction s.3.(1)4. [s. 3. (1) 4.]

Additional Required Actions:

CO # - 901 was 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #027 was not neglected by the licensee or staff; specifically the licensee failed to ensure that resident #027 received diagnostic tests as ordered by the physician and had their symptoms monitored and recorded on every shift.

A Critical Incident System (CIS) report was submitted to the Director for the unexpected death of resident #027. The CI report was reviewed by Inspector #542 and it indicated the cause of death. According to the report, the RN, on a specific date had entered the resident's room and found the resident deceased.

As per O. Reg. 79/10, neglect is defined as, "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Inspector #542 reviewed the health care records for resident #027. The progress notes indicated that the resident sustained an injury, developed an infection, was started on medication and had diagnostic testing ordered. The progress notes further revealed that over a four day period the resident's condition had deteriorated.

As per O. Reg. 79/10, s.229. (5), "the licensee shall ensure that on every shift, symptoms indicating the presence of infection are monitored in accordance with evidence based practices and if there are none, in accordance with prevailing practices; and symptoms are recorded and that immediate action is taken as required".

There was no documentation that the symptoms of infection of resident #027's injury were being monitored and recorded on every shift. Inspector #542 spoke with the DOC who confirmed that the staff did not monitor and record the symptoms of infection on every shift and should have.

As per the LTCHA 2007, c.8, 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." The licensee failed to ensure that the care set out in the plan of care for resident #027 was provided to the resident as specified in the plan, specifically related to the completion of the ordered diagnostic tests.

Inspector #542 completed a closed health care record review for deceased resident #027. The physician's order dated on a specific date, indicated that diagnostic tests were ordered and were to be completed within 48 hours. There was no documentation to indicate that the tests were completed or that the results were available. Inspector #542 spoke to the DOC who confirmed that the diagnostic tests had not been completed for resident #027. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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 has failed to ensure that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, where bed rails are used.

During the inspection, Inspector #625 observed two resident beds to have gap of approximately 15 cm between the head board and the mattress and a gap of approximately 15 cm between the foot board and the mattress.

Inspector #625 and RPN #110 attended another resident room and observed a gap of approximately 15 cm from the foot board to the mattress; another resident bed had a gap between the foot board and the mattress of greater than 15 cm; and another resident bed had a gap of approximately 15 cm from the headboard to the mattress.

The Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" effective March 17, 2008, identified the zone of entrapment from the mattress end to the head or foot board as a potential for entrapment and indicated a dimensional limit recommendation of 120mm.

On a day during the inspection, Inspector #625 met with a Manager who attended one of the resident rooms and measured the gap between the mattress and foot board and determined it to fail the entrapment zone test. The Bed System Measurement Device was then used by the Manager to conduct tests on beds in two other resident rooms and determined that both failed the zone of entrapment test between the mattress and headboard.

Inspector #625 reviewed the home's bed rail entrapment audit, which identified beds that failed the zone of entrapment test, failed specific zones of entrapment and required action by the home to ensure resident safety.

The Manager reported that there were outstanding items that needed to be addressed as identified in the bed rail entrapment audit. In addition, they confirmed that three mattresses identified in the audit required replacement as well the two beds identified by Inspector #625.

All beds identified had one to two bed rails in use when observations, measurements and Bed System Measurement Device testing were completed. [s. 15. (1) (b)]

2. The licensee failed to ensure that where bed rails are used, other safety issues related to the use of bed rails are addressed, including height and latch reliability.

Inspector #196 noted that resident room had a bed rail that was loose.

Inspector #625 observed the left bed rails in two resident rooms to be loose. The bed rail in one room could be moved to create a gap approximately 10 cm from the bed when positioned perpendicular to the mattress.

Inspector #625 met with RPN #110 who confirmed that the bed rails were loose in the identified resident rooms. [s. 15. (1) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On a day during the inspection, Inspector #625 observed a wet stain present, and an odour of urine emanating from, resident #007's mattress. Six dark brown stains were also present on the resident's pillow.

On another day, Inspector #625 noted that resident's room smelled of urine and observed the mattress to be wet.

On another day, Inspector #625 observed a white stain and brown smears on resident's bed and dark brown yellow stains were present on the resident's pillow.

On another day, Inspector #625 interviewed PSW #105 who stated that resident's bed constantly smelled. As the Inspector and PSW entered the resident's room, the PSW stated that they smelled an odour from resident's room as soon as they had entered it. PSW identified the white stain on resident's mattress as possible urine and brown streaks as feces or chocolate and stated that old blood and urine were present on resident's pillow.

PSW #103 was interviewed and identified that the resident's therapeutic mattress had cracks, urine stains and feces and stated that the resident's pillow was discoloured from possible blood and sweat.

During an interview with Inspector #625 the DOC stated that resident #007's pillow appeared to be stained with urine and blood.

On another day, Inspector #625 observed the smell of urine in resident's room emanating from their mattress where a moist urine stain was visible in the centre of the bed.

During an interview with Inspector #625, RN #109 discussed the process for cleaning resident #007's mattresses and covers.

Inspector #625 attended resident's room and observed that, eight days after initially noting the odour of urine and staining on the mattress, and alerting staff to it, the mattress had been exchanged and stains and odour of urine were no longer present. [s. 15. (2) (a)]

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

On three dates during the inspection, Inspector #625 spoke with the Manager who had reported that a number of lights on one of the units were burned out and the maintenance could not change them so an electrician had been contacted to replace them.

Inspector #625 spoke with PSWs #135 and PSW #137 on the same unit after noting seven of the 16 lights in the hallway were not illuminated. The hallway was dimly lit and the inspector asked the PSWs if all the lights in the hallway were turned on. The PSWs confirmed that all lights were turned on and the lights were burned out and could not be illuminated using a light switch. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the equipment, supplies, devices and assistive aids referred to in the home's falls prevention and management program are readily available at the home.

On a date during the inspection, Inspector #625 spoke with RPN #104, PSW #102 and PSW #103 and the PSWs reported that resident #031 and #032's fall prevention devices were not working and they required new fall prevention devices.

At 0840hrs, Inspector #625 attended resident #031's room and observed the fall prevention device was not functioning.

At 0912hrs, Inspector #625 heard resident #032 call out for assistance and observed them seated at the edge of their bed and the fall prevention device was not sounding. Inspector notified RPN #104 who stated that the fall prevention device box was missing from resident's room.

Inspector #625 reviewed resident #031's current care plan which indicated this resident was at risk for falls and required a fall prevention device as a falls prevention strategy.

Inspector #625 reviewed resident #032's current care plan which indicated this resident was at risk for falls and required a fall prevention device as a falls prevention strategy. (625) [s. 49. (3)]

2. Resident #007's current care plan identified the resident as at high risk for falls and required a fall prevention device as a falls prevention intervention. Progress notes indicated that this resident fell 12 times over an approximate seven month period.

During the inspection, Inspector #625 interviewed PSW #105 who reviewed the resident's care plan and attended resident #007's room with the Inspector. The PSW identified that the resident's fall prevention device was missing from the bed.

On another day, Inspector #625 observed that there was no fall prevention device in resident's room.

On another day, Inspector #625 spoke to RPN #104 regarding the missing fall prevention device. The RPN consulted with PSWs #102 and #103, who stated that the fall prevention device had been removed the previous day.

Inspector #625 spoke to RPN #104 regarding the absence of a fall prevention device on resident's bed and they reported that the resident did not have a fall prevention device on their bed because Maintenance was required to mount a component of the device before it could be used.

Inspector #625 interviewed the manager who stated that they had received a maintenance memo to install a fall prevention device for resident #007, as one component needed to be mounted to the wall. (625) [s. 49. (3)]

Additional Required Actions:

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

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there was a written plan of care for resident #042 that sets out clear directions to staff and others who provide direct care to this resident.

On a particular day in November 2015, resident #042 was observed seated in a specialized wheelchair with a front closing seat belt in place. The seat belt was loose fitting, approximately 15 centimeters away from the waist and the resident was sliding down in the chair, with both feet hanging off the foots rests.

Upon questioning, manager #152 confirmed to the Inspector that the seat belt was loose. RPN #147 then came to the resident's side and immediately reported to the Inspector that the seat belt was too loose and maintenance would have to make adjustments to the chair.

RPN #147 and RN #153 attempted to reposition the resident in the chair. The DOC reported that maintenance would have to take the chair to have it adjusted.

The care plan found in the binder on the unit, with a print date in July 2015, was reviewed

and did not include reference to the use of a specialized wheelchair or a front closing seat belt. The RAI Coordinator then provided the Inspector with a copy of the current care plan which identified the use of a specialized wheelchair initiated in October 2015. It did not include the use of a front closing seat belt. In addition, the current care plan identified that the resident was a two person transfer with a mechanical lift, and also noted that staff are to report to the nurse any decrease in ability to transfer self safely. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #011 as specified in the plan.

During lunch meal service on a day in November 2015, the Substitute Decision Maker (SDM) for resident #011 reported to Inspector #621 that there was a discrepancy between the resident's diet order and what was being served by staff. The resident's meal was observed to include a specific texture of food and consistency of fluids.

The meal service report as well as the separate line list of resident diets was reviewed and indicated resident #011 was on a particular diet with a specific texture of food and consistency of fluids. However, a review of resident's #011 chart identified an order from October 2015, from the Registered Dietitian (RD) for this resident to be on a different type of a diet with a specific texture of food and consistency of fluids.

During an interview with RPN #115 it was confirmed that the resident diet list and the meal service report as found in the unit servery continued to identify resident #011 as being on a a different type of diet and texture of food. This was inconsistent with diet orders found in the resident's chart on in October 2015.

Inspector #621 again reviewed the food services meal service report and diet line list for resident #011 in November 2015, and identified that only a partial update consistent with the most current diet order had been made. It was confirmed by RPN #115 that the diet texture had been revised correctly, but that the change from a one particular diet to a different diet had still not been completed.

On another day in November 2015, Inspector #621 identified that the meal service report showed resident #011 to be on a particular diet with specific texture and not on the currently ordered type diet. It was confirmed by Dietary Aide #117 that revisions to the diet line list had been made but not to the meal service report which outlines resident food allergies, diet preferences, special snack provisions, along with the diet order. [s. 6.

(7)]

3. The licensee has failed to ensure that the care set out in the plan of care for resident #027 was provided to the resident as specified in the plan, specifically related to the completion of the ordered diagnostic tests.

Inspector #542 completed a closed health care record review for deceased resident #027. The physician's order dated for a particular day in 2015, indicated that two types of diagnostic tests had been ordered. The chart contained a requisition for both tests indicating that they were to be completed within 48 hours. Inspector #542 was unable to locate any documents to support that the diagnostic tests were completed or that the results were available.

On a day during the inspection, Inspector #542 spoke to the DOC who confirmed that the diagnostic tests had not been completed for resident #027. [s. 6. (7)]

4. The licensee failed to ensure that the care set out in the plan of care for resident #018 was provided to the resident as specified in the plan, specifically related to resident #018's diet orders and adaptive aids.

Inspector #542 completed a health care record review for resident #018. The most recent care plan indicated that the resident was to receive a specific thickness of fluids, used a specific type of adaptive aids for meals and to avoid the use of straws for fluids due to the risk of injury.

On a particular day in 2015, during the inspection, Inspector #542 observed resident #018 in the dining room drinking regular consistency fluids with a straw. The resident was also observed not provided with the specific type of adaptive aids for meals.

At another time, Inspector #542 observed resident #018 consuming regular consistency fluids. Inspector spoke with PSW #118 who was not sure if the resident was to receive a different consistency of fluids. The PSW then proceeded to ask RPN #119 who confirmed that the resident was to have a different consistency of fluids. Inspector #542 observed both staff members continue with other duties as resident #018 continued to consume the regular fluids. Approximately ten minutes passed and the resident was still consuming the incorrect consistency of fluids. Inspector #542 approached the RPN #119 and asked if someone was going to provide resident #018 with the correct consistency of fluids. The RPN indicated that someone would and then removed the regular

consistency fluids, however they did not provide the resident with the different consistency of fluids.

Inspector #542 and #196 observed the supper meal and on this same day. Both Inspectors observed resident #018 to be drinking regular consistency of fluids instead of the different consistency. Inspector #196 asked the Administrator to observe this as well. The Administrator spoke with the staff involved and confirmed to the inspector that the incorrect consistency of fluids had been provided. [s. 6. (7)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident #007 as specified in the plan.

Resident #007's current care plan indicated that staff were to assist the resident to bed for a rest after lunch.

On a day during the inspection, PSW #105 confirmed resident #007's care plan interventions included returning them to bed after lunch.

Inspector #625 spoke with RPN #104 who had worked on this particular unit on six specific dates in November 2015, and they reported that they had not observed this resident to be assisted into bed after lunch on any of those dates.

PSW #105 provided care to resident on two specific dates in November, and informed Inspector #625 that resident was not put to bed after lunch on either date.

PSW #103 provided care to resident on a specific date in November and informed Inspector #625 that resident was not put to bed after lunch.

Inspector #625 attended the unit on five dates in November 2015, and resident #007 was not observed to be in bed during any time the Inspector was present on the unit. [s. 6. (7)]

6. The licensee has failed to ensure that the care set out in the plan of care for resident #020 was provided to the resident as specified in the plan.

A health care record review was conducted for resident #020. The current care plan indicated that resident #020 was a high risk for falls and was required to use specific interventions aimed at minimizing injury and preventing falls.

Inspector #542 spoke with PSW #118 who identified that the resident was not using one of the specific interventions.

On another day during the inspection, Inspector #542 and #196 observed resident #020 seated at the edge of their wheelchair seat without the specific fall prevention devices in place. Inspector #542 informed RPN #100, who immediately repositioned the resident and applied both of the devices. The RPN indicated that resident #020 would frequently remove one of the devices. [s. 6. (7)]

7. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #017 as specified in the plan.

Resident #017 was observed on two particular days in November 2015, and a protective material was not in place on a specific part of their body.

The health care record for resident #017 was reviewed and the care plan included the use of coverings to prevent injury.

An interview was conducted with RPN #120 and they confirmed that the coverings were not in place on resident #017 on a day in November 2015. PSW #121 reported to the Inspector that the coverings had not been applied on two other days, despite being documented on POC (Point of Care) as having been applied. [s. 6. (7)]

8. The licensee has failed to ensure that resident #017 was reassessed and the plan of care 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.

The health care record for resident #017 was reviewed and the current care plan indicated that the resident had a specific type of altered skin integrity. The physician's orders dated in September 2015, identified that the treatment for the altered skin integrity had been discontinued and no current Treatment Observation Record document was found.

During an interview with RPN #120, they stated that resident #017 no longer had altered skin integrity and confirmed that the care plan had not been updated according to the current needs of the resident. [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 that ensures the written plan of care for resident #042 sets out clear directions to staff and others who provide direct care to this and all residents, that the care set out in the plan of care is provided to residents #007, #011, #018, #020, #027 and to all residents as specified in their plans, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with. Specifically, the licensee has failed to ensure that policy LTC-E-90 "Skin and Wound Program" revised August 2015 was complied with.

(A) Inspector reviewed policy LTC-E-90 which stated that the "Initial Wound Assessment – Treatment Observation Record" should be initiated upon initial discovery when a resident has any open area or wound.

A review of resident #007's health care record identified a progress note in April 2015, that stated the resident had an area of impaired skin integrity. Eleven days after the impaired skin integrity was discovered, RN #109 completed the "Initial Wound

Assessment – Treatment Observation Record".

During an interview with Inspector #625, RN #109, reported that the "Initial Wound Assessment – Treatment Observation Record" should have been completed upon discovery of the area of impaired skin integrity.

The DOC confirmed that they were not able to locate documentation to indicate that a "Initial Wound Assessment – Treatment Observation Record" was completed upon initial discovery of the wound, as the home's policy LTC-E-90 "Skin and Wound Program" required.

(B) The policy LTC-E-90 stated that wounds were to be photographed initially and at least monthly, as per best practice.

The Inspector reviewed the "Treatment Observation Record" (TOR) which contained pictures of resident #007's impaired skin integrity on specific days in June, July, October and November, 2015. When requested by the Inspector, the DOC was not able to locate or provide photographs of the impaired skin integrity for the months of April, May, August or September 2015.

The DOC confirmed that they were not able to locate documentation to indicate that monthly pictures of the impaired skin integrity were taken, as the home's policy LTC-E-90 "Skin and Wound Program" required.

(C) The policy LTC-E-90 stated that the "Treatment Observation Record (TOR) – Ongoing Wound Assessment" should be completed with every dressing change, and a minimum of every seven days.

The Inspector reviewed the TOR and it did not contain entries for resident #007 for eight specific periods of time when seven day TOR entries were due.

The DOC confirmed that they were not able to locate documentation to indicate that weekly "Treatment Observation Record – Ongoing Wound Assessments" were completed, as the home's policy LTC-E-90 "Skin and Wound Program" required. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put into place was complied with. Specifically, the licensee

has failed to ensure that policy 04-04-10 "Discharged/Deceased Procedure" was complied with.

The Inspector reviewed Medisystems Pharmacy policy 04-04-10 "Discharged/Deceased Procedure" which indicated that staff were to remove all medications for deceased residents and place them into the medication destruction container.

On a day during the inspection, Inspector #625 observed a bottle of prescription mouth spray. The bottle had a small portion of a pharmacy label affixed to it and RPN #119 identified the bottle as belonging to a resident that was deceased.

Inspector #625 interviewed the DOC who stated that all medications belonging to deceased residents should be sent to drug destruction and could not be used on other residents. [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 that ensures that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put into place is complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are locked when they are not being supervised by staff.

During the inspection, Inspector #625 observed a unit's equipment room door open. A fridge with a sign "biohazard" affixed to the front was in the room and RPN #131 reported to the inspector that the door should be kept closed and locked.

On another day during the inspection, Inspector #625 observed a soiled utility room door, on one of the units, held open with a doorstop. PSW #151 entered the room and reported that the door should have been closed and locked and residents are not permitted access to the room.

On another day during the inspection, Inspector #625 observed the equipment room door, on one of the units and it was unlocked and open. PSW #121 stated that the expectation was that the door was to remain closed and locked, and then they walked away from the open door.

Inspector #625 then interviewed RPN #134 who stated that the equipment room door should be kept closed and locked at all times and also left the area with the door open.

Later, Inspector #625 observed the equipment room door to be open, despite four staff walking past the open door and two staff speaking to the inspector specifically about the opened door that was required to be kept shut and locked.

Inspector #625 again, observed the equipment room door propped open with a door stop from 0935hrs – 0943hrs on another day. [s. 9. (1) 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 that will ensure that all doors leading to non-residential areas are locked when they are not being supervised by staff, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a registered dietitian who was a member of the staff of the home completes a nutritional assessment for all residents whenever there was a significant change in a resident's health condition.

A review of the weight and vital reports in Point Click Care for resident #002 identified that there was a significant weight change in one months time. Despite this weight difference in weight, staff did not re-weigh the resident.

Review of the quarterly nutrition reassessment by RD for a specific day in August 2015, indicated that resident #002 was a high nutrition risk. However, as part of the RD assessment there was no documentation reporting on the significant weight change.

During an interview, the RD reported to Inspector #621 that they completed a review of all weight variances for each month as per homes policy LTC-G-60 titled Height Measure and Weight Management. However, they verified that they did not follow up or address resident's #002 weight variance as part of their August 2015 quarterly nutrition assessment. They also confirmed that they did not update information in the September 2015, Nutrition Risk care plan to address this resident's weight and nutrition risk changes from August 2015. [s. 26. (4) (a),s. 26. (4) (b)]

2. The licensee failed to ensure that a registered dietitian who was a member of the staff of the home completes a nutritional assessment for all residents whenever there was a significant change in a resident's health condition.

A review of the weight and vital reports by Inspector #621 in Point Click Care for resident #007 identified that there was a weight change between a day in October 2015, and a day in November 2015, which was a significant weight change of greater than five percent over one month. Additionally, on review of nutrition assessment documentation over an approximate six month period, it was identified that there were no quarterly nutrition review or re-assessment reports completed for a wound referral that had been received from the beginning of April 2015.

During an interview,the RD reported that they had not identified resident #007's significant weight change from review of the monthly weight reports as per homes policy, and did not complete a nutrition re-assessment of the resident. Further, the RD confirmed that they had not yet completed a nutrition assessment of the resident based on a referral received in April 2015, and while unsure that they received a copy, they indicated it could be in a stack of paperwork they still needed to go through on their desk. Inspector #621 provided a copy of the referral from a particular date in April 2015, which reported resident #007 had an area of impaired skin integrity. The RD confirmed that for resident #007 they did not complete a quarterly nutrition review, or nutrition re-assessment of resident #007 over an approximate six month time period in 2015. [s. 26. (4) (a),s. 26. (4) (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 that ensures that a registered dietitian who is a member of the staff of the home completes a nutritional assessment for all residents whenever there is a significant change in a resident's health condition, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration; O. Reg. 79/10, s. 71 (1).
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).
(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle included menus for regular, therapeutic, and texture modified diets for snacks was approved by a registered dietitian who was a member of the staff of the home; and was reviewed and updated at least annually.

On review of the 2015 menu review report completed by the homes RD, it was identified that there was no information as to whether a snack menu was reviewed and analyzed as per legislative requirements.

During an interview with the RD, it was confirmed that they did not complete a review of the snack menu to support the regular, therapeutic or texture modified diets, and did not complete a nutrient analysis for the snack component of the home's menu cycle for the spring/summer 2015 menu review. [s. 71. (1)]

2. The licensee failed to ensure that each resident was offered a between meal beverage in the morning, afternoon and a beverage in the evening after dinner.

During interviews with resident #006 and #004 on different dates during the inspection in November 2015, they reported to Inspector #621 that beverages were not offered in the morning, between breakfast and lunch times.

On two dates during the inspection in November 2015, between 0950-1045hrs, and 0955 -1030hrs respectively, Inspector #621 observed that a beverage pass was not provided to residents on one particular unit.

During an interview with the DOC, it was confirmed that beverages should be offered between meals in the morning, afternoon and after dinner. It was verified that the home's scheduled snack times begin daily at 1000, 1400 and 2100hrs with beverages to be offered at those times. [s. 71. (3) (b)]

3. The licensee failed to ensure that the planned menu items are offered and available at each snack.

It was observed by Inspector #621 on a date in November 2015, that snack choices prepared for the afternoon snack service by Dietary Aide (DA) #126 were not consistent with the snack menu posted in the snack binder which had a print date of January 6, 2014. DA #126 verified that the home was on menu cycle week #2 and that the most current snack menu was located in this snack binder.

During an interview, PSW #125 verified that snack choices prepared by dietary staff for the afternoon snack service did not include crispy rice squares, or rice pudding, which were listed on the snack menu for regular and therapeutic diets. There were also no appropriate therapeutic alternative to support residents on a minced texture diet.

On a particular date in November 2015, Inspector #621 observed snack choices provided for the afternoon snack service to be inconsistent with the snack menu found on the

nourishment cart. During an interview with PSW #123 it was confirmed that snack choices prepared for the afternoon snack service did not include bran crunch cookies or rice pudding as listed on the snack menu. Appropriate minced textured options were not available for residents.

Also during an interview with PSW #130, they stated that carrot muffins were available for the afternoon snack as identified on the June 3, 2014, snack menu cycle. However it was revealed that there were no minced snack options available for residents. PSW #130 reported that minced and pureed options were usually not available on the snack cart and that staff would generally offer the muffins to the residents on minced diets.

During a meeting with the RD, it was confirmed that it would be an expectation that snack choices offered would be of an appropriate texture for residents' prescribed diets. They verified that food services was to provide the exact the food textures to meet the required diet consistency for all meals and snacks for all residents. When asked if the carrot muffin was an appropriate snack item for a minced diet, they indicated that this would not be an acceptable snack.

During an interview with a manager, it was verified to Inspector #621 that minced diet orders should be provided a special labeled snack and not the regular texture snack option. [s. 71. (4)]

4. The licensee failed to ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle.

During the afternoon snack service on a day during the inspection, PSW #123 confirmed that resident #010 was to be provided with a specific food item for the afternoon snack as identified on the meal service report. PSW #123 confirmed that the meal service report identified that the food item was to be provided at afternoon snack for this resident since the start of January 2014, but stated that the specific food item was not available on the cart for afternoon snack service for this resident. [s. 71. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures the home's menu cycle includes menus for regular, therapeutic, and texture modified diets for snacks, is approved by a registered dietitian who is a member of the staff of the home, is reviewed and updated at least annually, that each resident is offered a minimum of a between meal beverage in the morning and afternoon and a beverage in the evening after dinner and that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #11: 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,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

s. 72. (4) The licensee shall maintain, and keep for at least one year, a record of,
(c) menu substitutions. O. Reg. 79/10, s. 72 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all food in the production system is prepared, stored and served using methods to prevent adulteration, contamination and food borne illness.

On a date during the inspection, Inspector #625 observed uncovered plastic containers containing cooked green beans and cooked chicken nuggets on an unattended cart outside of the elevator. At 1729 hrs, DA #138 approached the cart and stated that they were following the regular method used to transport leftover food from the units back to the kitchen and would cover the food prior to storing it in the refrigerator.

On another date, after lunch meal service, Inspector #625 observed a DA on the elevator with a cart of uncovered plastic containers with approximately 20 pieces of fish and shredded salad. The DA reported to the inspector that the fish and salad would be served for minced and puree diets and that they are generally covered during transport, although they were uncovered at this time.

During an interview with a manager, Inspector #621 questioned what the expectations were of staff transporting food items from the unit area serveries and back to the main kitchen area. The manager reported that the expectation was that staff cover all leftovers being transported down from the units to the kitchen. [s. 72. (3) (b)]

2. The licensee failed to ensure that records are maintained of all menu substitutions, and kept for at least one year.

During an interview with PSW #123, they reported to Inspector #621 that there are regular occurrences during meal times where what was served does not match the posted cycle menu. It was indicated that there is no notice given by food services staff of menu changes prior to service during these times.

During an interview with Inspectors #621 and #196, the manager reported that it was accepted practice to use leftovers from the previous days' meal service and incorporate it as part of the next days' menu offerings. It was confirmed by the manager that leftovers were commonly modified in texture to be used for the minced and pureed textured diets. When asked if a record of the menu substitutions could be provided, the manager reported that the home did not keep on file a menu substitutions list to track how and when leftovers, or any other menu substitution were being used in lieu of planned menu items. [s. 72. (4) (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 that ensures that all food in the production system is prepared, stored and served using methods to prevent adulteration, contamination and food borne illness and that records are maintained of all menu substitutions, and kept for at least one year, to be implemented voluntarily.

WN #12: 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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a snack service that includes a process to ensure that staff assisting residents is aware of residents' diets, special needs and preferences.

On a day during the inspection, Inspector #621 reviewed the contents of the nourishment cart snack binder. It contained a line list of resident diet orders, but no record of resident special diet needs, reported food allergies or individual diet preferences.

During afternoon snack service on one day, PSW #123 confirmed to Inspector #621 that other than a list of resident diet orders, there were no details in the snack binder to identify resident diet preferences, food sensitivities or special labelled snack items during snack service. In addition, PSW #123 stated that without this information staff relied on their personal knowledge of the residents diet needs or halted snack service to find the information elsewhere.

During an interview with Inspector #621 and #196, the manager confirmed that they did not print meal service reports for the snack binders on unit nourishment carts and admitted that staff delivering snacks would not have sufficient information about specific diet preferences, food allergies, other diet specifications when offering residents food and fluids between meals. [s. 73. (1) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that the home has a snack service that includes a process to ensure that staff assisting residents is aware of residents' diets, special needs and preferences, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a registered dietitian who is a member of the staff was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

The resident census on the first day of the home's RQI inspection in November, identified 127 residents in the home. The legislative requirement for on site RD time was determined to be a total of 63.5 hours per month. At full census of 128 beds, RD time requirements were 64 hours per month.

The Administrator reported to Inspector #621 that the RD provided 15 hours a week (60 hours per month) to the home in the evenings.

A review of the home's payroll records for the RD identified that a total of 55 hours was provided over a four week period between July 2015 and the end of August 2015; and a total of 62 hours over a four week period between a specific date in September 2015 – a specific date in October 2015.

During an interview with the RD, it was reported to Inspector #621 that dietitian services were provided on site in the evenings on Tuesdays, or Wednesdays with a total of 10-13 hours provided in the home on most weeks. It was confirmed by the RD that the remainder of the 15 hours per week allotment by the home was spent off site completing resident charting. [s. 74. (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 that ensures that a registered dietitian who is a member of the staff is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. 1. The licensee has failed to ensure that, as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, procedures are developed and implemented for addressing incidents of lingering offensive odours.

On a date during the inspection, Inspector #625 noted the smell of urine originating from resident #007's mattress.

On the following day, Inspector #625 noted that resident's room smelled of urine.

Inspector #625 interviewed PSW #105 who stated that resident's bed constantly smelled and, as Inspector and PSW entered the resident's room, the PSW stated that they smelled an odour from resident's room as soon as they had entered it.

On another date, Inspector #625 observed the smell of urine in resident's room emanating from the mattress. [s. 87. (2) (d)]

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 that ensures procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 120. Responsibilities of pharmacy service provider
Every licensee of a long-term care home shall ensure that the pharmacy service provider participates in the following activities:
1. For each resident of the home, the development of medication assessments, medication administration records and records for medication reassessment, and the maintenance of medication profiles.
2. Evaluation of therapeutic outcomes of drugs for residents.
3. Risk management and quality improvement activities, including review of medication incidents, adverse drug reactions and drug utilization.
4. Developing audit protocols for the pharmacy service provider to evaluate the medication management system.
5. Educational support to the staff of the home in relation to drugs.
6. Drug destruction and disposal under clause 136 (3) (a) if required by the licensee's policy. O. Reg. 79/10, s. 120.

Findings/Faits saillants :

1. The licensee has failed to ensure that that the pharmacy service provider participated in the following activities: Risk management and quality improvement activities, including review of medication incidents, adverse drug reactions and drug utilization.

The health care record for resident #022 was reviewed and the progress notes on a particular date revealed that a medication incident had occurred the previous week in which they received another resident's medications, in error.

An interview was conducted with DOC and they reported that resident #022 had in error received another resident's medications on a particular date and that a medication incident report was completed.

The Medisystem pharmacy manual policy # 04-09-10 titled "Medication Incidents" #5 read "The Medication Incident Reports" will be analyzed by nursing administration, the Pharmacy Manager, and /or the consultant pharmacist to determine whether pharmacy and/or nursing procedures require modification. The Pharmacy and Therapeutics Committee will also review a summary of all Medication Incident Reports at scheduled Nursing home meetings or annually in Retirement homes to determine if corrective actions are necessary to prevent future harm".

According to the a interdisciplinary team member for the home, a copy of the medication incident report regarding resident #022 which had occurred in the summer 2015 had not been received nor discussed at the MRCC (Multidisciplinary Resident Care Committee) meetings. They also reported that the pharmacy had only received one medication incident from the past summer, that they are not receiving the reports and therefore are unable to discuss at MRCC meetings, nor analyze and assess trends. The interdisciplinary team member also stated that in the past, the pharmacy used to get the reports all the time and then use them as a learning tool and that it was expected that all medication incident reports irregardless if it was a pharmacy error or nursing error would be received by their pharmacy.

An interview was conducted with DOC, and they reported that they were behind in completing some of the medication incident reports and provided five hard copies of different reports. None of these reports had page two completed, which would include comments/corrective actions completed by the DOC, and the pharmacy comments/corrective actions. [s. 120. 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that the pharmacy service provider participates in the following activities: Risk management and quality improvement activities, including review of medication incidents, adverse drug reactions and drug utilization, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

The health care record for resident #022 was reviewed and the progress notes from a particular date, revealed that a medication error had occurred the previous week.

A medication incident report was completed and identified that resident #022 received another resident's medications.

An interview was conducted with the DOC and they reported that resident #022 had in error, received another resident's medications. [s. 131. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident’s health; and reported to the resident, the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Inspector #196 reviewed the home's medication incident reports from an approximate four month period in 2015. During this time period, a medication incident occurred on a date in the summer of 2015, in which resident #022 received another resident's medication in error.

The health care records of resident #022 were reviewed for information regarding the medication incident. The progress notes, on the date on which the incident had occurred, included an entry by RPN #140 documenting the residents' vital signs. There was no record of the medication error in the progress notes, no documentation of physician contact, no record of the immediate actions to assess and maintain resident #022's health, and there was no documentation of resident or substitute decision makers (SDM) having been informed.

The resident's progress notes at a later date did not identify if the Substitute Decision Maker (SDM) was informed of the incident.

An interview with RN #109 was conducted and they confirmed that in the event of a medication incident, the resident would be assessed, the physician would be contacted, the resident and the POA (Power of Attorney) would be notified. In addition, RN #109 reported that this information would be documented in the progress notes of the resident's health care record and a medication incident report would be completed and given to the DOC.

The DOC confirmed that a progress note that included an assessment of the resident should have been documented. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that that every medication incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #18: 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 has failed to ensure that staff participate in the implementation of the infection prevention and control program.

(A) On a particular date, during the inspecion, Inspector #625 observed four resident rooms to have Personal Protective Equipment (PPE) hanging on the doors with unclear infection control precaution signage.

One resident room had PPE hanging from a shared doorway but did not have signage to identity which resident in the shared room was under these precautions. Another

resident room did not have signage posted to identify the type of infection control precautions that were in place. Another resident room did not have signage posted to identify the type of infection control precautions that were in place, or which resident in the shared room was under these precautions. Another resident room did not have signage to identify the type of infection control precautions that were in place.

Inspector #625 interviewed the DOC who stated that infection control precaution signage should be posted on the doors to the residents' rooms and, when two residents share a common hallway door, the specific resident requiring the precautions should be identified.

(B) During the inspection, Inspector #625 observed slings stored in the spa and bathing room on one of the units approximately three feet from the bath tub.

Inspector #625 interviewed the DOC who stated that slings should be stored in equipment rooms on each unit and not stored in tub rooms due to moisture, mold and contamination concerns.

(C) On another day, during the inspection, Inspector #625 observed a soiled green continent product and used green washcloths on the floor of a resident room.

Inspector #625 interviewed RPN #115 who stated that staff return to clean up rooms after the residents are finished in the dining room and that the used brief and washcloths on the floor would be disposed of at that time.

Inspector #625 interviewed the DOC who stated that soiled briefs, used linens and clothing removed from residents should immediately go into a laundry hamper or garbage bag and not thrown on the floor.

(D) On another day during the inspection, on one of the units, Inspector #625 observed a dirty laundry cart piled 40 cm above the top of the laundry bag, touching the exterior of the lid with an odour of urine present.

Inspector #625 interviewed PSW #103 who stated on a day shift many soiled beds were stripped and the laundry was left piled until the staff provided care on all residents, after which time a staff member would bag and remove the soiled linens.

Inspector #625 interviewed the DOC who stated that stacking of laundry above the laundry cart should not occur. When items fill the laundry bag, the bag should be removed and replaced. Soiled items should not be piled above the laundry cart lid.

(E) On another day during the inspection, on one of the units, Inspector #625 observed PSW #142 touch resident #029's throat, then used their hands to give a piece of toast to #007 to consume, then picked up a spoon to feed oatmeal to resident #040. No hand hygiene was completed in between assisting the three residents during breakfast meal service.

Inspector #625 spoke to PSW #142 who stated that the home's expectation was that staff perform hand hygiene in between assisting residents in the dining room. [s. 229. (4)]

2. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

During the inspection, three resident room were observed to have PPE (Personal Protective Equipment) hanging on the doors with unclear infection control precaution signage.

One resident room did not have signage to identify the type of infection control precautions that were in place, nor did it identify which resident in the shared room was under these precautions. Another resident room had "contact precautions" signage posted on the door but did not identify which resident in the shared room was under these precautions. Another resident room had a "check with nurse" sign and did not have infection control precautions signage posted.

RN #109 confirmed that resident shared double rooms, should have had a sign to identify the type of precautions with either an "a" or "b" written on it to indicate which resident was on infection control precautions and resident room should have had "contact precautions" signage on the door . [s. 229. (4)]

3. The licensee has failed to ensure that staff monitored the symptoms of infection for resident #019 and #008 on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Inspector #542 completed a health care record review for resident #019. The RAI-MDS

(quarterly review assessment) that was completed in August 2015, indicated that resident #019 had an infection. The progress notes were reviewed for resident #019, which indicated that during the month of August 2015, medication was ordered for the resident. Inspector #542 was unable to locate any further information indicating that the resident's infection was being monitored on every shift. The Inspector reviewed the resident's paper health care record and was able to find the physician's order for the medication however no other assessments were located.

Inspector #542 completed a health care record review for resident #008. The RAI-MDS assessment completed in August 2015, indicated that the resident had an infection. The progress notes revealed that medication was ordered on a day in August 2015, however no other documentation was located to indicate that the infection was being monitored on every shift for this resident.

The Inspector reviewed the Daily Infection Control Surveillance Forms that were provided by the DOC and noted that the daily monitoring of symptoms for both residents were not included on these forms. The Inspector spoke with RN #143, who stated that the nurses should be documenting in the progress notes and noted that they could not find any documentation to support that the resident's symptoms were being assessed. The Inspector spoke with the DOC who also confirmed that it was the home's expectation that the nurses document in the progress notes when a resident is exhibiting signs and symptoms of an infection. [s. 229. (5) (a)]

4. A health care record review was completed on resident #027. The progress notes revealed that they had sustained an injury on a day in 2015, and that the resident passed away approximately three weeks later.

Inspector #542 was also unable to locate any documentation to support that the symptoms indicating the presence of infection of resident #027's injury were being monitored and recorded on every shift. Inspector #542 spoke with the DOC who verified that the staff did not monitor and record the symptoms of infection on 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 that ensures that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #19: 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 resident-staff communication and response system was easily seen, accessed and used by residents, staff and visitors at all times.

On a day during the inspection on a unit, Inspector #625 observed that the shared washroom call bell in a resident room did not have a green pull cord attached to it.

Inspector #625 spoke with a manager who stated that staff had notified them of the need to replace the call bell cord in this resident room and had been provided with a replacement cord.

Later that day, Inspector #625 pulled the call bell cord in resident room bathroom after it had been replaced. The cord separated where it met the wall mounted unit. The end of the green cord had a crack and did not activate the call bell when it was pulled. [s. 17. (1) (a)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #018 was offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment is required.

Inspector #542 observed resident #018 to have an ill fitting denture. Inspector #542 reviewed the resident's progress notes and noted that on admission in 2013 it was documented that the resident's dentures were ill fitting. The most recent care plan also indicated the same.

On a date during the inspection, Inspector #542 spoke with RPN #147. The RPN indicated that the home typically wouldn't do anything with the resident's poor fitting dentures unless the resident was experiencing pain or a decrease in nutritional intake.

Inspector #542 spoke with RPN #110 who indicated that resident #018 most likely had not seen a denturist.

Inspector completed a health care record review for resident #018 and was unable to locate any documentation to support that the SDM had been contacted regarding their poor fitting dentures.

The DOC verified that the home did not offer the resident an annual dental assessment and other preventive dental services. [s. 34. (1) (c)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labeled within 48 hours of admission and of acquiring, in the case of new items.

On a day during the inspection, Inspector #625 observed unlabeled and used personal items in the spa on one of the units, which included a roll-on deodorant, three combs, nail file, finger nail clippers, and a personal wet razor.

On another day, Inspector #625 observed unlabeled and used personal items in another spa, which included a black comb with grey hairs, used toothpaste, a white brush soiled with brown and grey hairs, six used combs, makeup (foundation, eye shadow, blush, nail polish) and barrier cream tubes soiled with black and grey hairs.

On another day, Inspector #625 observed an unlabeled and used brush and comb on a care cart in a resident's room. Inspector #625 reviewed the "Resident Admission Checklists" for resident #003 and resident #038, the two residents sharing a resident room. Both checklists did not have the residents' personal care items initialed as having been labeled by staff. RPN #115 stated that combs are to be labeled. [s. 37. (1) (a)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #005 was dressed in appropriate clean footwear.

It was observed by Inspector #625 that resident #005 was not wearing appropriate footwear from approximately 1515-1555 hrs on a particular day during the inspection. Inspector #625 asked RPN #104 about the resident's footwear and they reported that the resident's care plan identified that they have a specific intervention regarding resident #005's footwear.

RPN #120 confirmed to Inspector #621 that resident #005 required assistance from staff to dress and that the specific intervention regarding resident's footwear was reported and that the issue was addressed with the resident's SDM and they had been in agreement.

In review of the most recent care plan in Point Click Care under the Risk for Falls section, RPN #149 confirmed with Inspector #621 that the specific intervention regarding resident's footwear was not in the resident's current plan of care. [s. 40.]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #016 had a documented area of impaired skin integrity was first identified in September 2015.

The health care records were reviewed for information regarding care for the area of impaired skin integrity. The Treatment Observation Record (TOR) did not include weekly assessments between two weeks in October 2015, nor between two particular weeks in October/November 2015.

An interview was conducted with RN #109 and they confirmed that weekly wound assessments were to be documented in the TOR. They also confirmed that the weekly wound assessment was not documented as was required. [s. 50. (2) (b) (iv)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the Homes' Nutrition Care and Hydration Program measures and records with respect to each resident a height annually.

Upon review of the following resident health records, it was found that an annual height measure was not recorded for the following residents:

- resident #001 whose last height was recorded in June 2014;
- resident #008 whose last height was recorded in June 2012;
- resident #009 whose last height was recorded in April 2012;
- resident #010 whose last height was recorded in July 2014;
- resident #011 whose last height was recorded in July 2014;
- resident #012 whose last height was recorded in January 2012;
- resident #004 whose last height was recorded in November 2013;
- resident #013 whose last height was recorded in September 2012 and
- resident #014 whose last height was recorded in September 2014.

A review of the home's policy titled "Height Measurement and Weight Management" last revised on June, 2014, identified that care staff are to take heights upon admission and, at minimum, annually thereafter, and record on the facility specific height worksheet.

During an interview it was reported by the Administrator that it was the home's expectation that staff measure residents' heights on admission and annually thereafter as per the homes policy. The Administrator confirmed that the staff were not consistently completing heights annually. [s. 68. (2) (e) (ii)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. As part of the organized program of laundry services under clause 15 (1) (b) of the Act, the licensee failed to ensure that, procedures were developed and implemented to ensure that, residents' personal items and clothing were labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing.

During the inspection, Inspector #625 observed five pairs of shoes and one single shoe, all of which were unlabeled, in a dirty utility room on one of the units. Inspector interviewed PSW #148 who was not able to identify the owner of the shoes as they were not labeled.

On another date, during the inspection, Inspector #625 counted 29 individual shoes, boots and slippers stored in a rectangular half-wall, and most of the 29 pieces of footwear were not labeled. Inspector #625 spoke to staff on the unit about the items. RPN #104 stated that the footwear stays in this area until someone finds a match and identifies to whom the shoes belong. RN #109 stated that storing the footwear in this manner was not the best system, but that it was the lost and found area for footwear, and stated the shoes should be labeled. [s. 89. (1) (a) (ii)]

WN #26: 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 has failed to ensure that written policies and protocols are developed for the medication management system that ensure accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home, specifically regarding accurate measuring of liquid medications.

Resident #037 was ordered 7.5 mg (7.5 ml) of a specific medication 1 mg/ml three times daily.

Resident #039 was ordered 0.5-1 mg (0.5-1ml) of a specific medication every four hours when needed.

The MediSystem pharmacy policy 04-01-40 "Medication System – Narcotics" used by the home, stated that narcotic formulations such as oral liquids may be dispensed in graduated bottles of their original containers.

On a day during the inspection, Inspector #625 and RPN #119 conducted a review of the narcotics count on one of the units. Liquid medications were dispensed to the home in scored containers and the RPN stated that staff use the scored markings on the container to measure the amount of medication to during the narcotics count.

The narcotics count sheet listed that 67.5 ml of liquid medication for resident #037, should be present. During a review of narcotic and controlled substances count, RPN #119 and Inspector #625 visually observed the bottle to contain 70 ml of liquid medication present, when measured using the scored lines on the pharmacy supplied bottle.

The narcotics count sheet listed that 5 ml of liquid medication for resident #039, should be present. During a review of narcotic and controlled substances count , RPN #119 and Inspector #625 visually estimated the bottle to contain six to seven ml. The pharmacy supplied bottle was not scored to measure 5 ml, the last measurement scored was at 10 ml.

On November 27, 2015, Inspector #625 interviewed the DOC who stated that it was not accurate to use bottles or containers with graduated markings to measure medication volumes. [s. 114. (2)]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug has been approved by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario.

During the inspection, Inspector #625 noted two boxes of medications that did not have a pharmacy service provider label on them, in one of the unit medication rooms. Both boxes had written information identifying they were for resident #041.

During an interview, RPN #119 stated that the medication was supplied by resident #041's family and not by the pharmacy service provider. [s. 122. (1)]

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On a particular day during the inspection, a units medication cart was reviewed. In the top drawer of the medication cart contained a "C and S" (Culture and Sensitivity) container half filled with brown coloured tablets marked with a letter "S".

During an interview with RPN #120, they confirmed that the container was not labeled by pharmacy and discussed what type of medication it was and that it should not be in a container like this. [s. 126.]

Issued on this 15th day of February, 2016

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) :	LAUREN TENHUNEN (196), JENNIFER LAURICELLA (542), JULIE KUORIKOSKI (621), KATHERINE BARCA (625)
Inspection No. / No de l'inspection :	2015_246196_0016
Log No. / Registre no:	029577-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 26, 2015; Feb 12, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	PINEWOOD COURT 2625 WALSH STREET EAST, THUNDER BAY, ON, P7E-2E5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHERYL GRANT

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that residents #007, #018, #020, #023, #031, #032 and #036 are cared for in a manner consistent with his or her needs.

The licensee must ensure the following is completed:

1. Reassess residents #007, #018, #020, #023, #031, #032 and #036 related to risk of falls and review and update the care plans to accurately reflect the current care needs of each resident.
2. An audit is to be conducted of all applicable residents in the home to ensure that the falls prevention equipment is in place and functioning and act upon the results of the audit.
3. Ensure that the care provided to resident #036 is as per the plan of care, regarding the use of a specific type of fall prevention device, or reassess the plan and update according to the residents current needs.
4. Meet with all staff working on the upcoming evening, night and day shift to review the importance of fall prevention interventions, including the application and monitoring of falls prevention equipment including, but not limited to, chair and bed alarms.

This immediate order is to be complied with, in entirety, by November 27, 2015, at 1400hrs.

Grounds / Motifs :

1. The licensee failed to ensure that residents #007, #018, #020, #023, #031,

#032 and #036 are cared for in a manner consistent with his or her needs.

On a particular day, during the inspection in November 2015, Inspectors #196 and #542 observed the following on one of the care units between 1129hrs through to 1150hrs:

A. Resident #020 was seated at the edge of their wheelchair seat, no seat belt fastened. The resident also had a device for falls prevention that was not attached properly. Inspector #542 informed RPN #100 that the resident was not attached properly to the device for falls prevention and that they were seated at the very edge of the wheelchair seat. The RPN stated that this resident was always unclipping the device and proceeded to reattach the device and reposition the resident.

The current care plan indicated that resident #020 was a high risk for falls and required a falls prevention device and specialized seat belt as interventions.

B. Resident #023 was in a wheelchair and both of their feet were on the floor, and the resident was sliding down out of the chair and the falls prevention device was taut. The wheelchair was positioned upright with the back of the chair at 90 degrees. Inspector #542 and #196 immediately obtained staff as the resident was at imminent risk of sliding out of the chair and falling to the floor. PSW #101 and the RPN #100 proceeded to tilt the wheelchair backwards and repositioned the resident in the chair.

The current care plan was reviewed and identified resident #023 as being at high/medium risk for falls and interventions included a specialized wheelchair.

C. Resident #036 was seated in a wheelchair with an ill-fitting falls prevention device in place. Inspector #196 informed RPN #100 who indicated that there should be two finger widths of space between the resident and the device. RPN #100 re-affixed the falls prevention device at that time and then realized that it was not activated. The resident did not have any other seat belt in place.

The care plan was reviewed and identified that the resident was to a particular type of seat belt. In addition, a restraint device was listed and noted the resident to be at high risk for falls and a falls prevention device was to be used.

D. Resident #018 was seated in their wheel chair. The resident was sitting on the edge of the seat leaning forward in their chair. Inspector #542 immediately retrieved PSW #101 to show them that the resident was at imminent risk of falling out of their wheel chair. PSW #101 stated that they wanted to put a seat belt on the resident however they are not allowed to and that it would prevent them from falling out. The PSW #101 then proceeded to walk away without assisting the resident to a safer position in their wheel chair. Inspector then asked the PSW to come back to ensure that the resident was safe. The PSW returned and then attempted to have the resident sit back in their wheel chair. The PSW then brought the resident to their room, tilted back the wheel chair slightly.

The current care plan indicated resident #018 was a high risk for falls and that they were to have a falls prevention device in place.

During the observations of the residents identified in A, B, C and D, staff walked past these residents and did not intervene until prompted by Inspectors #542 and #196.

E. Inspector #625 also observed three residents that did not have functioning fall prevention devices in place as per their care plans.

On a specific date during the inspection, Inspector #625 observed that the the fall prevention device for resident #031 was not functioning. Inspector #625 had overheard PSW #102 and #103 discuss that the fall prevention device for resident #031 was not working that morning when the PSW got resident up from bed.

The current care plan for resident #031 indicated that they were a high to medium risk for falls and required a fall prevention device as a falls prevention strategy.

On another day during the inspection, Inspector #625 heard resident #032 call out from their room. Inspector saw resident sitting at the edge of the bed on a small portion of the fall prevention device. The fall prevention device box was not visible and the fall prevention device was not sounding. RPN #104

confirmed that no fall prevention device box was present in resident's room nor on their bed.

The current care plan for resident #032 indicated that they were a high to medium risk for falls and required a fall prevention device as a falls prevention strategy.

On two other days, Inspector #625 observed that resident #007 did not have a fall prevention device on their bed. On another date during the inspection, Inspector observed resident to have a fall prevention device in place, however it did not did not activate when appropriate.

The current care plan for resident #007 indicated that they were a high risk for falls and required a fall prevention device on their bed and on chair.

The determination to issue an immediate order was based upon immediate risk of serious injury, harm or impairment to residents receiving care in the home.

The scope was identified as a pattern.

The compliance history included: Inspection # 2014_246196_0017 dated September 21, 2014 Written Notification s.3.(1)8; Inspection # 2013_211106_0027 dated September 16, 2013 Compliance Order s.3.(1)3; Inspection # 2013_211106_0004 dated February 11, 2013 Voluntary Plan of Correction s.3.(1)4. [s. 3. (1) 4.] (196)

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure compliance with LTCHA 2007, c.8, s.19. (1). that all residents are not neglected by the licensee or staff.

The licensee shall:

(A) ensure that staff monitor and record symptoms of infections in residents on every shift and take appropriate action as necessary.

(B) ensure that the care set out in the plan of care is provided to residents as specified in their plans, specifically that physician's orders are processed and implemented.

(C) ensure a system is initiated that is to be used by registered staff that will identify outstanding resident items requiring followup.

Grounds / Motifs :

1. The licensee failed to ensure that resident #027 was not neglected by the licensee or staff; specifically the licensee failed to ensure that resident #027 received diagnostic tests as ordered by the physician and had their symptoms monitored and recorded on every shift.

A Critical Incident System (CIS) report was submitted to the Director for the unexpected death of resident #027. The CI report was reviewed by Inspector #542 and it indicated the cause of death. According to the report, the RN, on a specific date had entered the resident's room and found the resident deceased.

As per O. Reg. 79/10, neglect is defined as, "the failure to provide a resident

with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Inspector #542 reviewed the health care records for resident #027. The progress notes indicated that the resident sustained an injury, developed an infection, was started on medication and had diagnostic testing ordered. The progress notes further revealed that over a four day period the resident's condition had deteriorated.

As per O. Reg. 79/10, s.229. (5), "the licensee shall ensure that on every shift, symptoms indicating the presence of infection are monitored in accordance with evidence based practices and if there are none, in accordance with prevailing practices; and symptoms are recorded and that immediate action is taken as required".

There was no documentation that the symptoms of infection of resident #027's injury were being monitored and recorded on every shift. Inspector #542 spoke with the DOC who confirmed that the staff did not monitor and record the symptoms of infection on every shift and should have.

As per the LTCHA 2007, c.8, 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." The licensee failed to ensure that the care set out in the plan of care for resident #027 was provided to the resident as specified in the plan, specifically related to the completion of the ordered diagnostic tests.

Inspector #542 completed a closed health care record review for deceased resident #027. The physician's order dated on a specific date, indicated that diagnostic tests were ordered and were to be completed within 48 hours. There was no documentation to indicate that the tests were completed or that the results were available. Inspector #542 spoke to the DOC who confirmed that the diagnostic tests had not been completed for resident #027.

The determination to issue a Compliance Order was based upon the severity of harm and the scope was isolated to one resident. The compliance history indicated that a VPC was previously issued in inspection # 2014_246196_0017 dated September 21, 2014. (542)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 07, 2016

Order # / Ordre no : 002

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 shall ensure that, where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The licensee shall:

(A) conduct an audit of all bed systems in the home, to ensure that all potential zones of entrapment are identified and meet the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" effective March 17, 2008.

(B) provide education to all interdisciplinary staff that have contact with bed systems, regarding the potential zones of entrapment, recognition of failing zones and the procedure for reporting concerns with these zones.

(C) ensure records are maintained of the training provided, including but not limited to, dates, attendees, content and post training assessment of staff understanding.

(D) ensure that routine audits of bed systems are conducted, including but not limited to auditing zones of entrapment, and records are maintained of such audits.

Grounds / Motifs :

1. The licensee has failed to ensure that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, where bed rails are used.

During the inspection, Inspector #625 observed two resident beds to have gap of approximately 15 cm between the head board and the mattress and a gap of approximately 15 cm between the foot board and the mattress.

Inspector #625 and RPN #110 attended another resident room and observed a gap of approximately 15 cm from the foot board to the mattress; another resident bed had a gap between the foot board and the mattress of greater than 15 cm; and another resident bed had a gap of approximately 15 cm from the headboard to the mattress.

The Health Canada Guidance Document "Adult Hospital Beds: Patient

Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" effective March 17, 2008, identified the zone of entrapment from the mattress end to the head or foot board as a potential for entrapment and indicated a dimensional limit recommendation of 120mm.

On a day during the inspection, Inspector #625 met with a Manager who attended one of the resident rooms and measured the gap between the mattress and foot board and determined it to fail the entrapment zone test. The Bed System Measurement Device was then used by the Manager to conduct tests on beds in two other resident rooms and determined that both failed the zone of entrapment test between the mattress and headboard.

Inspector #625 reviewed the home's bed rail entrapment audit, which identified beds that failed the zone of entrapment test, failed specific zones of entrapment and required action by the home to ensure resident safety.

The Manager reported that there were outstanding items that needed to be addressed as identified in the bed rail entrapment audit. In addition, they confirmed that three mattresses identified in the audit required replacement as well the two beds identified by Inspector #625.

All beds identified had one to two bed rails in use when observations, measurements and Bed System Measurement Device testing were completed.

2. The licensee failed to ensure that where bed rails are used, other safety issues related to the use of bed rails are addressed, including height and latch reliability.

Inspector #196 noted that a resident room had a bed rail that was loose.

Inspector #625 observed the left bed rails in two resident rooms to be loose. The bed rail in one room could be moved to create a gap approximately 10 cm from the bed when positioned perpendicular to the mattress.

Inspector #625 met with RPN #110 who confirmed that the bed rails were loose in the identified resident rooms.

All beds identified had one to two bed rails in use when observations, measurements and Bed System Measurement Device testing were completed.

The determination to issue a Compliance Order was based upon the severity of risk to residents, the potential for actual harm and the scope which affected a pattern of residents. The compliance history identified that a WN was previously issued in inspection # 2014_246196_0017. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 18, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

The licensee shall ensure that resident #007's furnishings and equipment, and the furnishings and equipment of all residents, are kept clean and sanitary.

Grounds / Motifs :

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

On a day during the inspection, Inspector #625 observed a wet stain present, and an odour of urine emanating from, resident #007's mattress. Six dark brown stains were also present on the resident's pillow.

On another day, Inspector #625 noted that resident's room smelled of urine and observed the mattress to be wet.

On another day, Inspector #625 observed a white stain and brown smears on resident's bed and dark brown yellow stains were present on the resident's pillow.

On another day, Inspector #625 interviewed PSW #105 who stated that resident's bed constantly smelled. As the Inspector and PSW entered the resident's room, the PSW stated that they smelled an odour from resident's room as soon as they had entered it. PSW identified the white stain on resident's mattress as possible urine and brown streaks as feces or chocolate

and stated that old blood and urine were present on resident's pillow.

PSW #103 was interviewed and identified that the resident's therapeutic mattress had cracks, urine stains and feces and stated that the resident's pillow was discoloured from possible blood and sweat.

During an interview with Inspector #625 the DOC stated that resident #007's pillow appeared to be stained with urine and blood.

On another day, Inspector #625 observed the smell of urine in resident's room emanating from their mattress where a moist urine stain was visible in the centre of the bed.

During an interview with Inspector #625, RN #109 discussed the process for cleaning resident #007's mattresses and covers.

Inspector #625 attended resident's room and observed that, eight days after initially noting the odour of urine and staining on the mattress, and alerting staff to it, the mattress had been exchanged and stains and odour of urine were no longer present. [s. 15. (2) (a)]

The determination to issue a Compliance Order was based upon the severity of minimal harm or potential for actual harm and the scope affected one resident with repeated occurrences . The compliance history identified that a WN was issued in inspection # 2014_246196_0017. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 19, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Order / Ordre :

The licensee shall ensure that the equipment, supplies, devices and assistive aids are readily available at the home.

The licensee shall:

(A) review all residents that require the use of fall prevention equipment, including but not limited to, bed alarm systems, wheelchair alarm systems and fall mats.

(B) provide education to interdisciplinary unit staff on the expectation to ensure the equipment is functioning each time its use is initiated, and the process to report malfunctioning or absent equipment, and the importance of promptly replacing any required equipment.

Grounds / Motifs :

1. Resident #007's current care plan identified the resident as at high risk for falls and required a fall prevention device as a falls prevention intervention. Progress notes indicated that this resident fell 12 times over an approximate seven month period.

During the inspection, Inspector #625 interviewed PSW #105 who reviewed the resident's care plan and attended resident #007's room with the Inspector. The PSW identified that the resident's fall prevention device was missing from the bed.

On another day, Inspector #625 observed that there was no fall prevention device in resident's room.

On another day, Inspector #625 spoke to RPN #104 regarding the missing fall prevention device. The RPN consulted with PSWs #102 and #103, who stated that the fall prevention device had been removed the previous day.

Inspector #625 spoke to RPN #104 regarding the absence of a fall prevention device on resident's bed and they reported that the resident did not have a fall prevention device on their bed because maintenance was required to mount a component of the device before it could be used.

Inspector #625 interviewed the manager who stated that they had received a maintenance memo to install a fall prevention device for resident #007, as one component needed to be mounted to the wall. (625) (196)

2. The licensee has failed to ensure that the equipment, supplies, devices and assistive aids referred to in the home's falls prevention and management program are readily available at the home.

On a date during the inspection, Inspector #625 spoke with RPN #104, PSW #102 and PSW #103 and the PSWs reported that resident #031 and #032's fall prevention devices were not working and they required new fall prevention devices.

At 0840hrs, Inspector #625 attended resident #031's room and observed the fall prevention device was not functioning.

At 0912hrs, Inspector #625 heard resident #032 call out for assistance and observed them seated at the edge of their bed and the fall prevention device was not sounding. Inspector notified RPN #104 who stated that the fall prevention device box was missing from resident's room.

Inspector #625 reviewed resident #031's current care plan which indicated this resident was at risk for falls and required a fall prevention device as a falls prevention strategy.

Inspector #625 reviewed resident #032's current care plan which indicated this resident was at risk for falls and required a fall prevention device as a falls prevention strategy. (625)

The determination to issue a Compliance Order was based upon the severity of minimal risk or potential for actual risk and the scope that affected a pattern of residents. The compliance history identified previous unrelated non-compliance in inspection #2014_246196_0017. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 07, 2016

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 26th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

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