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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 21, 2015	2015_265526_0018	H-003115-15	Resident Quality Inspection

Licensee/Titulaire de permis

BENNETT HEALTH CARE CENTRE
1 Princess Anne Drive Georgetown ON L7G 2B8

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

BENNETT HEALTH CARE CENTRE
1 Princess Anne Drive Georgetown ON L7G 2B8

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

THERESA MCMILLAN (526), CATHIE ROBITAILLE (536), JESSICA PALADINO (586), MELODY GRAY (123), MICHELLE WARRENER (107), SAMANTHA DIPIERO (619)

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): August 31, 2015; September 1, 2, 3, 4, 9, 10, 11, 14, 15, and 16, 2015.

The following Critical Incident System inspections were conducted simultaneously during this RQI: H-002907-15, H-002908-15, H-002909-15, H-002910-15, H-002905-15, H-002182-15, H-002409-15, H-003116-15, and H-002921-15.

The following Complaint inspections were conducted simultaneously during this RQI: H-002997-15 and H-003154-15.

The following Follow Up inspections were conducted simultaneously during this RQI: H-001915-15, H-001917-15, H-001920-15, H-001921-15.

During the course of the inspection, the inspector(s) spoke with the Administrator (CEO), the Director of Care (DOC), the Resident Care Coordinator (RCC), the Dietary Manager (DM), the Registered Dietitian (RD), the Programs Coordinator (PC), The Environmental Manager (EM), the Administrator's Assistant (AA), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Recreation Staff, Dietary Aids, housekeeping staff, residents and residents' family members.

During this course of this inspection, Long Term Care (LTC) Inspectors toured the home; observed meal service and resident care; reviewed resident health records, policies and procedures, training records, programme evaluation records, maintenance records, staff files, infection prevention and control documentation and investigation, complaints records, meeting minutes, and menus.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Critical Incident Response
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2014_265526_0018	526
O.Reg 79/10 s. 55.	CO #003	2014_265526_0018	526
LTCHA, 2007 S.O. 2007, c.8 s. 76. (4)	CO #006	2014_265526_0018	526
LTCHA, 2007 S.O. 2007, c.8 s. 84.	CO #007	2014_265526_0018	526

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for each resident set out the planned care for the resident.

A) Resident #025's RAI MDS completed in 2015 indicated that the resident had total dependence on two staff for bed mobility and transfers. The document the home referred to as resident #025's care plan completed after this assessment, indicated the resident's sleep and rest preference at night time only. During this inspection, the resident was observed in bed after breakfast until approximately 1145 hours. During interview, the resident's substitute decision maker (SDM) stated that they had told staff in the past that the resident should get up closer to 1100 hours; the SDM stated feeling that the resident was spending too much time in bed during the morning time.

During interview, PSW staff stated that the resident was assisted to bed each morning after breakfast, returned to their wheelchair before lunch and stayed up during the

afternoon; they were not aware of the SDMs preference for the resident to get up earlier. During interview, the DOC confirmed that the written plan of care did not set out the planned care for the resident regarding their rest routine during day time hours. (526)

B) The licensee did not ensure that there was a written plan of care for resident #044 that set out, the planned care for the resident in relation to falls prevention. Resident #044's health record indicated that the resident was at a high risk for falls.

Interview with the DOC and review of the Fall Committee Meeting minutes during 2015, revealed resident #044's risks for falls and recommended staff interventions. During interview the Resident Care Coordinator (RCC) confirmed the resident's use of falls prevention strategies. The above falls prevention interventions were not set out in the resident's documented plan of care. (586)

C) The licensee did not ensure that there was a written plan of care for resident #002 that set out, (a) the planned care for the resident in relation to oral hygiene. The plan of care for resident #002 did not include direction for staff in the provision of oral care. The resident wore dentures daily. The Director of Care confirmed the resident's plan of care and kardex did not include oral hygiene and directions for staff. Documentation did not reflect the resident was always receiving oral hygiene twice daily. (107) [s. 6. (1) (a)]

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

A) Review of health records indicated that resident #004 was a moderate risk for falls. Falls prevention strategies in place included a hi/low bed at the lowest position and the use of a bed alarm when the resident was in bed. According to progress notes, the resident's status had changed during a week in 2015. On a specified day at the end of this week resident #004 was found lying on the floor beside their bed with their head resting on the bedside table that was tipped over. The DOC reported that the falls mat was not in place at the time of the fall and the resident did not sustain injuries as a result of the fall.

Approximately 10 days after the fall, the home's Falls Committee recommended that the falls mat be reapplied for resident #004. Observations during this inspection indicated that the falls mat was not applied while the resident was in bed. The document the home referred to as the care plan completed five weeks after the fall indicated that the resident was to have a falls mat at the bedside when the resident was in bed. During interview on

September 4, 2015, the DOC stated that since the resident's condition had improved they were at an increased risk to fall out of bed and the falls mat should have been in place. On September 9, 2015, LTC Inspector observed resident laying in bed without falls mat in place at side of bed. PSW, RPN staff and DOC confirmed that care was not provided as per the plan of care. (526)

B) Resident #033's RAI MDS completed in 2015, indicated that the resident used a brief, was usually continent of bowels, and was incontinent of urine all or most of the time during the 14 day observation period. The associated RAP sheet indicated that the resident was toileted regularly, could not tell staff when they needed to use the bathroom. This was confirmed by PSW staff during interview.

The document the home called resident #033's care plan indicated that the resident used a continence brief and should be toileted before and after meals and at bedtime. During interview, day shift PSWs stated that the resident was toileted once during day shift and not again until afternoon shift. The resident's substitute decision maker (SDM) expressed concern that toileting occurred only two times during the day and not according to what they thought was the plan of care. During interview, PSW and RN staff confirmed that care had not been provided according to resident #004's plan of care regarding toileting and continence management. (526)

C) Resident #008 was a high risk for falls. Review of progress notes indicated that on a specified day in 2015, the resident fell while using their walker causing injury and a significant change in condition that required hospitalization and changes to the resident's plan of care. The resident's plan of care completed one month and six months after the fall directed staff to apply bed and chair alarms and not to leave resident unattended in their room while awake.

The resident fell five times after this incident over a six month time period; four of these falls involved the resident ambulating from their wheelchair without assistance. At least one incident occurred while the resident was unattended in their room.

On September 15, 2015, the Long Term Care (LTC) Inspector observed resident #008 to be sitting in their wheelchair without a chair alarm applied. During interview, a PSW stated that the resident's bed alarm had broken, staff used the chair alarm on the bed and resident had been going without a chair alarm for about one month. During interview, the Resident Care Coordinator (RCC) confirmed that the resident should have had a chair alarm in place according to their plan of care since the resident often attempted to

ambulate from their chair and could fall. The RCC also confirmed that the resident had been left unattended in their room while in their wheelchair on at least one occasion and this was not according to the plan of care. [s. 6. (7)]

3. The licensee failed to ensure that a 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.

Review of resident #004's health record indicated that the resident was a moderate risk for falls. In April 2015, plan of care for falls prevention was outlined and included the use of a falls mat when resident was in bed. The care plan completed in June 2015, also indicated that the falls mat was to be used.

i) Interview with PSW staff and the DOC indicated that the falls mat was removed during June and July, 2015, when the resident’s condition changed. However, an assessment of the resident’s falls risk which prompted the removal of the mat was not completed or found in the health record, and the plan of care was not updated to include the removal of the falls mats; this was confirmed by the DOC.

ii) According to health records, the resident fell at the side of their bed in July, 2015, and the falls prevention committee in the home recommended that the falls mat be re-installed. An assessment upon which this decision was based could not be found in the resident's health record, and the plan of care was not updated to reflect the change in care needs according to the DOC.

The DOC and registered staff confirmed that resident #004 was not reassessed and plan of care updated when their care needs changed regarding falls prevention. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan; and that the resident is 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 change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required 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, (b) was complied with.

A) The home's "Falls Prevention Program - 4.1.12, last reviewed November, 2014" directed the Interdisciplinary Falls Committee to review all falls incidents, including medical history, drug record, and the resident care plan and the Point Click Care Risk Management Tool.

Resident #008 fell 6 times between January and July 2015. During the fall in January, 2015, they sustained an injury that led to a significant change in condition, hospitalization, and a change in the plan of care. During review of the home's Interdisciplinary Fall Committee meeting minutes, it was noted that the resident's fall incidents had not been discussed until following a fall in July, 2015. The RCC confirmed the home's expectation that all six of resident #008's fall incidents should have been reviewed during committee meetings held between February and July, 2015. The DOC stated that the resident may have been discussed at meetings, however the discussions had not been recorded according to the home's policy. (526)

B) The home's policy, "Admission Care Conference/Annual Care Conference - 4.2.8, revised March 2011", stated that interdisciplinary team members would document in the resident's chart a summary of the conference as well as all attendees.

Resident #037 had an Annual Care Conference completed by the Interdisciplinary Team in July, 2015. A progress note identified the meeting occurred; however, did not include a summary of the conference for disciplines other than the Physician and did not include a record of all the attendees at the meeting.

The Resident Care Coordinator confirmed that staff were to document Annual Care Conferences in the electronic health record on the "Multidisciplinary Team Conference" form. Staff confirmed the form was not completed to record the Annual Care conference held for resident #037 on an identified date in July, 2015. (107) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rules were complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During this inspection, the door from the hallway by the nursing station to the servery was left unlocked and accessible to residents. Doors to the servery from the dining room were left propped open and unattended by staff. The servery was a non-resident area and contained an unrestricted hot water dispenser (reading 204 degrees Celsius); containers of accessible dishwashing chemicals; steam tables, and tripping hazards. The area was left unattended by staff and was accessible to residents.

The Director of Care confirmed that the area should not be accessible to residents. [s. 9. (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 all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's policy "Abuse and neglect prevention program - 4.1.2 last revised March 2011", stated that for existing staff and Volunteers: "All staff and volunteers are required to sign an annual declaration confirming his/her criminal background or record. The Administrator is responsible to confirm that all staff have signed a declaration." The Administrator and the Director of Care (DOC) both confirmed that an annual declaration had not been signed by staff and volunteers for at least the past three years. [s. 20. (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, without in any way restricting the generality of the duty provided for in section 19, that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The Recreational and Social Activities program was not evaluated at least annually in accordance with evidence-based practices. The Programs Coordinator confirmed that an evaluation of the Recreation program was not completed annually. [s. 30. (1) 3.]

2. The licensee has failed to ensure that actions taken with respect to resident #045 under the Nursing and Personal Support Services and Nutrition and Hydration Programs, including reassessments and interventions were documented.

The Assistant Director of Care (ADOC) confirmed the plan of care was revised to include the resident's Palliative Care status and needs; however, documentation did not reflect that the plan of care was updated with the revised care needs. The ADOC was unable to locate a copy of the revised document. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee did not ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

i) Ten of the 11 scheduled baths for the September 6, 2015, day shift were not completed, and as of September 9, 2015, had not been re-scheduled (Residents #013, #017, #040, #005, #029, #011, #002, #047, #048, #049, #050). During interview staff confirmed that there was a staffing shortage resulting in the baths not being completed. The Director of Care confirmed the home had been short staffed on the day shift September 6, 2015.

ii) Resident #031 had a plan of care that identified a preference for showers and the resident was scheduled for a shower ~~on~~ in August [redacted] 2015. Documentation did not reflect that a shower was offered, refused, or provided to the resident. The shower was not re-scheduled during the week and the resident received only one shower. The Director of Care confirmed the home was short staffed [redacted] on selected shifts in August 2015. Le Dec 2/15

iii) Resident #002 had a plan of care that identified a preference for showers and the resident was scheduled for a shower ~~on~~ in August [redacted] 2015. Documentation did not reflect that a shower was offered, refused or provided to the resident. The shower was not re-scheduled during the week and the resident received only one shower. The Director of Care confirmed that the home was short staffed [redacted] on selected shifts in August 2015. Le Dec 2/15

iv) Resident #023 had a plan of care that identified a preference for a bath on one day of the week and a shower on the alternate day of the week. Documentation did not reflect that the resident was offered, refused or received a bath or shower between during a week in 2015. Showers or baths were missed on three occasions. There was no evidence that the bath/showers were re-scheduled.

A shower was scheduled on three separate days in August, 2015. Documentation did not reflect that a shower was offered, refused, or provided to the resident on the specified day of the week, resulting in the resident receiving only one shower per week over a two week period during August, 2015. A shower was recorded for two days during this time period; however, the plan of care directed staff to provide a tub bath on the alternate bath day. Staff were unable to identify why the resident was provided a shower instead of the scheduled tub bath and documentation did not reflect a reason for providing a shower

versus tub bath. The resident was not able to voice their preference. The resident was observed with greasy hair on August 31 and September 9, 2015.

v) Documentation in the Resident's Council Meeting Minutes for August 31, 2015, identified residents were concerned that there was a shortage of staff resulting in residents not getting their showers/baths on time. [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #7: 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 a resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A) Resident #025's Resident Assessment Inventory Minimum Data Set (RAI MDS) completed in July, 2015, indicated that the resident used a brief and was incontinent of urine and stool all or most of the time during the 14 day observation period. The associated Resident Assessment Protocol (RAP) sheet directed staff to use interventions that would promote continence. The document the home called resident #025's care plan indicated that no toileting was required and that the resident used a continence brief. During interview, the day shift personal support worker (PSW) stated that they did not toilet the resident while the evening shift PSW stated that the resident was toileted once each shift and usually voided or had a bowel movement at that time.

Review of the resident's health record indicated the resident had been continent of bowel and frequently incontinent of bladder at the time of the resident's admission in 2014. This review further indicated that there had been no continence assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions between the time of the resident's admission in 2014, and this inspection. During interview the Resident Care Coordinator (RCC) stated that residents' continence should be assessed upon admission and when there was a change in condition and confirmed that resident #025's continence had not been assessed as required.

B) Resident #004's RAI MDS assessment completed in July, 2015, indicated that during the 14 day observation period the resident used a brief, was incontinent of urine all or most of the time and frequently incontinent of stool. The associated RAP sheet indicated that the resident's continence had deteriorated. PSW staff confirmed that the resident's continence had deteriorated over the past three months.

Review of the resident's health record indicated that there had been no continence assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions During interview the Resident Care Coordinator (RCC) stated that residents' continence should be assessed upon admission and when there was a change in condition and confirmed that resident #004's continence had not been assessed as required.

C) Resident #033's RAI MDS completed in July, 2015, indicated that the resident used a brief, was usually continent of bowels, and was incontinent of urine all or most of the time during the 14 day observation period. The associated RAP sheet indicated that the resident was toileted regularly, and could not tell staff when they needed to use the

bathroom. This was confirmed by PSW staff during interview.

Review of the resident's health record indicated there had been no continence assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions since the resident's admission in 2014. Registered staff confirmed that resident #033's continence had not been assessed.

D) Review of resident #041's health record indicated that the resident who was not mobile and required total care was incontinent of bowel and bladder. Interview with registered and non registered staff confirmed that the resident's condition had declined since admission. Registered staff confirmed that the resident did not receive a formal continence assessment upon the change in condition that included identification of causal factors, patterns, types of incontinence, and interventions.

An interview conducted with the Director of Care (DOC) on September 9, 2015 confirmed that the resident did not receive a formal continence assessment when a change in condition was identified and that a system for to formally assess all residents' continence was not currently implemented in the home. The DOC stated that this process was in development so that all residents' continence would be assessed in terms of causal factors, patterns, types of incontinence, and interventions.(619)

During interview, the DOC and RCC stated that the continence of residents who had been recently admitted had been assessed in terms of identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. They confirmed that residents who had been admitted prior to approximately two months prior to this inspection had not had their continence assessed as identified above. [s. 51. (2) (a)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).
(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).
(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are 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. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the matters referred to in subsection r. 53. (1) were integrated into the care that was provided to residents with responsive behaviours, specifically resident monitoring and internal reporting to meet the needs of residents with responsive behaviours; and referral of residents to specialized resources where required.

The home's "Responsive Behaviour Management policy - 4.11.10, last reviewed March 2015", directed staff when a resident exhibited behaviour that was a risk to themselves or other residents, to initiate behaviour documentation in the resident's record for a seven day period, and to make a referral to the home's Behavioural Support Resource Team.

Review of resident #031's health record and interviews with direct care staff indicated that the resident exhibited responsive behaviours that included physical aggression toward co-residents, and resistance to care. During interview, the Behavioral Supports Ontario (BSO) staff stated that they had been involved with resident #031's care when behaviours escalated. They stated not being involved with resident #031 during the previous two months to this inspection as there had been no responsive incidents until recently. Progress notes indicated that resident #031 was physically aggressive toward co-residents on four occasions over six weeks prior to and during this inspection.

i) Review of health records revealed that no monitoring of the resident had been completed after these incidents; the DOC and BSO staff person confirmed this and stated that the home's expectation was that staff were to use Dementia Observation Scale (DOS) charting to monitor residents for seven days following an escalation in behaviour.

ii) The DOC confirmed that the home's internal reporting system using the Risk Management System had not been initiated or completed by staff to record incidents of aggression involving resident #031 and co-residents as identified.

iii) The BSO staff confirmed that the Behavioural Support Resource Team had not received a referral following resident #031's aggressive behaviour toward co-residents that began July, 2015. The DOC stated that it was the home's expectation that registered staff complete the referral form when a resident had demonstrated aggressive behaviours toward co-residents.

The DOC confirmed that resident #031's monitoring, internal reporting, and referral to

specialized resources where required was not integrated into resident #031's care. [s. 53. (2) (a)]

2. The licensee failed to ensure that the responsive behaviour program was evaluated annually and updated in accordance with evidence-based practices or prevailing practices. Review of the home's responsive behaviour and programme evaluation documentation and interview with the DOC confirmed that the responsive behaviour programme had not been evaluated annually. [s. 53. (3) (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, for all programs and services, the matters referred to in subsection (1) are, (a) integrated into the care that is provided to all residents; and that at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition and hydration programs included, (e) a weight monitoring system to measure and record with respect to each resident, (ii) body mass index and height upon admission and annually thereafter.

Not all residents had their height measured at least annually.
Resident #003 - last recorded height on an identified date in April, 2013
Resident #012 - last recorded height on an identified date in November, 2012
Resident #013 - last recorded height on an identified date in September, 2013
Resident #020 - last recorded height on an identified date in September, 2011
Resident #032 - last recorded height on an identified date in April, 2013
Resident #034 - last recorded height on an identified date in November, 2010
Resident #036 - last recorded height on an identified date in July, 2011
Resident #038- last recorded height on an identified date in November, 2010

The Director of Care confirmed that not all residents had their height measured annually. [s. 68. (2) (e) (ii)]

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 nutrition and hydration programs includes, (e) a weight monitoring system to measure and record with respect to each resident, (ii) body mass index and height upon admission and annually thereafter, to be implemented voluntarily.

WN #10: 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. (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: 7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

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 failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council. The Nutrition Manager confirmed that meal and snack times were reviewed by the Food Council; however, were not reviewed by the Residents' Council. [s. 73. (1) 2.]

2. The licensee failed to ensure that sufficient time was provided for residents to eat at their own pace at the observed breakfast meal on September 11, 2015.

The posted start time for the breakfast meal was 0800 hours. The start of the breakfast meal was delayed and staff were still bringing residents to the dining room until 0825

hours when the service began. The last few residents to be served, including resident #030, did not receive their entree until 0920 hours and staff stated they were finished their meal by 0930 hours. Resident #030 was unable to communicate if they had finished their meal. All residents had been assisted out of the dining room by 0935 hours. Sufficient time for residents to eat at their own pace in a pleasurable manner was not provided at the observed meal for residents receiving their entrees towards the end of the meal service. During interview, staff confirmed that residents were often rushed at the breakfast meal and stated that at times residents were not always offered the full menu due to the rushed meal service. [s. 73. (1) 7.]

3. The licensee failed to ensure that proper techniques were used to assist residents with eating at the observed breakfast meal September 11, 2015.

One staff was assisting three to four residents at tables #2 and #5 in the East dining room. Staff at table #2 was observed standing (not at eye level) and moving between three residents assisting with feeding without being seated in-front of the residents. Proper techniques were not used to assist residents with eating and safe positioning. [s. 73. (1) 10.]

4. The licensee failed to ensure that staff members assisted only one or two residents at the same time who needed total assistance with eating or drinking at the observed breakfast meal September 11, 2015.

Four residents at table #5 required extensive to full staff assistance with eating and three residents at table #2 required extensive to full assistance with eating at the observed meal. Staff at table #2 were observed moving from resident to resident to provide assistance to all three residents at the table and staff at table #5 were also moving around the table assisting all of the four residents with eating. Residents who were not being assisted sat at the table without eating until the staff returned and assistance was provided. [s. 73. (2) (a)]

5. The licensee failed to ensure that residents requiring assistance with eating or drinking were served a meal only when someone was available to provide the assistance at the observed breakfast meal September 11, 2015.

Resident #019 was served a hot meal at 0835 hours and was not assisted with eating until 0850 hours. The resident's plan of care required extensive assistance with eating. Staff came to assist the resident at 0850 hours and then returned to a different table to

finish assisting there. The resident sat in-front of their meal and beverages until 0932 hours when the meal service was finished.

Four residents received food prior to full assistance being available to them. The food was placed on the table for all four residents at table #5 and three residents at table #2 with only one staff member available to provide the assistance to all residents. [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, (a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and (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, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home were labeled properly and kept inaccessible to residents at all times.

The door to the East wing tub/shower room was left unlocked and unattended by staff at 1100 hours on August 31, 2015 and 1430 hours on September 1, 2015. The sign on door directed staff to keep the door locked and closed at all times. Ten bottles of disinfectant cleaner (label stated poisonous and corrosive) and a spray bottle of Wipe-Away cleaner (label stated toxic substance) were accessible in an unlocked cupboard with the door to the cupboard in an open position. The Inspector was in the room over 10 minutes without staff attending the room. The inspector notified a staff member who confirmed that the door did not automatically close and lock and was left open and unattended with hazardous chemicals accessible to residents.

On September 02, 2015, at 1134 hours, the Housekeeping room 2104 door left open and unattended by staff. The cupboard in the room was unlocked and contained three bottles of Rescue sporicidal gel (avoid contact with eyes, skin and clothing); 1 bottle of Oxivir Five 16 Concentrate One step disinfectant cleaner and another large bottle of cleaner. The Director of Care confirmed the door was to be kept closed and locked at all times when not in use. The sign on the door also stated the door was to be locked and closed at all times. Hazardous chemicals were accessible to residents while the door was open and unattended. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #12: 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 failed to ensure that at least once in every calendar year, an evaluation is conducted to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

The LTC Inspector asked both the Administrator and the Director of Care (DOC) for the last annual evaluation of the abuse policy and program. The Administrator and the DOC both stated that the home was in the process of reviewing the current policy and completing an evaluation for 2015 however, they did not have any evidence to provide the inspector. The DOC also confirmed that there had not been any previous evaluations completed. [s. 99. (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 (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, to be implemented voluntarily.

WN #13: 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. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that (a) the documented record of complaints was reviewed and analyzed for trends at least quarterly; (b) the results of the review and analysis were taken into account in determining what improvements were required in the home; and (c) a written record was kept of each review and of the improvements made in response.

Review of the home's complaints management process included written documentation of the complaints made in the home. The DOC described the home's process in documenting and management of verbal and written complaints. The DOC confirmed that the home did not review or analyze documented complaints for trends to determine areas of improvement. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, (a) the documented record is reviewed and analyzed for trends at least quarterly; (b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and (c) a written record is kept of each review and of the improvements made in response, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's training and orientation programme was evaluated at least annually.

Review of the home's orientation and training records indicated that an annual evaluation of home's training and orientation programme had not been completed at least annually. The DOC confirmed this. [s. 216. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #15: 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 failed to ensure that staff implemented the home's infection prevention and control program.

A) On August 31, 2015 and September 3, 2015, Long Term Care Homes (LTC) Inspectors observed unlabeled personal care items in bathrooms used by more than one resident as follows:
i) Bathroom in room N2033 contained an unlabeled comb;
ii) Bathroom in room N2031 contained an unlabeled toothbrush;
iii) Bathroom in room N2043 contained an unlabeled catheter bag hanging from a grab bar; and
iv) Bathroom in room N2045 contained an unlabeled toothbrush and bed pan.

The Resident Care Coordinator (RCC) who was the Infection Prevention and Control lead in the home, toured the home with the LTC Inspector. They verified that staff had not implemented the home's Infection Prevention and Control Program since these items were not labeled or stored according to the home's expectations. [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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #030 received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

A) Resident #030 was dependent on staff for oral care and had a plan of care that required oral hygiene every morning, after meals, and in the evening. Staff confirmed they were not providing oral care four times daily and could not confirm that the resident was receiving oral care twice daily. Documentation on the Point of Care Flow sheets indicated the resident received oral care only once per day on nine days over a 30 day period in 2015. Staff were documenting "Not Applicable" or care was not documented on those occasions.

The home's policy, "4.7.1 Oral Care Program - revised March 2011", stated "To keep gums healthy, brush with a soft toothbrush or fingers wrapped in a washcloth to massage the upper and lower gum. The tongue requires brushing daily." The resident was not able to be interviewed by the inspector.

B) Staff were unable to confirm that oral hygiene was provided at least twice daily over a 30 day period in 2015. Point of Care documentation reflected oral care was completed only once daily during this time period.

The resident's plan of care did not provide direction to staff in relation to providing oral care for the resident. The resident required assistance with activities of daily living. [s. 34. (1) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #031 received fingernail care, including the cutting of fingernails.

The resident's fingernails were observed to be dirty and long on August 31, 2015 and September 3, 2015. Point of Care flow sheet documentation did not include cleaning of fingernails over a 30 day period prior to this inspection. Personal Support Workers interviewed stated nails were to be cleaned on shower days and documented on the Point of Care system. Documentation did not reflect that the resident refused nail care assistance on shower days and staff were unable to confirm the resident's nails were cleaned on their shower days. [s. 35. (2)]

WN #18: 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 failed to ensure that the resident who exhibited 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 is specifically designed for skin and wound assessment.

Review of resident #004's health record revealed that the resident had an alteration in skin integrity that required treatment. No clinically appropriate assessment instrument that was specifically designed for skin and wound assessment of the area could be located in the health record. In addition, weekly assessments of the area was not found. During interview, RPN staff stated that the area would deteriorate and improve. Review of the weekly wound assessment binder and interview with the DOC confirmed that the alteration in skin integrity had not been assessed weekly to monitor the healing progress. The DOC confirmed that no skin assessments, either initial or weekly, had been completed for resident #004's alteration in skin integrity. [s. 50. (2) (b) (i)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee consulted regularly with the Residents' Council at least every three months.

Documentation in the Resident Council Meeting Minutes did not reflect that the licensee had consulted with the Council at least every three months. The Administrator and President of the Residents' Council confirmed that the Council was not consulted at least every three months. [s. 67.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the menu cycle was reviewed by the Residents' Council. The Nutrition Manager confirmed the home's menu cycle was reviewed by the Food Council; however, was not reviewed by the Residents' Council. [s. 71. (1) (f)]

WN #21: 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. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that required information as indicated in section s. 79(3) was posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations.

During the initial tour of the home at approximately 1045 hours on August 31, 2015, the LTC Inspector could not locate the following required information posted in an easily accessible location in the home:

i) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3);
ii) 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);
iii) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3);
iv) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3);
v) copies of the inspection reports from the past two years for the long-term care home 2007, c. 8, s. 79 (3);
vi) 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); and
vii) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2).

During interview, the Director of Care (DOC), the Administrator and the Administrator's Assistant confirmed that the required information as listed was not posted in an easily accessible location in the home. [s. 79. (1)]

December 2, 2015- PHI removed for the purposes of publication

Issued on this 1st day of October, 2015

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

Original report signed by the inspector.