Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Amended October 30, 2015 MG

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 15, 2015	2015_376594_0017	0011107-15	Resident Quality Inspection

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

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

BELVEDERE HEIGHTS
21 BELVEDERE AVENUE PARRY SOUND ON P2A 2A2

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

MONIKA GRAY (594), LINDSAY DYRDA (575), MARINA MOFFATT (595)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 08 - 12 and 15-19, 2015

This inspection includes Ministry Logs 4012-14; S-000294-13; 007022-14; 008801-14; 002253-15; 006888-15; S-000293-14 and S-000897-15.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Dietary staff, Housekeeping staff, Family Council Chair, Registered Practical Nurses (RPNs), Dietary Manager, Dietitian, Program Manager, Associate Director of Resident Care (ADORC), Director of Nursing Administration (DONA) and the Administrator.

The inspector(s) also reviewed policies, plans of care 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.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

MG 16 ~~17~~ **WN(s)**
5 ~~6~~ **VPC(s)**
3 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 155. (1)	CO #001	2015_282543_0004	594

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 the home's policy titled 'Weights - Monitoring of Resident Weights', was complied with.

During a review of resident #062's health care record, Inspector #575 noted that the resident had a 7.6% change in body weight over a three month period in 2015. Additionally, the resident had a 2.9 kg weight change from over a two month period in 2015.

The inspector interviewed the Dietitian regarding the process for responding to resident weight changes. The Dietitian indicated that they review resident weights on a monthly basis and manually determine any changes in weight. When there is a weight change of 2 kgs or more over a one month period, staff are to re-weigh the resident to ensure accuracy. If an actual change of 2 kgs or more is verified, the registered staff are to refer the resident to the Dietitian using the Diet Requisition Form. The Dietitian confirmed that there was no requisition submitted for resident #062's weight loss and indicated that the staff are aware that they (Dietitian) reviews the weights monthly.

The home's policy titled 'Weights - Monitoring of Resident Weights'#NR G 589 effective May 2010 was reviewed by the inspector. The policy indicated that weight changes would be assessed using an interdisciplinary approach and applied to residents with:
1. A change of 5 % of body weight, or more, over one month;
2. A change of 7.5 % of body weight, or more, over three months;
3. A change of 10 percent of body weight, or more, over six months; and
4. Any other weight change that compromises the resident's health status.

The policy also indicated that the PSW is to immediately re-weigh any resident with a weight variance (from the previous month) of 2 kgs and to report variances to registered staff immediately. The RN/RPN is to investigate potential causes of weight variance including a review of resident's current eating patterns, hospitalizations within the past month, related symptoms and observations. The RN/RPN is to document possible cause of weight change following the procedure for weight change note entry, and note any follow up in the quarterly summary notes. A referral is to be made to the Dietitian for variances.

The inspector noted, and three staff (Dietitian, S #121 and S #122) confirmed that the resident was not re-weighed after the 2.9 kg weight change. The inspector interviewed

and reviewed the policy with S #121. S #121 indicated that the RN/RPN did not investigate the cause of the resident's weight change, confirmed a progress note was not completed identifying the change in weight, and that there was no referral to the Dietitian completed. The staff member further indicated that they thought the Dietitian was responsible for investigating the causes of weight changes.

Resident #062 experienced a weight change of more than 2 kgs (2.9 kgs), the resident was not immediately re-weighed and the RN/RPN did not investigate the potential causes of the weight change or document/respond to the variance as indicated in the home's policy. As well, there was no referral to the Dietitian related to the weight variance. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's policy for minimizing of restraining was complied with. Multiple non-compliances have been previously identified related to complying with this policy; during an inspection completed June 2013 inspection #2013_139163_0018, a compliance order (CO) was issued pursuant to O.Reg 79/10, s.8. (1) the licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with. During a follow-up inspection completed June 2014 inspection #2014_320576_0007 a CO was re-issued pursuant to the O.Reg 79/10, s.8. (1) with a compliance date of July 4, 2014.

Inspector #575 reviewed the home's policy titled 'Policy to Minimize Restraints (#NR F 405)'. The policy indicated that documentation in the resident's health care record related to the use of restraints is to include: all assessment, reassessment and monitoring including the resident's response; every release of the device and all repositioning; and the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. Additionally, the policy indicated that restrained residents must be released and repositioned at least every two hours and when restraints are used, the resident's condition is to be reassessed and the effectiveness of restraining evaluated by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours and at any other time when necessary based on the resident's condition or circumstances.

During an interview, the inspector confirmed with the DONA that restraint monitoring documentation is completed on the restraint monitoring form by the PSWs and included all application, repositioning, and responses. The DONA also confirmed with the inspector that registered nursing staff sign the resident's Medication Administration

Record/Treatment Administration Record (MAR/TAR) each shift to indicate that the reassessment was completed every eight hours.

The inspector reviewed the health care records of three residents (the same residents identified in the grounds to the previous order during inspection #2014_320576_0007). Restraint monitoring forms and MAR/TARs were reviewed for the period of two months in 2015 for resident #064 and #065; restraint monitoring forms were reviewed for the period of two months in 2014, for resident #065.

From the review the inspector noted the following:
i) Restraint documentation indicated that resident #064 was restrained without being repositioned every two hours; on 20 occasions for three hours and one occasion for five hours; documentation was missing for three entire shifts; the resident's response to the restraint was not documented on two entire shifts, and on two other occasions; and registered staff did not initial the MAR/TAR to indicate a reassessment on 11 night shifts during one month and two night shifts during another month.

ii) Restraint documentation indicated that resident #066 was restrained without being repositioned every two hours; on 17 occasions for three hours, seven occasions for four hours, five occasions for five hours, and two occasions for six hours; documentation was missing on one occasion; the resident's response to the restraint was not documented on two entire shifts and on approximately 55 other occasions; and registered staff did not initial the MAR/TAR to indicate a reassessment on four night shifts during one month and two night shifts during another month.

iv) Restraint documentation indicated that resident #065 was restrained without being repositioned every two hours; on 22 occasions for three hours, seven occasions for four hours, five occasions for five hours, two occasions for six hours, and three occasions for eight hours; documentation was missing on two entire shifts and on one other occasion; the resident's response to the restraint was not documented on three entire shifts and on approximately 30 other occasions; and registered staff did not initial the MAR/TAR to indicate a reassessment on one night shift during one month and nine night shifts and one evening shift during another month.

Therefore, the licensee failed to ensure that the home's policy to minimize restraints was complied with, in that the documentation indicated restrained residents were not released and repositioned at least every two hours; hourly monitoring and the resident's response to the restraint was not documented on several occasions; and the effectiveness of the

restraining was not documented on every eight hour shift. [s. 8. (1) (b)]

3. The licensee has failed to ensure that the home's policy 'Continence/Incontinence Program' was complied with.

A) In a complaint received by the Director, it was stated that in 2014 resident #032 was found by the complainant, to have been incontinent. The complainant later asked the PSW if the resident was toileted earlier, and the staff replied that the resident was.

Inspector #595 reviewed the home's policy 'Continence/Incontinence Program' (NR E 300) which identified that at the time of the quarterly review, during annual assessments and when there is any change in a resident's condition that affects a resident's bladder and bowel functioning the following is to be completed:
- Obtain information about bowel and bladder routine
- Identify contributing factors to incontinence
- Complete Continence Assessment NR E 303.

Inspector #595 reviewed resident #032's health care record. It was identified in a progress note dated in 2014 that the resident was placed on a toileting routine. In the resident's health care binder, a 'Request for Resident Assessment and Product Change with Attends Products' form was completed one month later in 2014 which indicated that the reason for the product change was due to a decrease in the resident's continence. The inspector spoke with the DONA who stated that continence assessments would be in the resident's paper chart (binder). Inspector #595 reviewed the resident's health care record and could not locate a continence assessment.

The inspector interviewed S #123 and S #119 who stated that resident #032's continence had declined, in that resident #032 could no longer voice their need to go to the washroom or did 'not understand the toilet'.

B) During Stage One of the inspection, Inspector #594 and #595 observed resident #031 wandering in and out of other residents' rooms. The inspectors spoke with S #123 about this resident's behaviours, and were told that the resident will void in inappropriate areas.

Inspector #595 reviewed resident #031's health care record, including care plans in the PSW binders at the nursing station. It was identified in the 'Risk of Injury from Falls' care plan that the resident voids/defecates inappropriately. In the 'CCL Assistance' care plan it

was identified that the resident had deterioration in continence. The inspector also reviewed the most recent MDS assessment dated in 2015 which indicated that the resident had a decline in continence. In the resident's health care record, the inspector located three completed 'Request for Resident Assessment and Products Change with Attends Products', two dated during one month and one dated three months later in 2015. Under the 'reason' section of the latest 2015 assessment, it was indicated that the change in product type was for during the night, as the resident 'tends to wet through their product', and a regular product was to be used instead.

The inspector reviewed the progress notes for resident #031 over a three month period in 2015. There were numerous instances of the resident voiding in inappropriate areas.

On June 16, 2015 the inspector detected a strong odour in the resident home area of resident #031. It was observed that there was a large wet spot on the floor with a wet floor sign. The inspector asked S #107 what had happened, the staff explained that resident #031 had voided on the floor.

The inspector spoke with the ADORC about the resident's continence and they stated that the resident had been voiding inappropriately since admission. The ADORC and five other nursing staff confirmed that the resident will void in inappropriate areas and resist toileting.

It was verified by the inspector that the staff did not assess the resident for interventions related to incontinence and inappropriate voiding.

The inspector spoke with the DONA who stated that continence assessments would be in the resident's paper chart (binder). The inspector reviewed resident #031 and #032's health care records, including their filed/thinned chart, and could not locate Continence Assessment NR E 303.

The inspector spoke with S #114 about resident #031 and #032's continence assessments. The staff member said that the home does not do continence assessments when conditions change, only when the resident is admitted does the home complete a 7-day observation. The staff also mentioned that when there was a change in the resident's status, the home would use the product assessment form and indicate why the current product needs to be changed. Inspector asked S #114 if they look at why the resident's incontinence changed and they said the home doesn't look at those things, rather staff will document/report if the resident is having increased incontinence.

Consequently, given that resident #031 and resident #032 had no continence assessment completed after experiencing a decline in their continence and S #114 stated the home does not complete continence assessments when a resident's condition changes, the licensee has failed to ensure the policy Continence/Incontinence Program was complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that actions were taken to meet the needs of resident #031 with responsive behaviours including assessments, reassessments, interventions and documentation of the resident's responses to the interventions.

During stage one of the RQI, Inspector #594 and #595 observed resident #031 demonstrating responsive behaviours. At this time, both inspectors were engaged in conversation with S #123 regarding resident #031's behaviours. S #123 listed the resident's responsive behaviours, that the resident is not on any medications, and that staff have to keep a close eye on resident #031.

Inspector #595 reviewed resident #031's health care record. It was identified in the plan of care titled 'Refuses/Resists Care', that resident #031 had episodes of physically responsive behaviours with staff and co-residents, and that two staff were required to assist with Activities of Daily Living (ADLs) due to responsive behaviours as per the ADL care plan. In the plan of care titled 'Risk of Injury from Falls', it identified two responsive behaviours of the resident. Interventions in this plan of care did not identify how staff are to respond to resident #031.

The inspector reviewed the Quarterly Medication Check Long Term Care dated during one month in 2015, where it documented in the Pharmacist's Recommendations, that there was no change in the resident's behaviours, and could consider adding a medication for behaviours and sedative effect, if problematic.

Inspector #595 located a referral to a community agency dated during 2014, and faxed one month later. Responsive behaviours were noted on the referral. The inspector was not able to locate an assessment or note from the community agency in regards to resident #031 after the referral.

In an interview with the inspector, the ADORC confirmed that the resident had not been seen/assessed by the community agency since the referral, that the resident has not had any behaviour assessments, been on any tracking, and had not been 'referred' for an assessment. At the end of the interview, the ADORC verified that resident #031 was not referred to the community agency for their behaviours, but was referred for support for their family member.

The ADORC listed resident #031's responsive behaviours to the inspector and stated that the resident's behaviours have not dramatically changed. The ADORC identified the following interventions for resident #031's behaviours, to the inspector when requested:
- The home has not had much luck in addressing resident #031's behaviours as they happen when they happen;
- Staff can try to catch or redirect the resident when exhibiting responsive behaviours;
- The ADORC has had weekly discussions with the resident's family about interventions;
- No medications are needed for the resident as the responsive behaviours are due to staff approach, and as a result need to educate the staff;
- A community agency has reviewed the interventions for resident #031 and are 'ok' with what's in place;
- To address resident #031's responsive behaviours, visual barriers were put up on the doors of cognitive residents and for those residents whose families have expressed

concern;
- Monitor resident #031 hourly, however it is an expectation that staff check residents on the specific home area more often;
The inspector asked the ADORC how the home determined interventions for the resident as they have not had an assessment. The ADORC stated that they received the ideas from the resident's family member for the responsive behaviours. Inspector #595 asked the ADORC whether the visual barriers were preventing the resident from entering other rooms, the ADORC stated that there is another resident on the unit that will go around and take the visual barriers down, so resident #031 will then just walk into the rooms.

On June 19, 2015, at 1015h Inspector #595 checked all resident rooms on the specific resident home area and did not observe any visual barriers on any doors.

Upon review of the progress notes for resident #031 over a three month period in 2015, by the inspector, it was identified that there were numerous instances of responsive behaviours. Further review of the progress notes by the inspector, documented incidents where the resident was in other resident rooms and in some instances exhibiting responsive behaviours.

Inspector spoke with S #124, S #108, S #107 and S #106 who all stated that resident #031 will exhibit responsive behaviours. The staff members stated that they would keep checking on the resident by walking around the unit to determine resident #031's whereabouts.

On June 16, 2015, Inspector #595 observed resident #031 walking up and down the halls of the unit. The next day, the inspector observed the resident sitting in another resident's room in a chair. The door to the room was open and no staff were observed to be around. Later that afternoon, the inspector observed the resident in the same room again. This time, the resident was exhibiting responsive behaviours. A housekeeper had walked by and saw the resident in the room. S #107 then noticed the resident in the room and removed them and attempted to get the resident to sit and watch TV in the common lounge area. On June 18, 2015, Inspector #595 observed resident #031 walk down the hallway and into the same room as identified above.

Given that resident #031 demonstrated responsive behaviours, no assessment had been completed of the resident's responsive behaviours, the plan of care did not provide interventions specific to responsive behaviours and the inspector observed the resident demonstrating responsive behaviours the licensee failed to respond to the needs of

resident #031 with responsive behaviours. [s. 53. (4) (c)]

2. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Inspector #575 reviewed a complaint from a family member of resident #015 regarding alleged responsive behaviours by resident #070 towards resident #015.

Resident #015's health care record was reviewed and an internal incident report indicated that in 2015, staff observed a responsive behaviour incident between resident #070 in resident #015's room. Both residents are cognitively impaired.

Following the incident, resident #070 was referred to a community agency, for responsive behaviours, an assessment was conducted and faxed to the home. An additional assessment was also completed three months later by another community agency and the report faxed to the home.

The inspector reviewed resident #015's progress notes over a six month period in 2015, regarding responsive behaviours. There were numerous occasions documented of resident #015 responsive behaviours toward other residents.

The inspector interviewed the ADORC regarding resident #015. The ADORC indicated that the resident had displayed responsive behaviours since admission and that new responsive behaviours started in 2015. The ADORC explained that at the time of the incident involving resident #070, the home focused on interventions and assessments for resident #070 as this resident had a history of responsive behaviours. The ADORC explained that resident #015 had displayed approximately six additional responsive behaviour incidents with four different residents (including resident who was involved in the 2015 incident).
The ADORC indicated that resident #015 had not had any assessments regarding their responsive behaviours and that it was not until an incident later in 2015 when the home applied visual barriers on the doorways of vulnerable residents (however also indicated that the resident had been seen navigating past these visual barriers), introduced a new medication to aid with behaviours, and referred the resident to two community agencies. The ADORC indicated that the home's Responsive Behaviour program had protocols that they follow for developing care plans and for referring residents to community

agencies, etc. The ADORC indicated that no assessments had been completed for the resident prior to the later 2015 incident because the resident had displayed some responsive behaviours since admission, it was part of their day, and it was not a behaviour that they felt needed to be addressed. The ADORC further indicated that they were not sure how they would assess a resident's new responsive behaviours. To date, the ADORC indicated that the resident's behaviours had been managed by the home through the introduction of a new medication and by attempting to have the resident involved in more activities in the home.

The home's policy titled 'Responsive Behaviours/Gentle Care Approach NR G 532 A' and 'Resident Observation Policy' last reviewed in 2014, was reviewed by the inspector. The policies indicated that staff would achieve consistency of care through screening protocols, assessment and re-assessment, with the goal of identifying triggers that may cause or result in responsive behaviours by creating a consistent person centered approach to care and that residents presenting with challenging behaviours would be monitored for a period of 14 days until behaviour trends and patterns are identified.

The policies further outlined prevention and screening protocols to assist caregivers to identify causes of a resident's responsive behaviour and to track the patterns of these behaviours. Assessment tools were identified and the ADORC confirmed that no assessments were completed for this resident regarding their wandering or sexual behaviours.

The inspector interviewed the DONA regarding the responsive behaviour program and the process for dealing with behaviours. The DONA indicated that when behaviours are noticed, the DONA and ADORC review the documentation every 24hrs and determine if there might be a trigger and implement interventions. Residents with behaviours are also reviewed by the Responsive Behaviour Committee which consists of nursing staff, ADORC, and the DONA. The DONA confirmed that there had not been any meetings in regards to resident #015, nor any assessments for behaviours.

The inspector interviewed S #125 and asked them to describe the behaviours observed and interventions for resident #015. S #125 indicated that staff focused on resident #070 initially however, resident #015 had been involved in more incidents since then and it was not until a later incident with another resident that staff started to realize that they needed do something more. After one incident S #125 indicated visual barriers were applied to vulnerable residents' rooms. The RN and ADORC were informed of the incident and that is when the resident was referred to a community agency. S #125

indicated that the behaviours were escalating and staff had been observing and trying to keep ahead of resident #015 and that the new medications were helping with the behaviours.

The inspector noted that the resident had displayed numerous responsive behaviours towards other residents and staff since the initial incident in 2015, and that actions were not taken to respond to the needs of resident #015 until six month later. [s. 53. (4) (c)]

Additional Required Actions:

CO # - 002 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. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that resident #032 and resident #031, who were incontinent, received an assessment that:
- included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and
- was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Inspector #595 reviewed resident #032's health care record. It was identified in a progress note dated in 2014, that the resident was placed on a toileting routine. In the resident's health care binder, a 'Request for Resident Assessment and Product Change

with Attends Products' form was completed one month later, which indicated that the reason for the product change was due to a decrease in the resident's continence.

Inspector spoke with S #123 and #119 who indicated that resident #032's continence had declined, as the resident used to be continent and aware of when to (ask to) go to the washroom. At the time of the inspection, the staff members stated that resident #032 could not voice their need to go to the washroom or did 'not understand the toilet'.

Inspector #595 reviewed resident #031's health care record. It was identified in the 'Risk of Injury from Falls' care plan that the resident voids/defecates inappropriately. In the 'CCL Assistance' care plan it was identified that the resident had deterioration in continence. Inspector also reviewed the most recent Minimum Data Set (MDS) assessment dated in 2015, which indicated that the resident had a decline in continence. In the resident's health care binder, inspector located three completed 'Request for Resident Assessment and Products Change with Attends Products', two dated during one month and one dated three months later in 2015. Under the 'reason' section of the latest 2015, form, it was indicated that the change in product type was for during the night, as the resident 'tends to wet through their product', and a regular product was to be used instead.

The inspector reviewed the progress notes for resident #031 over a three month period in 2015. There were numerous instances of the resident voiding in inappropriate areas.

On June 16, 2015, the inspector detected a strong odour in the resident home area of resident #031. It was observed that there was a large wet spot on the carpeted floor with a wet floor sign. Inspector asked S #107 what had happened and they explained that resident #031 had voided on the floor.

The inspector spoke with the ADORC about the resident's continence, they stated that the resident had been voiding inappropriately since admission. The ADORC and five other nursing staff confirmed that the resident will void in inappropriate areas and resist toileting.

It was verified by the inspector that the staff did not assess the resident for interventions related to incontinence and inappropriate voiding.

The inspector spoke with the DONA who stated that continence assessments are located in the resident's paper chart (binder). Inspector #595 reviewed both resident #032 and

resident #031's health care records, including their filed/thinned paper chart in the nursing station, and could not locate an assessment. The inspector spoke with S #114 about resident #032's and resident #031's continence assessments. The staff member stated that the home does not do continence assessments when conditions change, only when the resident is admitted to the home, by completing a 7-day observation. The staff also said that when there was a change in the resident's status, the home would use the product assessment form and indicate why the current product needs to be changed. Inspector asked S #114 if they look at why the resident's continence changed and they said the home doesn't look at those things, rather staff will document/report if the resident is having increased incontinence.

Inspector #595 reviewed the home's policy 'Continence/Incontinence Program' (NR E 300) which identified that at the time of the quarterly review, during annual assessments and when there is any change in a resident's condition that affects a resident's bladder and bowel functioning the following is to be completed:
- Obtain information about bowel and bladder routine
- Identify contributing factors to incontinence
- Complete Continence Assessment NR E 303.

Both resident #032 and resident #031 who were incontinent, were not assessed using a clinically appropriate assessment instrument. [s. 51. (2) (a)]

Additional Required Actions:

CO # - 003 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' #005, #004, #001, #063, #002 and #032 right to be treated with courtesy and respect and in a way that fully recognized the residents' individuality and the residents' dignity was respected and promoted.

A) During resident interviews, the inspectors were made aware of the following:
i) Resident #062 told inspector #595 that while S #120 doesn't provide direct care to them any longer, this staff member had treated the resident roughly in the past. S #120 had previously grabbed resident #062 while providing care, resulted in the resident experiencing pain. Resident #062 stated that S #120 would yell at residents, treat them unkindly and has heard from other residents that S #120 was bad to them as well and is rude and mean. Resident #062 stated to Inspector #595 that staff had yelled or been rude by telling the resident to 'be quiet'; and resident #062 further stated that they feel afraid because of seeing how some of the older residents are treated and staff are mean to them.

ii) In an interview with Inspector #595, resident #005 stated that staff have yelled at them several times, so the resident yelled back at the staff. Resident #004 told Inspector #613 that a couple of staff needed to watch their tone when speaking to them.

B) In a family interview with Inspector #595, it was stated that the family noticed, regularly, one or two staff members, talking in a demeaning way or yelling at residents and they have spoken regularly with the ADORC about these staff members. Staff will be loud and will talk around the resident, ignore the resident, and are demanding of residents instead of requesting ('give me that', 'put that down').

C) Inspector #594 reviewed a staff to resident abuse critical incident report submitted to the Director in 2013, which stated that the treatment of resident #001 by staff while providing care was forceful/inappropriate. The resident was resistive and staff continued to provide care against the resident's wishes.

D) In a complaint received by the Director in 2014, it was stated that the complainant had reported an incident to the home, of a staff member being 'unprofessional' with resident #032. The staff member was, while working with a team of other staff, expressing in a loud voice they will not be helping the resident without a registered staff member present and that the staff member became very upset and yelled at the complainant. The complainant stated to the Director they were very concerned about the

worker's demeanour and attitude towards residents.

Review of the home's Prevention of Abuse and Neglect Policy #Pers-2300 Effective Date: February 2013 stated that Belvedere Heights has a resident centered, zero tolerance policy and means that Belvedere shall uphold the right of the residents of the Long Term Care facility to be treated with dignity and respect within the facility and to live free from abuse and neglect; tolerate no abusive behaviour and allow no exceptions.

Given the interviews with residents #062, #005, #004, #001 and a family interview, a report of abuse, and a complaint regarding the staffs' interactions with residents, the licensee has failed to ensure that the residents' right to be treated with courtesy and respect and in a way that fully recognized the residents' individuality and respected the residents' dignity. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for resident #062, #005, #004, #001, #0063, #002 and all other residents of the home, their right to be treated with courtesy and respect, is fully respected and promoted, to be implemented voluntarily.

WN #5: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #015's written plan of care set out clear directions to staff and others who provide direct care to the resident.

Inspector #575 reviewed a complaint received by the Director that indicated resident #015's hearing aids had been reported missing on several occasions and that the staff were storing the hearing aids in a cup in the medication room at night, however the hearing aids were to be stored in the resident's bedside table. Additionally, the complaint indicated the resident had a barrier alarm across their door however it was never up or turned on.

The inspector reviewed the resident's plan of care. Under 'Impaired Communication' last updated in a month in 2015, the care plan indicated that the resident's hearing aids were to be kept in the medication room at night and during bath times. Under 'ADL Assistance' last updated during the same month in 2015, the care plan indicated staff are to place the resident's hearing aid in the case every night and put in the resident's night stand. Additionally, under 'Confusion' last updated during the same month in 2015, the care plan indicated that the resident was to be on hourly checks and an alarmed barrier strip placed in their doorway. The alarm was to be on at all times, whether the resident was in or out of their room. However, under the 'ADL Assistance' last updated during the

same month in 2015, the care plan indicated that the barrier door alarm strip was to be put across the resident's doorway at night, and that it was okay to leave off during the day.

The inspector interviewed S #126 regarding where the resident's hearing aids were to be stored. S #126 indicated that the resident's hearing aids were to be stored in the medication room. S #126 indicated that they find direction in the resident's care plan. The staff reviewed the resident's care plan and found that under 'ADL Assistance' the resident's hearing aids were to be kept in the resident's bedside drawer. The staff member then indicated that it must have changed, looked up the 'Impaired Communication' care plan and indicated that it was updated on the 'ADL Assistance' care plan but that someone must have missed it on the 'Impaired Communication' care plan.

The inspector observed the barrier alarm in the 'off position' on June 17, 2015. The inspector interviewed S #127 who confirmed the alarm was not on. S #127 indicated that staff are to check each shift that the alarm is on and working, and that some residents play with the alarms and that resident #015 is capable of turning off the alarm.

During an interview, the DONA indicated that the barrier alarm is to only be applied at night and that they updated the 'ADL Assistance' care plan but that they must have been missed the 'Confusion' care plan and then stated 'that is the problem with having so many care plans'.

The resident's care plans were not updated to reflect the current care to be provided and therefore did not provide clear direction to staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #032's plan of care set out clear directions to staff and others who provide direct care to the resident.

A complaint received by the Director, identified that resident #032 was not provided oral care. Inspector #595 reviewed resident #032's ADL Functional Status kardex (printed in a month in 2015), which identified that resident #032 required total assistance from staff for personal hygiene, and staff were to assist the resident with oral care.

Inspector spoke with S #124 who stated that the resident's oral care is provided in the evening. When asked about providing oral care in the morning, S #124 stated that there are time constraints in the morning and staff don't have time to provide oral care to

resident's before breakfast, so if there is available time after breakfast they will do it.

Inspector spoke with S #123 who stated that the resident receives oral care in the morning and evening, however is difficult to perform as the resident will resist care and staff cannot perform the care. In these cases, staff are to leave the resident for 10 minutes and re-approach later.

Inspector spoke with S #119 who stated that the resident's oral care is provided at night as there are time constraints in the morning. They also stated that staff struggle with the resident's care and would have to re-approach the resident.

The most recent MDS assessment for resident #032 dated in 2015, identified that the resident was to receive daily oral care by the resident or staff. Upon further review of resident #032's care plans in the PSW binders, there was one intervention under the 'Behaviour Problem' care plan which identified that staff were to leave the resident in a safe manner if they became physically aggressive; however there was no indication in any care plan that staff were to leave and re-approach the resident if they refused or resisted care. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the Substitute Decision Maker (SDM) had been provided the opportunity to participate fully in the development and implementation of the plan of care for resident #031.

In an interview, the SDM of resident #031 told the inspector that the home does not promptly notify the responsible party of a change in the resident's condition. They identified that during one month in 2015, the home had changed resident #031's medication without notifying them. The inspector reviewed resident #031's Medication Administration Record from that month in 2015 and noted that there was an order to change the resident's medication.

Inspector #595 spoke with S #128 who said that when there is a change in medication, the home is to phone/contact the SDM to notify them of the change, and document the conversation in a progress note. Additionally, S #128 stated that on the medication order, there is a place to 'check' if the staff contacted the SDM regarding the medication change. S#-128 reviewed the progress notes from the date of the order to the end of that month and confirmed that there was no note that identified that the SDM was notified of the change in medication.

Inspector #595 reviewed the order for the medication change and noted that the staff had not checked off that the SDM/POA was notified. [s. 6. (5)]

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

Resident #061 triggered through Stage 1 of the inspection regarding a wound. In a staff interview, it was indicated that the resident currently had a wound and that the Minimum Data Set (MDS) trigger indicated the resident's wound was worsening.

Inspector #575 reviewed resident #061's health care record. The 'pressure ulcer/skin' care plan indicated the resident had a history of a wound upon admission, there were ongoing episodes of closing and re-opening and that the wound currently remained closed. According to the same plan, staff were to report changes or if the area reopened, to the physician, dietitian, and restorative staff. The resident's annual care conference record dated in 2014 indicated the resident had a wound that healed in 2014 and had reopened six months later.

A physician order dated 2015, indicated the following treatment: cleanse wound with water, apply treatment and change every 2-3 days. The three month medication review for 2015, indicated to continue the order.
The most recent MDS assessment dated in 2015, indicated the resident had a wound and no history of resolved wounds.

The inspector interviewed the DONA regarding skin and wound care for this resident. The DONA indicated that typically the physician does not write an order to discontinue a dressing change and that it is a long standing practice within the home that when a wound is healed registered staff can discontinue the order and start basic skin care for protection and stage I wounds. The DONA further indicated that when a wound is closed, staff are to monitor on bath days.

The inspector interviewed S #129 regarding the resident's treatment orders. S #129 indicated that usually when a wound closes and re-opens, the staff would notify the physician and the physician would typically re-order the same thing, and that it would depend on the resident whether or not staff stopped and started the order.

The inspector noted that the resident's wound closed and re-opened on several occasions during a four month review in 2015.

During this period, the TAR indicated that the original physician order was stopped and started although the physician order read to change every 2-3 days. There was no documentation in the resident's progress note that indicated staff reported when the area reopened to the physician, dietitian, or restorative staff. [s. 6. (7)]

5. The licensee has failed to ensure that the care was provided to resident #001 as specified in the plan.

In a staff to resident abuse report submitted to the Director in 2013 it was stated that the treatment of the resident, by staff, while providing assistance, was forceful/inappropriate. The resident was resistive and staff continued to provide care against the resident's wishes. According to the same report and the licensee analysis of the event, staff failed to provide care set out in the plan of care as the resident was permitted medication prior to their activity of daily living and staff failed to provide that medication or implement other effective strategies when the resident refused or resisted care.

The inspector reviewed resident #001's current care plan which stated medication to be administered ½-1 hour prior to activity of daily living by registered staff as ordered. The inspector reviewed the activity of daily living flow sheet for the resident which stated during a month in 2015, three activity of daily living encounters documented the resident's response to the activity as resistive; and during three of four activities in the next month of 2015, the resident's response to the activity was resistive. Review of the Medication Administration Record by the inspector for two months in 2015, had no documentation that medication was given prior to activity of daily living as ordered.

During an interview with the inspector, S #118 stated that direct care staff would coordinate with the registered staff when they would be attempting to assist the resident with the activity of daily living so that the medication would be effective. S #119 stated that about five to six months ago the resident received a medication prior to their activity of daily living but there wasn't really a difference in the resident's response when the resident received the medication and when they didn't, so staff don't use the medication anymore. S #114 told the inspector that recently the resident's pre-activity of daily living medication had been discontinued but prior to that, the resident was to receive the medication prior and stated that the resident had been receiving it. S #114 reviewed the resident Medication Administration Record (MAR) and activity of daily living flow sheet, and stated to the inspector that the documentation indicated no administration of the medication. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that clear direction is provided to staff regarding the care resident #015 and #032 are to receive; that resident #031's substitute decision-maker, be given an opportunity to participate fully in the development and implementation of the resident's plan of care and that the care set out in the plan of care is provided to the resident as specified in the plan for residents #061 and #001, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that abuse of a resident that resulted in a risk of harm had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A) In a Critical Incident Report submitted to the Director by the ADORC, it stated that staff to resident abuse occurred in 2014 but was not reported until four days later. The inspector reviewed resident progress notes which identified that resident #063 told S #130 that S #131 hit them hard on the head.

Inspector #594 interviewed S #112, S# 113, S# 110 and S #111 who all stated that they would report to their supervisor or directly to the DONA or ADORC if they witnessed or suspected abuse.

During an interview with the inspector, the ADORC stated they were not aware of the reporting requirements at the time of the incident.

B) Inspector #595 reviewed a Critical Incident report submitted to the Director which identified an incident of resident-to-resident abuse that occurred in 2014. The report described that resident #034 struck resident #033. Resident #034 was removed from the scene and was later sent to ER for assessment and treatment of responsive behaviours.

Upon further review of the report, it was noted that the report was first submitted to the Director seven days later. The ADORC confirmed that the incident was reported late as they were new to their position and were not aware of reporting requirements.

Inspector #594 reviewed the home's Prevention of Abuse and Neglect Policy #Pers-2300, which documented that the CEO/DOC/ADOC/designate will report to the Ministry of Health, all incidents of suspected or witnessed abuse and complete a Critical Incident Report online as noted in the Critical Incident Policy. The inspector reviewed the Critical Incident Reporting policy #ADM-2001/NRG 501 which documented that a person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director (Ministry of Health and Long-Term Care). [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any person who has reasonable grounds to suspect that abuse of a resident that resulted in a risk of harm has occurred, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council. During an interview with the Inspector, the Resident Council Chair and member of the Resident Food Services Committee, stated they were not familiar with having reviewed the meal and snack times.

The inspector reviewed the Resident Food Services Committee Meeting minutes for the period of one year and four months which did not identify a review of the meal and snack times.

During an interview with the inspector, the Dietary Manager stated that the meal and snack times are posted but that they do not review these times with the Resident Food

Services Committee or the Residents' Council. [s. 73. (1) 2.]

2. The licensee failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

On June 8, 2015, Inspector #595 observed the dinner meal service on a resident home area. Two staff members were in the dining room throughout the meal service. One additional staff from another home area arrived in the dining room near the end of the service. At one table, two plates were served to residents. At that table, resident #099 required total assistance from staff to eat their meal, and the other plate was served to a resident who was not in the dining room at that time. The staff member began to feed resident #099, then left the dining room to get the missing resident, leaving resident #099 unattended with their plated meal. The staff member returned with the missing resident, and started to assist resident #099 with their meal again. A few moments later, resident #031 got up from the table to leave the dining room. The staff member had to again, leave resident #099 with their meal, to assist resident #031 back to their table and offer them dessert. The staff member then left the dining room to get the resident their dessert. Upon return, the staff member was able to assist resident #099.

On June 17, 2015 Inspector observed the lunch meal service on a resident home area. There were two staff members in the dining room at the time of the observation. S #120 assisted resident #099 to eat their meal, prompted resident #001, provided assistance to resident #098, and also left to go to another table to cut up resident #097's food. At one point during the meal, S #120 had to get up to assist resident #031 back to the table. At another table, resident #096 was sitting with resident #097 and their family member. Inspector observed resident #096 eating their paper napkin. The family member got up and removed the paper napkin from resident #096 and informed staff of what happened. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council, and that no resident who requires assistance eating or drinking is served a meal until someone is available to provide the assistance required by the resident,, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following: MG

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants : MG

1. The licensee has failed to ensure that all controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. MG

During an interview with Inspector #594, S #114 indicated that the government stock medication was located in a room on a home area. MG

The inspector entered the locked government stock supply room on the resident home area with S #114 where the inspector observed in an unlocked cupboard: three bottles of Olanzapine 5mg tablets. S #114 told the inspector that Olanzapine was not required to be double locked. MG

Review of the home's Drug Inventory Control policy, index #02-06-10 last reviewed June 23, 2014, stated that narcotic and controlled drugs must be stored in a double locked cabinet in the medication cart or in the medication room. Controlled substances will be stored according to facility policy, taking into consideration applicable legislation. Review of the Medication system- Narcotics policy, index #04-01-40 last reviewed June 23, 2014, identified that narcotic and controlled substances must be stored in a double locked cabinet in the medication cart or in the medication room. MG

According to the Controlled Drugs and Substances Act 1996, a "controlled substance" means a substance included in Schedule I, II, III, IV or V. According to the same Act, Olanzapine is a schedule IV substance. [s. 129. (1) (b)] MG

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily. MG

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program. During the initial tour of the home the inspector observed the following:

In a resident home area tub room:
a) green used comb in top drawer of storage area with the name illegible

In resident home area shower room:
a) used unlabelled Head and Shoulders shampoo

In another resident home area tub room:
a) unlabelled clippers on table by tub
b) one unlabelled nail clipper sitting on window ledge
c) used unlabelled diaper rash cream in cupboard
d) unlabelled used after shave in cupboard

In a resident home area lounge and patio room:
a) used unlabelled men's slippers sitting on a storage counter top
In another resident home area shower room:
a) used unlabelled nail clippers in caddy on storage cart

In another resident home area tub room:
a) used unlabelled nail clippers and used Ivory soap bar sitting on shelf by the tub
b) used unlabelled nail clippers on window shelf
c) i) located in the top drawer of the storage area: used unlabelled comb and used unlabelled nail clippers in basket of clean shavers, along with hair and nail clipping debris in basket
ii) located in the second drawer of the storage area: used unlabelled pick comb, used unlabelled brushes x 3
iii) located in the third drawer of the storage area: used unlabelled head band
iv) located in the top cupboard (double doors) of the storage area: basket of hair curlers

used and unlabelled
v) located in the top cupboard (single door) of the storage area: used puff sponge unlabelled

In another resident home area shower room:
a) hanging off a shelving unit; a basket of clean unused razors that contained unlabelled tweezers and nail clippers
b) a dirty dressing cover on floor by toilet
c) a used facecloth and towel on floor by shower unit

In another resident home area shower room:
a) used unlabelled nail clippers on the edge of the bathroom sink
b) open unlabelled shaving cream on shower bench

In another resident home area tub room:
a) used unlabelled brush and shaving cream on storage cart
b) cutlery and cup sitting in sink used to wash hair
c) located on a counter: pink and white used unlabeled combs sitting within a basket with clean nail and mouth, used unlabelled body lotion and used unlabelled perineal spray [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #10: 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 failed to ensure that resident #032 received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

A complaint received by the Director, identified that resident #032 was not provided oral care. Inspector #595 reviewed resident #032's ADL Functional Status kardex (printed in a month in 2015), which identified that resident #032 required total assistance from staff for personal hygiene, and staff were to assist the resident with oral care.

The inspector spoke with S #124 who stated that the resident's oral care is provided in the evening. When asked about providing oral care in the morning, S #124 stated that there are time constraints in the morning and staff don't have time to provide oral care to the resident before breakfast, so if there is available time after breakfast they will do it.

Inspector spoke with S #123 who stated that the resident receives oral care in the morning and evening, however is difficult to perform as the resident will resist and staff cannot perform the care. In these cases, staff are to leave the resident for 10 minutes and re-approach later.

Inspector spoke with S #119 who stated that the resident is provided oral care at night as there are time constraints in the morning. They also stated that staff struggle with the resident's care and would have to re-approach the resident.

The most recent Minimum Data Set (MDS) assessment for resident #032 dated for a month in 2015, identified that the resident was to receive oral care by the resident or staff. Upon further review of resident #032's care plans in the PSW binders, there was one intervention under the 'Behaviour Problem' care plan which identified that staff were to leave the resident in a safe manner if they became physically aggressive; however there was no indication in any care plan that staff were to leave and re-approach the resident if refused or resisted care.

Inspector reviewed resident #032's flow sheets for one week in 2015. Under the section pertaining to mouth care, only two check marks were evident, indicating that the resident was only provided oral care twice throughout the seven-day period. It was also noted that additional routine care was provided to the resident for each day of that period, as signatures, numbers, and check marks were made under all other appropriate care areas. [s. 34. (1) (a)]

WN #11: 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 resident #015 had their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the case of new items, of acquiring.

Inspector #575 reviewed a complaint that indicated resident #015's hearing aid and glasses had gone missing on several occasions and that these items were not labelled.

The inspector interviewed the DONA regarding the process for labelling residents' personal items. The DONA indicated that labelling should occur on admission and that the home does not label residents' hearing aids or glasses, however the hearing aid case should be labelled.

The home's policy titled 'Personal items, personal aids and personal belongings, etc' stated that each resident would have their personal items such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring new items. The DONA indicated that the policy did not state who is responsible for labelling these items, however the home does not label these items and staff are to advise family to label these items.

During an interview with the inspector, S #126 indicated that resident hearing aids are not labelled however the cases are and that glasses are not labelled.

The inspector observed the resident and noted the resident's glasses and hearing aid were not labelled. [s. 37. (1) (a)]

WN #12: 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 resident #061 who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #575 reviewed resident #061's health care record. The inspector noted that the resident was admitted with a wound with ongoing healing and re-opening.

The inspector interviewed the DONA regarding skin and wound care weekly assessments. The DONA indicated that weekly assessments are completed by registered staff on any wound, and are completed on the home's software program Goldcare under 'assessments'.

The treatment administration record (TAR) and weekly skin assessments in Goldcare were reviewed by the inspector for a three month period in 2015. The inspector noted that during this period, the resident's wound was documented as healed/closed on three occasions. The weekly assessment was not completed on three occasions. On one date, the TAR was missing a signature and the assessment was not completed; on another date, the TAR indicated the assessment was completed, however the assessment was not completed; an assessment was completed 19 days later, however the next assessment was not completed until 12 days later.

The inspector interviewed the DONA regarding resident #061's weekly wound assessments, the DONA confirmed the three assessments were not completed as required. [s. 50. (2) (b) (iv)]

WN #13: 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 has failed to ensure the implementation of the weight monitoring system to measure and record with respect to each resident; weight on admission and height upon admission and annually thereafter.

While demonstrating to the inspectors how to use the home's electronic health record system, the ADORC stated that a resident's height was taken only on admission. During an interview with Inspector #594, S #102 stated that a resident's height was only taken on admission. In an interview with the inspectors, the administrator stated that resident's heights were taken on admission and would only be taken again if the resident had a change in their condition affecting their height. In an interview with Inspector #594, the DONA stated that registered staff are expected to complete a Baseline height and weight on the day after admission.

During a census record review, the inspectors identified the following:
Resident #020 – height taken 10 days after admission
Resident #021 – height taken 10 days after admission
Resident #022 – height taken 2 days after admission
Resident #023 – height taken 24 days after admission
Resident #024 – height taken 2 days after admission
Resident #004 – height taken 6 days after admission

The inspector reviewed the home's Admissions, Discharges, Transfers, LOA's and Deaths policy #NR D 2014 which stated registered staff are to complete the checklist requirements and the ADOC will ensure that all the tasks are completed and initialed within 21 days of admission. Review of the home's Resident Height policy #NR G 591, by the inspector stated a resident's height will be taken upon admission. [s. 68. (2) (a)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home had been posted in the home.

During an initial tour of the home, the inspector reviewed the Belvedere Heights Ministry of Health and Long-Term Care Compliance Reviews and Resident Information Binder located across from the main entrance, which contained only the most recent inspection report (dated May 2015).

The inspector reviewed the home's inspection history which stated inspections occurred in May 2015; May, June and September 2014 and July 2013.

Review of the home's Information Required to be Posted for Residents policy #ADM-8001 stated information required to be posted for residents, as specified by the LTCH Act, will be posted for review: Inspection reports for the past two years; copies of any orders made by an inspector or the Director (Ministry of Health) that are in effect or have been made within the last two years.

During an interview with the Inspector, the DONA stated the Belvedere Heights MOHLTC Compliance Reviews and Resident Information Binder only contained the most recent inspection reports and orders. [s. 79. (3) (k)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

The inspector reviewed the home's Prevention of Abuse and Neglect Policy #Pers-2300 Effective Date: February 2013 which failed to identify procedures and interventions to assist and support residents who had been, or allegedly been abused or neglected.

The inspector and DONA reviewed the home's policy and the DONA stated to the inspector that the policy was lacking the above procedures and interventions. [s. 96. (a)]

2. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate.

The inspector reviewed the home's Prevention of Abuse and Neglect Policy #Pers-2300 Effective Date: February 2013 which failed to identify procedures and interventions to deal with residents who have abused or neglected or allegedly abused or neglected other residents.

The inspector and DONA reviewed the home's policy and the DONA stated to the inspector that the policy detailed immediate actions, but no long term actions and did not contain interventions for resident to resident abuse. [s. 96. (b)]

3. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identified measures and strategies to prevent abuse and neglect.

The inspector reviewed the home's Prevention of Abuse and Neglect Policy #Pers-2300 Effective Date: February 2013 which failed to identify measures and strategies to prevent abuse and neglect.

The inspector and DONA reviewed the home's policy and the DONA stated to the inspector that the policy did not address measures and strategies to prevent abuse and neglect. [s. 96. (c)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

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

The inspector reviewed the home's Prevention of Abuse and Neglect Policy #Pers-2300 Effective Date: February 2013 which stated that the policy will be evaluated and updated annually in August. In an interview with the Inspector, the DONA stated the policy is required to be updated annually but was not evaluated in 2014.

The inspector was provided an evaluation of the Abuse program dated December 2014 at a later time, the evaluation did not include a review of the licensee's policy to promote zero tolerance of abuse and neglect of residents. [s. 99. (b)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response had been made to the person who made the complaint, indicating:
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

Inspector #595 reviewed a complaint submitted to the Director which described that in 2014, the complainant had reported to the DONA, an incident of a staff member being 'unprofessional' with resident #032. The complainant stated that they have not heard

back from the home about any investigation into the incident.

Inspector spoke with the DONA who stated that all complaints are kept in the Complaints Binder. The inspector reviewed the binder from 2014 and could not locate anything related to resident #032 or their family. The inspector spoke with the DONA about any complaints from this resident's family dated from 2014. The DONA confirmed that they could not locate documentation of the complaint, and explained that regardless of whether the complaint was lodged verbally or in writing, all complainants would be notified of the outcomes of the investigation (usually via phone). The DONA also stated to the inspector that there would be documentation in the resident's progress notes that the family was contacted.

Inspector #595 reviewed the progress notes for resident #032 which did not include a note documenting the notification of the family of the outcomes of the investigation. [s. 101. (1) 3.]

2. The licensee has failed to ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made in turn by the complainant

Inspector #595 reviewed a complaint submitted to the Director which described that in 2014, the complainant had reported to the DONA, an incident of a staff member being 'unprofessional' with resident #032.

The inspector spoke with the DONA who stated that all complaints are kept in the Complaints Binder. The inspector reviewed the binder from 2014 and could not locate anything related to resident #032 or their family. The inspector spoke with the DONA about any complaints from this resident's family dated from 2014. The DONA could not locate any documentation of the complaint in the binder or resident file, and suggested that the lack of documentation could be that it was lodged as a verbal complaint, and not submitted in writing. [s. 101. (2)]

MG Amended ~~Issued~~ on this 30 ~~28th~~ day of October, 2015

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

M Gray

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) :	MONIKA GRAY (594), LINDSAY DYRDA (575), MARINA MOFFATT (595)
Inspection No. / No de l'inspection :	2015_376594_0017
Log No. / Registre no:	0011107-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 15, 2015
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST 21 Belvedere Avenue, PARRY SOUND, ON, P2A-2A2
LTC Home / Foyer de SLD :	BELVEDERE HEIGHTS 21 BELVEDERE AVENUE, PARRY SOUND, ON, P2A-2A2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DONNA DELLIO

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

To BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_320576_0007, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the home's Policy to Minimize Restraints (NR F 405) is complied with. The licensee shall provide education to all direct care staff to ensure that the staff understand the requirements of this policy. The licensee shall develop and implement a process to audit compliance with this policy.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's policy for minimizing of restraining was complied with. Multiple non-compliances have been previously identified related to complying with this policy; during an inspection completed June 2013 inspection #2013_139163_0018, a compliance order (CO) was issued pursuant to O.Reg 79/10, s.8. (1) the licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with. During a follow-up inspection completed June 2014 inspection #2014_320576_0007 a CO was re-issued pursuant to the O.Reg 79/10, s.8. (1) with a compliance date of July 4, 2014.

Inspector #575 reviewed the home's policy titled 'Policy to Minimize Restraints (#NR F 405)'. The policy indicated that documentation in the resident's health care record related to the use of restraints is to include: all assessment, reassessment and monitoring including the resident's response; every release of

the device and all repositioning; and the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. Additionally, the policy indicated that restrained residents must be released and repositioned at least every two hours and when restraints are used, the resident's condition is to be reassessed and the effectiveness of restraining evaluated by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours and at any other time when necessary based on the resident's condition or circumstances.

During an interview, the inspector confirmed with the DONA that restraint monitoring documentation is completed on the restraint monitoring form by the PSWs and included all application, repositioning, and responses. The DONA also confirmed with the inspector that registered nursing staff sign the resident's Medication Administration Record/Treatment Administration Record (MAR/TAR) each shift to indicate that the reassessment was completed every eight hours.

The inspector reviewed the health care records of three residents (the same residents identified in the grounds to the previous order during inspection #2014_320576_0007). Restraint monitoring forms and MAR/TARs were reviewed for the period of two months in 2015 for resident #064 and #065; restraint monitoring forms were reviewed for the period of two months in 2014, for resident #065.

From the review the inspector noted the following:
i) Restraint documentation indicated that resident #064 was restrained without being repositioned every two hours; on 20 occasions for three hours and one occasion for five hours; documentation was missing for three entire shifts; the resident's response to the restraint was not documented on two entire shifts, and on two other occasions; and registered staff did not initial the MAR/TAR to indicate a reassessment on 11 night shifts during one month and two night shifts during another month.

ii) Restraint documentation indicated that resident #066 was restrained without being repositioned every two hours; on 17 occasions for three hours, seven occasions for four hours, five occasions for five hours, and two occasions for six hours; documentation was missing on one occasion; the resident's response to the restraint was not documented on two entire shifts and on approximately 55 other occasions; and registered staff did not initial the MAR/TAR to indicate a

reassessment on four night shifts during one month and two night shifts during another month.

iv) Restraint documentation indicated that resident #065 was restrained without being repositioned every two hours; on 22 occasions for three hours, seven occasions for four hours, five occasions for five hours, two occasions for six hours, and three occasions for eight hours; documentation was missing on two entire shifts and on one other occasion; the resident's response to the restraint was not documented on three entire shifts and on approximately 30 other occasions; and registered staff did not initial the MAR/TAR to indicate a reassessment on one night shift during one month and nine night shifts and one evening shift during another month.

Therefore, the licensee failed to ensure that the home's policy to minimize restraints was complied with, in that the documentation indicated restrained residents were not released and repositioned at least every two hours; hourly monitoring and the resident's response to the restraint was not documented on several occasions; and the effectiveness of the restraining was not documented on every eight hour shift. (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 16, 2015

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. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee shall ensure that for resident #031 and resident #015, and any other resident demonstrating responsive behaviours that:
• actions are taken to respond to the needs of the residents including assessment, reassessment and interventions
• strategies are developed and implemented to respond to the behaviours
• triggers are identified
• there is communication of the identified triggers and interventions to all staff who provide care and assistance to those residents
• that the residents' responses to interventions are documented.

Grounds / Motifs :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Inspector #575 reviewed a complaint from a family member of resident #015 regarding alleged responsive behaviours by resident #070 towards resident #015.

Resident #015's health care record was reviewed and an internal incident report indicated that in 2015, staff observed a responsive behaviour incident between

resident #070 in resident #015's room. Both residents are cognitively impaired.

Following the incident, resident #070 was referred to a community agency, for responsive behaviours, an assessment was conducted and faxed to the home. An additional assessment was also completed three months later, by another community agency and the report faxed to the home.

The inspector reviewed resident #015's progress notes over a six month period in 2015, regarding responsive behaviours. There were numerous occasions documented of resident #015 responsive behaviours toward other residents.

The inspector interviewed the ADORC regarding resident #015. The ADORC indicated that the resident had displayed responsive behaviours since admission and that new responsive behaviours started in 2015. The ADORC explained that at the time of the incident involving resident #070, the home focused on interventions and assessments for resident #070 as this resident had a history of responsive behaviours. The ADORC explained that resident #015 had displayed approximately six additional responsive behaviour incidents with four different residents (including resident who was involved in the 2015 incident). The ADORC indicated that resident #015 had not had any assessments regarding their responsive behaviours and that it was not until an incident later in 2015 when the home applied visual barriers on the doorways of vulnerable residents (however also indicated that the resident had been seen navigating past these visual barriers), introduced a new medication to aid with behaviours, and referred the resident to two community agencies. The ADORC indicated that the home's Responsive Behaviour program had protocols that they follow for developing care plans and for referring residents to community agencies, etc. The ADORC indicated that no assessments had been completed for the resident prior to the later 2015 incident because the resident had displayed some responsive behaviours since admission, it was part of their day, and it was not a behaviour that they felt needed to be addressed. The ADORC further indicated that they were not sure how they would assess a resident's new responsive behaviours. To date, the ADORC indicated that the resident's behaviours had been managed by the home through the introduction of a new medication and by attempting to have the resident involved in more activities in the home.

The home's policy titled 'Responsive Behaviours/Gentle Care Approach NR G 532 A' and 'Resident Observation Policy' last reviewed in 2014, was reviewed by

the inspector. The policies indicated that staff would achieve consistency of care through screening protocols, assessment and re-assessment, with the goal of identifying triggers that may cause or result in responsive behaviours by creating a consistent person centered approach to care and that residents presenting with challenging behaviours would be monitored for a period of 14 days until behaviour trends and patterns are identified.

The policies further outlined prevention and screening protocols to assist caregivers to identify causes of a resident's responsive behaviour and to track the patterns of these behaviours. Assessment tools were identified and the ADORC confirmed that no assessments were completed for this resident regarding their wandering or sexual behaviours.

The inspector interviewed the DONA regarding the responsive behaviour program and the process for dealing with behaviours. The DONA indicated that when behaviours are noticed, the DONA and ADORC review the documentation every 24hrs and determine if there might be a trigger and implement interventions. Residents with behaviours are also reviewed by the Responsive Behaviour Committee which consists of nursing staff, ADORC, and the DONA. The DONA confirmed that there had not been any meetings in regards to resident #015, nor any assessments for behaviours.

The inspector interviewed S #125 and asked them to describe the behaviours observed and interventions for resident #015. S #125 indicated that staff focused on resident #070 initially however, resident #015 had been involved in more incidents since then and it was not until a later incident with another resident that staff started to realize that they needed do something more. After one incident S #125 indicated visual barriers were applied to vulnerable residents' rooms. The RN and ADORC were informed of the incident and that is when the resident was referred to a community agency. S #125 indicated that the behaviours were escalating and staff had been observing and trying to keep ahead of resident #015 and that the new medications were helping with the behaviours.

The inspector noted that the resident had displayed numerous responsive behaviours towards other residents and staff since the initial incident in 2015, and that actions were not taken to respond to the needs of resident #015 until six month later. (575)

2. The licensee failed to ensure that actions were taken to meet the needs of resident #031 with responsive behaviours including assessments, reassessments, interventions and documentation of the resident's responses to the interventions.

During stage one of the RQI, Inspector #594 and #595 observed resident #031 demonstrating responsive behaviours. At this time, both inspectors were engaged in conversation with S #123 regarding resident #031's behaviours. S #123 listed the resident's responsive behaviours, that the resident is not on any medications, and that staff have to keep a close eye on resident #031.

Inspector #595 reviewed resident #031's health care record. It was identified in the plan of care titled 'Refuses/Resists Care', that resident #031 had episodes of physically responsive behaviours with staff and co-residents, and that two staff were required to assist with Activities of Daily Living (ADLs) due to responsive behaviours as per the ADL care plan. In the plan of care titled 'Risk of Injury from Falls', it identified two responsive behaviours of the resident. Interventions in this plan of care did not identify how staff are to respond to resident #031.

The inspector reviewed the Quarterly Medication Check Long Term Care dated during one month in 2015, where it documented in the Pharmacist's Recommendations, that there was no change in the resident's behaviours, and could consider adding a medication for behaviours and sedative effect, if problematic.

Inspector #595 located a referral to a community agency dated during 2014, and faxed one month later. Responsive behaviours were noted on the referral. The inspector was not able to locate an assessment or note from the community agency in regards to resident #031 after the referral.

In an interview with the inspector, the ADORC confirmed that the resident had not been seen/assessed by the community agency since the referral, that the resident has not had any behaviour assessments, been on any tracking, and had not been 'referred' for an assessment. At the end of the interview, the ADORC verified that resident #031 was not referred to the community agency for their behaviours, but was referred for support for their family member.

The ADORC listed resident #031's responsive behaviours to the inspector and stated that the resident's behaviours have not dramatically changed. The

ADORC identified the following interventions for resident #031's behaviours, to the inspector when requested:
- The home has not had much luck in addressing resident #031's behaviours as they happen when they happen;
- Staff can try to catch or redirect the resident when exhibiting responsive behaviours;
- The ADORC has had weekly discussions with the resident's family about interventions;
- No medications are needed for the resident as the responsive behaviours are due to staff approach, and as a result need to educate the staff;
- A community agency has reviewed the interventions for resident #031 and are 'ok' with what's in place;
- To address resident #031's responsive behaviours, visual barriers were put up on the doors of cognitive residents and for those residents whose families have expressed concern;
- Monitor resident #031 hourly, however it is an expectation that staff check residents on the specific home area more often;
The inspector asked the ADORC how the home determined interventions for the resident as they have not had an assessment. The ADORC stated that they received the ideas from the resident's family member for the responsive behaviours. Inspector #595 asked the ADORC whether the visual barriers were preventing the resident from entering other rooms, the ADORC stated that there is another resident on the unit that will go around and take the visual barriers down, so resident #031 will then just walk into the rooms.

On June 19, 2015, at 1015h Inspector #595 checked all resident rooms on the specific resident home area and did not observe any visual barriers on any doors.

Upon review of the progress notes for resident #031 over a three month period in 2015, by the inspector, it was identified that there were numerous instances of responsive behaviours. Further review of the progress notes by the inspector, documented incidents where the resident was in other resident rooms and in some instances exhibiting responsive behaviours.

Inspector spoke with S #124, S #108, S #107 and S #106 who all stated that resident #031 will exhibit responsive behaviours. The staff members stated that they would keep checking on the resident by walking around the unit to determine resident #031's whereabouts.

On June 16, 2015, Inspector #595 observed resident #031 walking up and down the halls of the unit. The next day, the inspector observed the resident sitting in another resident's room in a chair. The door to the room was open and no staff were observed to be around. Later that afternoon, the inspector observed the resident in the same room again. This time, the resident was exhibiting responsive behaviours. A housekeeper had walked by and saw the resident in the room. S #107 then noticed the resident in the room and removed them and attempted to get the resident to sit and watch TV in the common lounge area. On June 18, 2015, Inspector #595 observed resident #031 walk down the hallway and into the same room as identified above.

Given that resident #031 demonstrated responsive behaviours, no assessment had been completed of the resident's responsive behaviours, the plan of care did not provide interventions specific to responsive behaviours and the inspector observed the resident demonstrating responsive behaviours the licensee failed to respond to the needs of resident #031 with responsive behaviours. (595)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 16, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall ensure that resident #031 and #032 and any other resident who is incontinent, receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.
The licensee shall educate all staff who are responsible for completing the continence assessments and shall develop and implement a process to audit compliance with this requirement

Grounds / Motifs :

1. The licensee failed to ensure that resident #032 and resident #031, who were incontinent, received an assessment that:
- included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and
- was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Inspector #595 reviewed resident #032's health care record. It was identified in a progress note dated in 2014, that the resident was placed on a toileting routine. In the resident's health care binder, a 'Request for Resident Assessment and Product Change with Attends Products' form was completed one month later, which indicated that the reason for the product change was due to a decrease in the resident's continence.

Inspector spoke with S #123 and #119 who indicated that resident #032's continence had declined, as the resident used to be continent and aware of when to (ask to) go to the washroom. At the time of the inspection, the staff members stated that resident #032 could not voice their need to go to the washroom or did 'not understand the toilet'.

Inspector #595 reviewed resident #031's health care record. It was identified in the 'Risk of Injury from Falls' care plan that the resident voids/defecates inappropriately. In the 'CCL Assistance' care plan it was identified that the resident had deterioration in continence. Inspector also reviewed the most recent Minimum Data Set (MDS) assessment dated in 2015, which indicated that the resident had a decline in continence. In the resident's health care

binder, inspector located three completed 'Request for Resident Assessment and Products Change with Attends Products', two dated during one month and one dated three months later in 2015. Under the 'reason' section of the latest 2015, form, it was indicated that the change in product type was for during the night, as the resident 'tends to wet through their product', and a regular product was to be used instead.

The inspector reviewed the progress notes for resident #031 over a three month period in 2015. There were numerous instances of the resident voiding in inappropriate areas.

On June 16, 2015, the inspector detected a strong odour in the resident home area of resident #031. It was observed that there was a large wet spot on the carpeted floor with a wet floor sign. Inspector asked S #107 what had happened and they explained that resident #031 had voided on the floor.

The inspector spoke with the ADORC about the resident's continence, they stated that the resident had been voiding inappropriately since admission. The ADORC and five other nursing staff confirmed that the resident will void in inappropriate areas and resist toileting.

It was verified by the inspector that the staff did not assess the resident for interventions related to incontinence and inappropriate voiding.

The inspector spoke with the DONA who stated that continence assessments are located in the resident's paper chart (binder). Inspector #595 reviewed both resident #032 and resident #031's health care records, including their filed/thinned paper chart in the nursing station, and could not locate an assessment. The inspector spoke with S #114 about resident #032's and resident #031's continence assessments. The staff member stated that the home does not do continence assessments when conditions change, only when the resident is admitted to the home, by completing a 7-day observation. The staff also said that when there was a change in the resident's status, the home would use the product assessment form and indicate why the current product needs to be changed. Inspector asked S #114 if they look at why the resident's continence changed and they said the home doesn't look at those things, rather staff will document/report if the resident is having increased incontinence.

Inspector #595 reviewed the home's policy 'Continence/Incontinence Program'

(NR E 300) which identified that at the time of the quarterly review, during annual assessments and when there is any change in a resident's condition that affects a resident's bladder and bowel functioning the following is to be completed:
- Obtain information about bowel and bladder routine
- Identify contributing factors to incontinence
- Complete Continence Assessment NR E 303.

Both resident #032 and resident #031 who were incontinent, were not assessed using a clinically appropriate assessment instrument. (595)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 16, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 15th day of October, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Monika Gray

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