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 prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jan 10, 2017	2016_332575_0021 (A1)	017976-16	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

LINDSAY DYRDA (575) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Legislation change for WN #008

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 10 day of January 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
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Jan 10, 2017	2016_332575_0021 (A1)	017976-16	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

LINDSAY DYRDA (575)
AMY GEAUVREAU (642)
CHAD CAMPS (609)
SYLVIE BYRNES (627)
LINDSAY DYRDA (575) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 17-21 and 24-28, 2016.

Additional logs inspected during this RQI include:

Follow-Up log, related to two previous compliance orders (CO) issued on March 24, 2016, from inspection #2016_332575_0004. CO #001 was related to the home's policy to minimize the restraining of residents with a compliance date of May 4, 2016, and CO #002 was related to continence assessments with a compliance date of May 20, 2016;
Follow-up log, related to deferred inspection items from the RQI conducted in 2015 (inspection #2015_376594_0017);
Three complaints submitted to the Director related to the care of residents;
One complaint submitted to the Director related to improper care of residents and lack of staff training;
Four critical incidents submitted to the Director by the home related to allegations of staff to resident improper care, abuse and neglect;
One critical incident submitted to the Director by the home related to a missing resident; and
Two critical incidents submitted to the Director by the home related to resident falls.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer/Administrator, Director of Nursing Administration (DONA), Associate Director of Resident Care (ADORC), Environmental Services Manager(s), Program and Support Services Manager (PSSM), Training Coordinator, Education Assistant, Registered Dietitian, Activation staff, Housekeeping staff, Dietary staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **14 WN(s)**
- **11 VPC(s)**
- **1 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. 51. (2)	CO #002	2016_332575_0004	575
O.Reg 79/10 s. 8. (1)	CO #001	2016_332575_0004	609

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. 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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 the resident received a skin assessment by a member of the registered nursing staff within 24 hours of admission.

During stage one of the inspection, it was identified during a record review, that resident #018 developed altered skin integrity within the first 30 days of admission.

Inspector #575 reviewed resident #018's health care record. The Inspector reviewed the resident's progress notes, and noted that three days after admission, a PSW reported that the resident had altered skin integrity on a certain area of their body. The Inspector

reviewed the wound assessment completed on the same day, which indicated that the resident had altered skin integrity to a certain area of their body. The Minimum Data Set-Resident Assessment Protocol (MDS-RAP), completed 13 days after admission, indicated that the resident had altered skin integrity to two areas of their body, and one of the areas was being followed by a specialist outside of the home.

The Inspector reviewed the home's policy titled, "Skin and Wound Care Management", effective June 2016, which indicated that registered staff would complete a "Braden Scale assessment" and a "Skin Assessment in the AIM module of Goldcare to identify residents at risk for altered skin integrity" within 24 hours of admission.

During an interview with the DONA on October 26, 2016, they confirmed that the resident did not have a Braden Scale and Skin Assessment completed on Goldcare within 24 hours of admission. [s. 50. (2) (a) (i)]

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

During stage one of the inspection, it was identified during a record review, that resident #018 developed altered skin integrity within the first 30 days of admission.

Inspector #575 reviewed resident #018's health care record. A progress note on a certain date in September 2016, indicated that the resident had altered skin integrity to a certain area of their body. The September and October 2016 Treatment Administration Records (TARs), indicated that the resident had altered skin integrity to a certain area of their body and staff were to monitor the area. No wound assessment was completed.

The Inspector reviewed the home's policy titled, "Skin and Wound Care Management", effective June 2016, which indicated that upon discovery of a pressure ulcer, registered staff were to initiate a baseline assessment using the "AIM Pressure Ulcer Wound Assessment Record".

During the inspection, Inspector #575 observed the resident and noted altered skin integrity to a certain area of their body.

During an interview, RPN #137 stated that no wound assessment was completed, and

that a wound assessment was not required as the wound was not open.

During an interview with the ADORC, they confirmed that no assessment was completed and that a wound assessment should have been completed. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that the resident exhibiting 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.

During stage one of the inspection, it was identified through a staff interview and record review, that resident #017 had altered skin integrity.

Inspector #575 reviewed resident #017's health care record. The Inspector noted and confirmed with RPN #114, that the resident currently had altered skin integrity to five different areas of their body.

The Inspector reviewed the weekly wound assessment's for a one month period and noted that wound assessments were not completed at least weekly:
For three areas, wound assessment's were completed on a certain date in October 2016, and then not until 12 days later.
For one other area, a wound assessment was completed on a certain date in October 2016, and then not until 10 days later.

The Inspector reviewed the home's policy titled, "Skin and Wound Care Management", effective June 2016, which indicated that after a dressing change, registered staff should completed the "AIM Pressure Ulcer/Wound Assessment Record (weekly)".

During an interview with the Inspector, RPN #114 indicated that wound assessments should be conducted weekly. The RPN indicated that all registered staff were trained on how to complete the wound assessments. [s. 50. (2) (b) (iv)]

4. During stage one of the inspection, resident #014 was identified during a staff interview and record review as having altered skin integrity to a certain area of their body.

Inspector #575 reviewed the resident's health care record and noted a wound assessment completed on a certain date in August 2016, identifying a new area of altered skin integrity to a certain area of their body. The TAR for September 2016 indicated that staff were expected to monitor the area daily. The Inspector noted the next

assessment was not completed until approximately five weeks later, which identified deterioration to the certain area. Another assessment was completed on a certain date in October 2016, however, the next assessment was not completed until almost three weeks later.

During an interview with RPN #140, they stated that the resident's dressing to the certain area had been changed every two to three days, however, the assessment was not completed weekly.

During an interview with the DONA, they stated that staff should have completed weekly assessments for the resident's altered skin integrity. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 ensuring that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity, was fully respected and promoted.

A Critical Incident (CI) report, was submitted to the Director in April 2016, which indicated that on a certain day in March 2016, PSW #115 was observed by other staff members to be using their cellphone while assisting residents at a meal service.

Inspector #609 reviewed the home's internal investigation of the incident which found that PSW #115 used their cellphone while assisting residents with a meal service on a certain day in March 2016.

PSW #115 received disciplinary action as a result of violating the home's policy not permitting cellphones in resident areas.

During an interview with PSW #131, they stated to the Inspector that the use of a cellphone while assisting residents at a meal service was "disrespectful" to the residents.

During an interview with resident #025, they stated to the Inspector that it would be "quite rude" for a staff member to use a cellphone while assisting any resident.

During an interview with the DONA, they stated that PSW #115's use of their cellphone while assisting residents was discourteous and disrespectful. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the resident's right to participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, was fully respected and promoted.

A CI report was submitted to the Director in January 2016, which alleged that resident #005 was denied a transfer to the hospital despite multiple requests by the resident.

Inspector #642 reviewed the home's internal investigation documentation which found PSW #109 and PSW #117 had informed RN #108 that resident #005 was not feeling well, was requesting to go to the hospital, and that RN #108 was aware of the request and did not send the resident.

RN #108 received disciplinary action as a result of violating resident #005's rights by failing to respond to their requests to be transferred to the hospital for assessment.

A review of the home's policy titled, "Residents' Bill of Rights- Per-2003a", effective December 2011, indicated that every resident had the right to participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term home or a secure unit and to obtain an independent opinion with regard to any of those matters.

During an interview with PSW #109, they explained to the Inspector that they were with

resident #005 on the specific day, had informed RN #108 that the resident had requested to go to the hospital, and that RN #108 did not send resident #005 to the hospital.

During an interview with RPN #104 and RN #105, they verified to the Inspector that it was the right of the resident to be transferred to the hospital, if they requested.

During an interview with the DONA, they stated that RN #108 denied resident #005's multiple requests to be transferred to the hospital for further assessment. [s. 3. (1) 11. iii.]

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 ensuring that residents are treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity and that resident #005's right to participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters is fully respected and promoted, to be implemented voluntarily.

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

During an interview with a family member of resident #009, they alleged that resident #009 was not involved in activities over the weekends.

a) Inspector #609 reviewed the current plan of care for resident #009, which indicated that the resident was to be invited to a specific activity if they could maintain certain criteria.

A review of the home's October 2016 activity services calendar, indicated that there were services offered on seven dates in October 2016.

Inspector #609 reviewed the October 2016 program attendance flow sheet for resident #009 and found that six of the seven activities available to the resident had no documentation indicating that the resident was unavailable, invited, refused or participated.

During an interview with the Program and Support Services Manager (PSSM), they indicated to the Inspector that all care performed by activation staff was to be documented on each residents' monthly program attendance flow sheet.

b) Inspector #609 reviewed the current plan of care for resident #023, which indicated that the resident's activation goal was to accept one to one visits from program staff, two times per week, for three months.

A review of resident #023's October 2016 program attendance flow sheet found 24 of 26 days had no documentation indicating that any invitation was offered, or that the resident participated in any activities.

During an interview with Activation staff #130, they indicated to the Inspector that on multiple days during October they did attempt activities with resident #023 who had refused, however, had not documented these interactions into the program attendance flow sheet.

During an interview with the PSSM, they stated yes to the Inspector when asked if it was the expectation of the home that the provision of the care set out in the plan of care was documented and that this did not occur. [s. 6. (9) 1.]

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

During inspection #2016_332575_0004, a compliance order (CO #002) was issued to ensure that resident #011 (resident #008 in previous report), received a continence assessment.

Inspector #575 reviewed resident #011's health care record. The resident received a continence assessment in February 2016, which indicated that the resident was incontinent of bladder and bowel, used a continence product, and they were not toileted. The resident's care plan contained specific interventions related to toileting the resident.

During an interview with PSW #133, they stated to the Inspector that resident #011 was not toileted. The PSW explained the resident no longer required a specific intervention as described in the resident's care plan.

During an interview with RPN #103, they stated to the Inspector that resident #011 was no longer toileted. The Inspector reviewed the resident's care plan with RPN #103 and they confirmed that the care plan was not updated when staff discontinued toileting the resident. The RPN was not sure when the staff stopped toileting the resident.

During an interview with RN #116, they reviewed the resident's health care record and stated to the Inspector there were no notes to identify when the staff discontinued a specific intervention related to toileting. [s. 6. (10) (b)]

3. During stage one of the inspection, it was identified through Minimum Data Set (MDS), that resident #011 had worsening responsive behaviors.

A review of the "Behaviour Problem" care plan in effect for resident #011, revealed focuses for six different types of responsive behaviours.

During an interview with Inspector #627, PSW #133 stated that resident #011 had demonstrated an increase in a certain responsive behavior. They explained that resident #011 displayed this behaviour when they were given any type of care. The PSW stated that two of the certain responsive behaviours in the care plan were was no longer displayed by the resident.

During an interview with Inspector #628, RN #138 stated that resident #011 demonstrated a certain responsive behaviour when care was provided. The RN explained that one of the certain responsive behaviours was no longer a concern. RN #138 confirmed that the care plan had not been updated and that the focus for one of the responsive behaviours was no longer necessary. [s. 6. (10) (b)]

4. During stage one of the inspection, it was identified that resident #015 had increased resistance to care since admission and incidence of worsening behaviours.

Inspector #575 reviewed resident #015's health care record. The resident's current "Behaviour Problem" care plan indicated a focus for two certain responsive behaviours. Interventions indicated that staff were to identify patterns of behaviours over time and identify which behaviours required intervention. The resident's current MDS-RAP assessment, indicated that the resident had not displayed the certain responsive behaviours. The assessment indicated that the resident had three other responsive behaviours. The assessment also indicated that the resident had another responsive behaviour and identified a specific trigger to the behaviour.

During an interview with Inspector #627, PSW #139 stated to the Inspector that the resident did not exhibit the two certain responsive behaviours identified on the care plan.

During an interview with Inspector #575, RPN #137 stated to the Inspector that once the MDS-RAP assessment was completed, there was a meeting to discuss what needed to be added to the care plan. The RPN reviewed the care plan and stated that it had not yet been updated to reflect the current assessment and needs of the resident. [s. 6. (10) (b)]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

Inspector #575 reviewed a complaint submitted to the Director, regarding the care and safety of resident #020.

Inspector #575 spoke with the complainant who stated that there were not many interventions initiated to deal with a certain behaviour, and interventions that were initiated had not been effective. The complainant described a specific intervention the home initiated that had not been effective.

Inspector #575 reviewed the resident's health care record for a six month period. The Inspector noted the resident had displayed a certain behaviour on approximately four occasions.

The Inspector reviewed the current care plan, which indicated that on a certain date in June 2016, the home initiated a specific intervention to help manage the certain behaviour. The intervention indicated specific instructions for the resident and staff.

The Inspector observed the specific intervention, which appeared to be out of reach for the resident.

The Inspector noted a progress note the day after the intervention was initiated in June 2016, that indicated a PSW observed the resident displaying the certain behaviour. The resident did not utilize the intervention as indicated in the care plan.

The Inspector reviewed a progress note related to a certain behaviour that occurred in September 2016, which indicated that the resident did not utilize the specific intervention implemented by the home.

During an interview with the ADORC, they stated to the Inspector that on a certain date in June 2016, they implemented the specific intervention for the resident. The Inspector

asked if this intervention had been effective, and the ADORC indicated that it had not been effective. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that resident #009 and #023's provision of care set out in the plan of care is documented, resident #011 and #015's plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, and that resident #020 is reassessed and their plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

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

During stage one of the inspection, Inspector #609 observed two upper quarter length

bed rails engaged in the guard position on the beds of resident #009 and #019. On the same day, Inspector #575 observed two upper quarter length bed rails in the guard position on the bed of resident #011.

Inspector #609 reviewed the health care records for residents #009, #011 and #019, which found no resident specific assessment was conducted to evaluate the use of bed rails for each of the residents.

During an interview with the Administrator and the ADORC, they indicated to Inspector #609 that the home utilized the "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings", effective April 2003 and the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", last revised February 29, 2008, to direct the home's evidence-based practice related to bed rail use.

A review of the clinical guidance documents by the Inspector, indicated that the resident's chart should have included a risk-benefit assessment that identified why other care interventions were not appropriate, or not effective, if they were previously attempted and determined not to be the treatment of choice for the resident. The clinical guidance documented also recommended that residents be reassessed for risk of entrapment whenever there was a change in the resident's medication or physical condition.

The Inspector reviewed the home's policy titled, "Bed Rails and Pad Use- NR G 565", effective July 2015, and found that there was no resident specific assessment to determine the need of bed rail use, or lack of use, nor did the policy indicate that residents were to be reassessed for bed rail use when there was a change in the resident's medication or physical condition.

During the interview conducted with the Administrator and ADOC, they both verified that there was no written framework utilized by the home to assess the resident's use of bed rails, and that the policy did not apply the evidence-based practices outlined in the clinical guidance documents.

Inspector #609 observed 10 beds in one of the home areas and found seven or 70 per cent, had two upper quarter length bed rails engaged in the guard position. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that where bed rails are used, the resident is assessed in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

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

A CI report was submitted to the Director in May 2016, which alleged PSW #100 had been verbally and physically abusive towards resident #006.

Inspector #642 reviewed the home's internal investigation and found that PSW #101 and PSW #112 had witnessed PSW #100 being physically and verbally abusive toward resident #006, when they responded to resident #006's activated bed alarm. PSW #101 and #112 verified that they had witnessed the incident.

PSW #100 received disciplinary action for not complying with the home's zero tolerance of abuse and neglect policy.

A review of the home's policy titled, "Prevention of Abuse and Neglect Zero Tolerance, PER-2300", effective date October 2015, indicated that zero tolerance meant that the home would uphold the rights of the residents of the home to be treated with dignity and respect, and to live free from abuse and neglect. The policy further stated that the home would allow no exceptions, tolerate no abusive behaviour and require strict compliance and enforcement of the policy.

During an interview with PSW #112, they verified that they were present and working and witnessed PSW #100 physically and verbally abuse resident #006.

During an interview with the DONA, they stated that PSW #100 did not comply with the policy. [s. 20. (1)]

2. A CI report was submitted to the Director in April 2016, which indicated that on a certain day in March 2016, PSW #115 was observed by other staff members to be using their cellphone while feeding residents at a meal service.

Inspector #609 reviewed the CI report which found that one of the home's staff members observed PSW #115 using their cellphone while feeding residents.

A review of the home's policy titled, "Prevention of Abuse and Neglect- Pers-2300", effective October 2015, indicated that zero tolerance meant that the home would uphold

the rights of the residents of the home to be treated with dignity and respect. The policy further stated that the home would allow no exceptions. The policy indicated that the person witnessing the mistreatment of the resident should intervene to ensure the health, safety and well being of the resident and immediately inform the RN.

During an interview with a certain staff member who witnessed the incident, they stated to the Inspector that they had received training in the home's policy on zero tolerance of abuse and neglect. The staff member verified that they did not intervene at the time of the incident as they were not sure if the actions of PSW #115 constituted abuse or neglect, nor did they immediately report the incident to the RN.

The staff member stated to the Inspector that they did not comply with the home's policy, when they did not intervene to ensure the health, safety and well being of the residents, nor immediately report the incident to the RN. [s. 20. (1)]

3. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 to make mandatory reports.

A CI report was submitted to the Director in April 2016, which contained allegations of abuse and neglect of residents.

Inspector #609 interviewed Housekeeper #136, who verified that they had received training in the home's zero tolerance of abuse and neglect policy. Housekeeper #136 stated that they would notify the Ministry of any suspected or witnessed abuse if it was by someone "higher up" in the home; Otherwise, they would notify the RPN on the unit.

During an interview with PSW #135, they verified to the Inspector that they had received training in the home's zero tolerance of abuse and neglect policy. PSW #135 also stated that if abuse or neglect was witnessed or suspected they would notify the RPN on the unit or fill out an incident form at the nurses' station.

A review of the home's policy titled, "Prevention of Abuse and Neglect- Pers-2300", effective October 2015, under the mandatory reports section, indicated "Belvedere Heights is mandated to make reports to the Director (Ministry of Health)".

During an interview with the ADORC, the home's zero tolerance of abuse and neglect policy, as well as the LTCH Act was reviewed. The ADORC verified that it was the

expectation of the home that any person who suspected or witnessed abuse or neglect of a resident immediately reported the information upon which it was based to the Director. The ADORC further verified that the home's zero tolerance of abuse and neglect of residents policy did not make a clear explanation of the duty under section 24, that any person must make mandatory reports to the Director. [s. 20. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home's policy to promote zero tolerance of abuse and neglect contains an explanation of the duty under section 24 to make mandatory reports and that the policy is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

During stage one of the inspection, resident #012 was identified as frequently incontinent according to the most recent MDS assessment.

Inspector #575 reviewed the resident's most recent MDS assessment, and the Resident Assessment Protocol (RAP), which indicated that the resident was continent of bowel and incontinent of bladder. The resident's current continence care plan, indicated that the resident was incontinent of bowel and bladder. The care plan did not provide interventions related to bowel continence.

During an interview with PSW #133, they stated to the Inspector that the resident was incontinent of bladder and usually continent of bowels. PSW #133 stated that staff would ask the resident when they needed to use the toilet and the resident would advise staff when they needed their incontinent product changed.

During an interview with RPN #103, they stated to the Inspector that resident #012 directed their own care, was incontinent of bladder and usually continent of bowel. The Inspector reviewed the MDS and RAP assessments with RPN #103 and the RPN stated that the care plan did not reflect the assessment.

During an interview with the DONA, they confirmed that there were discrepancies with the MDS and RAP assessments and the care plan. [s. 26. (3) 8.]

2. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.

During stage one of the inspection, it was identified during a record review that resident #018 developed altered skin integrity within the first 30 days of admission.

Inspector #575 reviewed resident #018's health care record. The MDS-RAP, completed 13 days after admission, indicated that the resident had altered skin integrity to a certain area of their body that was being followed by a specialist outside of the home. No wound assessments were completed. On a certain date in July 2016, an order by the specialist directed a certain intervention until the resident returned to the specialist. The July 2016 TAR was reviewed and indicated a verbal order from the specialist, with a new intervention. The TAR for September and October were reviewed. In September, signatures on two occasions, indicated that a dressing was changed. No other signatures were noted. In October, the TAR indicated that the resident saw the specialist on a certain date in October 2016, and a handwritten note indicated that the specialist advised updated directions regarding the care of resident #018's dressing. The TAR indicated that staff changed the dressing on two occasions in October 2016. The current

physician order reviewed for October 1 to December 31, 2016, indicated the order indicated by the specialist in July 2016.

The resident's current care plan indicated that the resident had a lack of skin integrity, and staff were to document any episodes of skin redness/breaks/rash, assess skin condition daily, keep skin clean and dry, and consult the Dietitian. The care plan did not address the specific altered skin integrity followed by the specialist.

During an interview with RN #125, they stated to the Inspector that they were not sure how often staff were required to change the dressing and indicated that it was not clear. RN #125 observed resident #018's certain area on their body indicated that there was no current dressing, and the wound was healed. The RN indicated that there were no notes from the specialist regarding the resident's appointments.

During an interview with the Inspector, the DONA stated that the staff should have been doing an assessment if they were changing the dressing. The DONA stated that it was not clear, and staff should have clarified with the specialist. [s. 26. (3) 15.]

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 ensuring that resident #018's plan of care is based on an interdisciplinary assessment with respect to the resident's skin condition and altered skin integrity, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

Inspector #609 interviewed resident #001 who indicated that staff performed mouth care every evening. The resident further indicated that they wanted mouth care in the morning, but that staff were too busy. Resident #001 could not recall the last time oral care was performed in the morning.

A review of the current plan of care for resident #001, found that staff were to provide oral care in the morning and at bed time.

During an interview with PSW #123, they explained to the Inspector that oral care was not performed in the morning with resident #001.

A review of the PSW daily care flow sheets for a period of 10 days in October, found that nine out of 10 days reviewed, no oral care was performed in the morning with resident #001.

During an interview with the DONA, they stated yes to the Inspector when asked if it was the expectation of the home that residents received oral care in the morning and the evening. [s. 34. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that resident #001 receives oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provided direct care to residents, as a condition of continuing to have contact with residents, received training in any other areas provided for in the regulations.

A complaint was submitted to the Director which alleged safety concerns related to residents being assisted with meal and snack services by housekeeping staff, who were not trained in dietary policies and procedures.

Inspector #609 reviewed the home's staffing back up plan titled, "Working Short Plan Form- NRC 111 (a)", no revision date, which found that program and housekeeping staff were to report to the charge nurse for direction as to where they were needed.

During an interview with the Administrator, they stated to the Inspector that when the home was short direct care staff, housekeeping and activation staff would be called upon to assist with the dining and snack services.

During an interview with Housekeeper #119, they explained to the Inspector that when the home was short direct care staff, they would be required to serve coffee and tea, add thickener into fluids, take dietary choices and deliver plates to the tables. They further indicated that training related to these meal service duties consisted of a one-time discussion, six to nine months previously, that did not address diet types, restrictions or safety concerns and that there was no annual retraining in the cited meal service duties. Housekeeper #119 stated no when asked if they felt competent in their meal service roles or responsibilities.

During an interview with Activation staff #120, they explained to the Inspector that when the home was short direct care staff they would be required to assist with meal service duties, including but not limited, to feeding residents. Activation staff #120 further indicated that no formal training was conducted related to meal service duties and stated no when asked if they felt competent in their service duties.

During an interview with the Program and Support Services Manager, they verified to the Inspector that there was no formal or annual training for activation staff in meal service duties.

During an interview with the home's previous Environmental Services Manager, a review of the education provided to housekeeping staff in meal service duties dated March 4, 2016, was conducted and found that diet types, restrictions and other safety concerns were not addressed.

During the interview with the Administrator, they stated yes to the Inspector when asked if it was the expectation of the home that staff received training in any other areas provided for in the regulations, including meal service duties, in order for staff to safely and competently perform the assigned meal service duties. The Administrator also verified that there was currently a gap in the training of activation and housekeeping staff in their meal service roles and responsibilities. [s. 76. (7)]

(A1) WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

A complaint was submitted to the Director which alleged safety concerns related to residents being assisted with meal and snack services by housekeeping staff, who were not trained in dietary policies and procedures.

Inspector #609 reviewed the home's staffing back up plan titled, "Working Short Plan Form- NRC 111 (a)", no revision date, which found that program and housekeeping staff were to report to the charge nurse for direction as to where they were needed.

During an interview with the Administrator, they stated to the Inspector that when the home was short direct care staff, housekeeping and activation staff would be called upon to assist with the dining and snack services.

During an interview with Housekeeper #119, they explained to the Inspector that when the home was short direct care staff, they would be required to serve coffee and tea, add thickener into fluids, take dietary choices and deliver plates to the tables. They further indicated that training related to these meal service duties consisted of a one-time discussion, six to nine months previously, that did not address diet types, restrictions or safety concerns and that there was no annual retraining in the cited meal service duties. Housekeeper #119 stated no when asked if they felt competent in their meal service roles or responsibilities.

During an interview with Activation staff #120, they explained to the Inspector that when the home was short direct care staff they would be required to assist with meal service duties, including but not limited, to feeding residents. Activation staff #120 further indicated that no formal training was conducted related to meal service duties and stated no when asked if they felt competent in their service duties.

During an interview with the Program and Support Services Manager, they verified to the Inspector that there was no formal or annual training for activation staff in meal service duties.

During an interview with the home's previous Environmental Services Manager, a review of the education provided to housekeeping staff in meal service duties dated March 4, 2016, was conducted and found that diet types, restrictions and other safety concerns were not addressed.

During the interview with the Administrator, they stated yes to the Inspector when asked if it was the expectation of the home that staff received training in any other areas provided for in the regulations, including meal service duties, in order for staff to safely and competently perform the assigned meal service duties. The Administrator also verified that there was currently a gap in the training of activation and housekeeping staff in their meal service roles and responsibilities. (s. 76. (2) 10)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all staff who provide direct care to residents, receive training in dietary policies and procedures, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

During stage one of the inspection, it was identified through a staff interview, that resident #010 had a low body mass index.

Inspector #627 reviewed resident #010's current care plan, which indicated under the the focus of diet, that the resident was to receive a nutritional supplement, three times per day (TID).

A review of the physician’s orders revealed that on a date in April 2016, a specific supplement was ordered TID. On a date in June 2016, another supplement was ordered TID. On a date in September 2016, the supplement that was ordered in April 2016, was discontinued.

A review of the Medication Administration Record (MAR) for the month of September 2016, revealed that the supplement ordered in April 2016 was not administered during the month of September 2016, and the supplement ordered in June 2016 had been administered until a specific date in September 2016. A line was drawn across the dates with a notation indicating that it was discontinued on a specific date in September 2016.

During an interview, the Registered Dietitian (RD) stated to the Inspector that resident #010 was receiving a supplement three times daily for weight gain. A review of the MAR sheet by the Inspector and the RD revealed that the resident had not received the supplement for 28 days. During a review of the physician's orders, the RD stated that they had asked the physician to discontinue the supplement ordered in April 2016 as the resident was receiving the supplement ordered in June 2016, which was the supplement given to the residents unless otherwise specified. The resident was to continue to be given the nutritional supplement, however, it had been discontinued in error.

During an interview with the Inspector, the DONA stated that resident #010 should have received the nutritional supplement three times per day. The DONA stated that there was an error processing the order and that it could have been avoided if staff had verified with the RD or the physician. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that drugs are administered to resident #010 in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff were provided annual training in skin and wound care.

During stage one of the inspection, resident #014, #017, and #018 were identified as having had altered skin integrity.

Inspector #575 interviewed the Training Coordinator, who stated that staff were given a calendar year to complete the annual mandatory skin and wound care training. They indicated that there were several modules assigned to staff via the online platform, Surge Learning. The Training Coordinator stated that there was one main module titled, "Skin and wound care program for front line staff and families", however, if staff completed any of the assigned modules, the home would consider the training completed. The Training Coordinator stated that staff were not required to review the home's skin and wound care policy, and that the training did not include information regarding completing skin and wound assessments. The Training Coordinator indicated that not all staff completed the required training.

The Inspector reviewed the training records for 2015. The Inspector noted the following direct care staff did not complete the training:

10/57 PSWs, or 17.5 per cent;
1/8 RNs, or 12.5 per cent; and
3/10 RPNs, or 30 per cent. [s. 221. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all direct care staff are provided annual training in skin and wound care, to be implemented voluntarily.

WN #11: 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. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents and took immediate action as required.

During stage one of the inspection, resident #008, #012, and #013 were identified through MDS as having had an infection.

1.) A review of resident #008's health care record revealed that resident #008 developed an infection and was placed on antibiotics for a period of seven days.

A review of the electronic records in Gold Care, including progress notes and vital signs electronic flow sheet, for the seven day period, revealed no documentation of infection symptoms on approximately five dates.

The Inspector reviewed the "24 Hour High Risk Event List" for the same period and noted that none of the resident's symptoms were documented.

2.) A review of resident #012's health care record by the Inspector revealed that resident #012 developed an infection on a certain date and was placed on isolation for a period of five days.

A review of the electronic records in Gold Care, including progress notes and vital signs electronic flow sheet for an 11 day period, revealed no documentation of infection symptoms on approximately nine dates.

The Inspector reviewed the "24 Hour High Risk Event List" for the same period and noted none of the resident's symptoms were documented.

3.) A review of resident #013's health care record by the Inspector revealed that resident #013 developed an infection and was placed on antibiotics for a period of eight days.

A review of the electronic records in Gold Care, including progress notes and the vital signs electronic flow sheet, for the eight day period, revealed no documentation of infection symptoms on approximately eight dates.

The Inspector reviewed the "24 Hour High Risk Event List" for the eight day period and noted none of the resident's symptoms were documented.

The home's policy titled "Infection Prevention and Control: Surveillance and Data Collection", number IPC:Fn25.00, last revised July 2015, was reviewed by the Inspector. The policy revealed that every shift, the RPN would examine and evaluate the resident after any report or observation of unusual infection symptoms and document the observations, assessment and the actions taken on the resident chart.

A review of the home's policy titled "Infection Prevention and Control: Organization and Communication", number IPC: B-10.00, last revised August 2015, revealed that all infections are communicated on the 24 Hour High Risk Report.

During an interview with the Inspector, RPN #103 stated that symptoms of infection that residents were exhibiting were monitored every shift and documented in Gold Care, in the resident's chart and on the 24 Hour High Risk Events List.

During an interview with RN #118, who was also the Infection Prevention and Control Lead for the home, they stated that all residents with symptoms of an infection would be monitored on every shift. The symptoms were documented on the 24 Hour High Risk Events List. They further stated that documentation of the symptoms had not occurred daily for all three residents. They were unaware that symptoms of infection were required to be documented in the resident's chart daily.

The DONA stated to the Inspector that symptoms of an infection should be documented in Gold Care for every shift, for every resident who exhibited symptoms. As well, the symptoms exhibited should be documented on the 24 Hour High Risk Event List. The DONA confirmed that this was not done on every shift for resident #008, #012, and #013. [s. 229. (5) (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 ensuring that staff on every shift record symptoms of infection and immediate action is taken as required, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in writing was provided to the the Residents' Council within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Inspector #609 reviewed three Residents' Council meeting minutes dated June 28, August 30 and September 27, 2016. The Inspector noted that during the September 27, 2016, meeting, concerns were brought forward related to residents' privacy not being respected as well as infection control practices during meal times. The Inspector was unable to find any written response to the Residents' Council concerns.

During an interview with the Administrator, they stated yes to the Inspector when asked if it was the expectation of the home that the Residents' Council would receive a written response within 10 days of the home receiving their concerns. The Administrator further stated that they had verbally responded to the Residents' Council concerns on September 27, 2016, but had not provided a written response to the council in over three weeks. [s. 57. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of a resident who was missing for less than three hours and who returned to the home with no injury or adverse change in condition, no later than one business day after the occurrence of the incident.

Inspector #575 reviewed a CI report submitted to the Director by the home in June 2016. The CI report described an incident that occurred involving resident #020 four days prior (three business days). The Director was not informed within one business day after the occurrence.

During an interview with the ADORC, they stated to the Inspector that the incident occurred on a Saturday, they did not work Mondays, and they became aware of the incident on the Tuesday; therefore, they reported the incident on a Wednesday (3 business days after the incident).

Inspector #575 reviewed a second CI report, submitted to the Director by the home in April 2016 regarding another incident involving resident #020. The CI report described an incident that occurred five days prior. The Director was not informed within one business day after the occurrence.

During an interview with the ADORC, they confirmed to the Inspector that the incident was not reported to the Director within one business day. [s. 107. (3) 1.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols developed for the medication management system were implemented.

During stage one of the inspection, it was identified during a record review, that resident #018 developed altered skin integrity within the first 30 days of admission.

1.) On a certain date in July 2016, a wound care protocol was initiated for a wound acquired by resident #018's, which directed staff to change the resident's dressing every two days. Wound assessments were completed weekly, and indicated that the wound had healed on a certain date in August 2016.

The Treatment Administration Record (TAR) was reviewed for September and October 2016 which continued to indicate that staff were to complete the dressing change for resident #018, however, no signatures were noted to indicate the treatment was provided. In addition, the TAR sheets were only checked by one nursing staff for accuracy at the beginning of each month.

During an interview with RN #125, they stated to the Inspector that the resident's wound was healed and staff should have discontinued the order.

The home's policy titled, "Medication Pass – MAR/TAR Sheets", last reviewed June 23, 2014, indicated that when a resident's medication was discontinued, a line should be drawn through the subsequent spaces on the MAR/TAR sheet, write "discontinued" and

the date above the line.

The policy also stated that upon receipt of the new MAR/TAR sheets, two nurses must check all printed information for correctness, make appropriate changes and inform pharmacy of any changes. To ensure accuracy, each new sheet must be double checked against the Physician's Order Review, as well as the previous month's MAR/TAR sheets before being used.

During an interview, the ADORC stated to Inspector #575 that the RN checked the new MAR/TAR with the previous MAR/TAR each month, however, there was no double check because there was not enough time. The ADORC confirmed that staff should have discontinued the treatment order for the resident's wound when the wound healed in August 2016.

2.)The MDS-RAP completed in July 2016, indicated that resident #018 had altered skin integrity to a certain area of their body that was being followed specialist outside of the home. On a certain date in July 2016, an order by the specialist provided specific instructions to staff until the resident returned to the specialist at a later date. The July 2016 TAR was reviewed and indicated a verbal order from the specialist with updated instructions for the dressing.

The Inspector reviewed the August-October 2016 TARs. All TARs indicated that staff were to follow specific instructions from the specialist and were not updated with the verbal order instructions. The September and October TARs were only checked by one nursing staff for accuracy at the beginning of each month.

During an interview, the ADORC stated to Inspector #575 that the directions for the resident's dressing should not have been carried forward to the August-October 2016 TARs.

3.) A progress note on a certain date in September 2016, indicated that resident #018 was forming altered skin integrity to a certain area of their body. The TAR indicated on the same date that staff were to monitor the area. For a period of approximately 26 days in September 2016, signatures were missing on six occasions. The October 2016 TAR indicated a different area of altered skin integrity, and staff were to monitor. Signatures were missing on nine occasions.

The home's policy titled, "Medication Pass – MAR/TAR Sheets", last reviewed June 23,

2014, indicated that when a medication was administered, the nurse or care provider must initial in the box opposite that medication for the date and time given.

During an interview, the ADORC stated to the Inspector that staff should have been signing the TAR daily that the area of altered skin integrity was monitored. [s. 114. (3) (a)

Issued on this 21st day of December, 2016

Issued on this 10th day of January, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LINDSAY DYRDA (575), AMY GEAUVREAU (642), CHAD CAMPS (609), SYLVIE BYRNES (627)
Inspection No. / No de l'inspection :	2016_332575_0021
Log No. / Registre no:	017976-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 21, 2016
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

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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that all residents, and specifically resident #014 and #017 exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident exhibiting 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.

During stage one of the inspection, resident #014 was identified during a staff interview and record review as having altered skin integrity to a certain area of their body.

Inspector #575 reviewed the resident's health care record and noted a wound assessment completed on a certain date in August 2016, identifying a new area of altered skin integrity to a certain area of their body. The TAR for September 2016 indicated that staff were expected to monitor the area daily. The Inspector noted the next assessment was not completed until approximately five weeks later, which identified deterioration to the certain area. Another assessment was completed on a certain date in October 2016, however, the next assessment was not completed until almost three weeks later.

During an interview with RPN #140, they stated that the resident's dressing to the certain area had been changed every two to three days, however, the assessment was not completed weekly.

During an interview with the DONA, they stated that staff should have completed weekly assessments for the resident's altered skin integrity. (575)

2. During stage one of the inspection, it was identified through a staff interview and record review, that resident #017 had altered skin integrity.

Inspector #575 reviewed resident #017's health care record. The Inspector noted and confirmed with RPN #114, that the resident currently had altered skin integrity to five different areas of their body.

The Inspector reviewed the weekly wound assessment's for a one month period

and noted that wound assessments were not completed at least weekly:
For three areas, wound assessment's were completed on a certain date in October 2016, and then not until 12 days later.
For one other area, a wound assessment was completed on a certain date in October 2016, and then not until 10 days later.

The Inspector reviewed the home's policy titled, "Skin and Wound Care Management", effective June 2016, which indicated that after a dressing change, registered staff should completed the "AIM Pressure Ulcer/Wound Assessment Record (weekly)".

During an interview with the Inspector, RPN #114 indicated that wound assessments should be conducted weekly. The RPN indicated that all registered staff were trained on how to complete the wound assessments.

The decision to issue this compliance order was based on the severity which was determined to have been a potential for actual harm to the health and well-being of residents with altered skin integrity and the scope which was determined to be a pattern as two out of three residents reviewed were affected. During a previous inspection (2015_376594_0017), a written notification was issued to the home on October 15, 2015. Despite previous non-compliance (NC), NC continues with this area of the legislation.
(575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 20, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 21st day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lindsay Dyrda

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