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
Inspection de soins de longue durée

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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
Jun 8, 2016	2016_325568_0010	007526-16	Resident Quality Inspection

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE ARTHUR NURSING HOME
215 ELIZA STREET P.O. BOX 700 ARTHUR ON N0G 1A0

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

DOROTHY GINTHER (568), AMIE GIBBS-WARD (630), CHARLES SMITH (635), MARIAN MACDONALD (137), NUZHAT UDDIN (532), SHARON PERRY (155), SHERRI GROULX (519)

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): March 16, 2016; April 20, 21, 22, 25, 26, 27, 28, 29, 2016; and May 1, 2, 3, 4, 5, 2016

The following inspections were conducted concurrently during this inspection:
Critical Incidents log # 006163-16 related to improper transfers; 004385-16, 000364-16, 033676-15, 024805-15, 006766-15, 008665-16, 002839-15 all related to alleged abuse
Complaints log # 026831-15 related to staff qualifications; 027983-15 related to continence product supply, 034791-15 and 035999-15 both related to availability of supplies, 001198-16 related to cleanliness of the home, alleged neglect, and medication administration; 002415-16 relating to sufficient staffing, and 007704-16 related to Administrator coverage.
Follow-up to CO #001 log # 026489-15 related to the evaluation of bed systems and entrapment; CO #001 log #019233-15 related to plan of care - clear direction; and CO #004 log #019233-15 related to skin and wound assessments.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, Administrator, Director of Nursing Care, Assistant Director of Nursing Care, Physiotherapist, Physiotherapy Assistant, RAI Coordinator, Ward Clerk, Clerical Assistant, Registered Dietitian, Corporate Dietitian, Food Nutritional Manager, Recreation Manager, Clerical Assistant, Retirement Home Manager, Cook, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Activity Aide, Housekeepers, students, Dietary Aide, Maintenance staff, Family Council representative, Resident`s Council representative, residents and their families.

The inspector(s) also toured the home; observed meal service, medication administration, medication storage areas; reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, posting of required information, investigation notes, purchase orders; observed the provision of resident care, resident -staff interaction, and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **16 WN(s)**
- **10 VPC(s)**
- **4 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. 15. (1)	CO #001	2015_303563_0034	568
O.Reg 79/10 s. 50. (2)	CO #004	2015_171155_0015	137

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Record review of an identified resident's care plan indicated that they were incontinent. The resident was to be toileted before meals or after meals, before bed and when necessary (PRN). The resident's Kardex indicated that the resident was to be toileted every two hours.

During an interview with care staff they revealed that the identified resident was to be toileted every two hours.

Interview with the Director of Nursing Care # 116 and Assistant Director of Nursing Care # 102 revealed that the resident was to be toileted every two hours. The Assistant

Director of Nursing Care # 102 confirmed that the care plan did not provide clear direction to staff who provide direct care to the identified resident. [s. 6. (1) (c)]

2. The licensee shall ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of the resident.

During an interview with an identified resident's substitute decision maker (SDM) they shared that when the resident was admitted to the home they were advised that one of their beverage preferences was not provided by the home. If they wished the resident to have their specified choice they would have to purchase it.

Record review revealed a Food Preference Checklist for the identified resident completed on admission. The checklist identified the specified beverage of choice for the resident.

The Food and Nutrition Manager (FNM) #110 confirmed that the home was not providing the identified resident's choice of beverage and that family were providing it for them. The FNM indicated that this would be changing as their head office had decided to start providing the specified beverage effective immediately. [s. 6. (2)]

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

a) During stage one of the Resident Quality Inspection a resident revealed that they required assistance from staff to clean their teeth, but indicated that they only got them cleaned sometimes.

Review of the identified resident's plan of care revealed that the resident's teeth were to be cleaned after meals. The Kardex indicated that staff were to brush the identified resident's teeth after meals.

On a specified date during the inspection at 1120 hours the identified resident was found sitting in their room. The resident denied that they had had their teeth brushed that day.

On a second day during the inspection at 1056 hours, the resident revealed that they had not had their teeth brushed yet that day. Their toothbrush was observed to be dry. At 1305 hours the resident advised the inspector that they had their teeth brushed before lunch. The resident revealed that they never get their teeth brushed after meals.

During an interview with PSW # 131 they revealed that the resident did not brush their teeth but required staff to brush them. On day shift PSW #131 revealed that they brush the resident's teeth in the morning. On evenings, PSW #129 revealed that they brush the resident's teeth at bedtime. PSW #131 and #129 confirmed that most days they did not brush the resident's teeth after meals.

b) The identified resident's plan of care stated that the resident was to be toileted every two hours. Interviews with Personal Support Worker # 131, Assistant Director of Nursing Care #102 and Director of Nursing Care #116 confirmed that the resident was to be toileted every two hours.

Observations during two days of the inspection revealed that the identified resident was not toileted every two hours. PSW #131 confirmed that the resident had not been toileted every two hours during day shift.

c) Clinical record review, for the identified resident, indicated they were on a Q2H (every two hours) toileting plan. There was no documented evidence that the Q2H toileting plan was added to the Point of Care (POC) task list.

During an interview,with Registered Practical Nurse (RPN) # 109, it was confirmed that the Q2H toilet plan was not included in the POC task list and the home's expectation was that it be added to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Observations, during three days of the Resident Quality Inspection (RQI), revealed the resident was not toileted every two hours.

During an interview, with Personal Support Worker (PSW) # 138, it was revealed that the resident was not toileted every two hours. The PSW shared that the resident was toileted/changed upon rising and before lunch, if they were not too busy or not working short.

During a family interview, it was revealed that the resident was not toileted or changed every two hours and was often incontinent, upon arrival for a visit. (137)

The licensee failed to provide the identified residents with the care as specified in the plan of care. [s. 6. (7)]

4. 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 change or care set out in the plan was no longer necessary.

a) Review of the identified resident's plan of care revealed that the resident required two person extensive assistance with transfers. The resident used a wheelchair to move throughout the facility or the resident was to be supervised while walking.

On two consecutive days during the inspection the identified resident was observed independently transferring from sit to stand and walking in the halls with no supervision.

During interviews with Personal Support Worker #125 and #133 they indicated that the resident had become more independent of late. PSW #125 indicated that physiotherapy had reassessed the resident and they no longer needed the wheelchair. Staff were advised to provide oversight to ensure resident safety. PSW #133 indicated that the resident was independent with transfers, but needed one staff assist with toileting.

During an interview with the Director of Nursing Care (DONC) #116 they acknowledged that the resident had become more independent with their transfers and mobility over the last several weeks. The DONC #116 confirmed that the plan of care had not been revised to reflect the change in resident care needs.

b) During observations on two days during the inspection the identified resident's bed was observed with bed rails raised.

Clinical record review revealed that the resident's bed rails were used for bed mobility and positioning. The bed rails were identified as PASD's.

During interviews with Personal Support Worker #114 and Registered Practical Nurse #115 they indicated that the resident required total assistance for most of their care. The staff reported that the resident was not able to reposition themselves in bed and even with cueing would not hold the bed rails to assist with care.

The DONC #116 acknowledged that the resident was not using the bed rails for repositioning and confirmed that the plan of care had not been reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

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 to ensure that care set out in the plan of care was based on an assessment of the resident and the needs and preferences of the resident; that the care set out in the plan of care was provided to the resident as specified in the plan; and 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 change or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

A review of staff schedules and payroll records identified that the home worked short personal care staff, between February 29 – March 12, 2016, for 16.56 shifts; March 13 – March 26, 2016, for 29.7 shifts; March 27 – April 9, 2016, for 25.7 shifts and April 10 – April 23, 2016, for 12.7 shifts.

The 2016 Residents' and Family Council meeting minutes identified staff shortages and call bells not being responded to which resulted in residents not being toileted and increased episodes of incontinence.

A review of the bathing report, on Point Click Care (PCC), revealed on March 4, 5 and 8, 2016, due to staff shortages, 13 residents received a bed bath rather that their preferred shower or tub bath. Of those residents, 11/13 (84.6 per cent) did not have his/her hair washed and 4/13 (30.8 per cent) did not receive nail care. On March 14, 16, 19, 20, 21, 22, 23, 24 and 25, 2016, due to staff shortages, 28 residents received a bed bath rather than their preferred shower or tub bath.
Of those residents, 18/28 (64.3 per cent) did not have his/her hair washed and 10/28 (35.7 per cent) did not receive nail care.

During a review of the bathing report, the Director of Nursing Care # 116 confirmed, that due to staff shortages, residents received a bed bath rather than their preferred shower or tub bath. Some residents did not have their hair washed and/or nail care was not provided, on the identified days during the month of March 2016.

During interviews with three identified residents, they shared that the home was frequently short staffed and due to having to wait a long time to go to the washroom they ended up having accidents. The residents also shared that they had received either a bed bath or no bath at all rather than their preferred shower or tub bath, due to staff shortages.

Negative outcomes identified by residents and family included missed tub baths/showers, hair not being washed, oral and nail care not provided, and residents not being toileted and changed. The licensee failed to ensure that the staffing plan provided a staffing mix that was consistent with resident's assessed care and safety needs. [s. 31. (3) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented.

The Minimum Data Set (MDS) assessment for an identified resident indicated that they were frequently incontinent of bladder, meaning the resident tended to be incontinent daily, but some control was present. The Caressant Care Assessment of Resident Continence Status 1 indicated that the resident had a gradual onset of incontinence with accidents occurring several times a week. The assessment did not identify any treatment approaches to promote and manage the resident's bladder incontinence.

The care plan for the identified resident indicated that they were sometimes incontinent of urine. The resident would ask for and receive the necessary assistance with toileting.

Staff interview with Personal Support Worker #119 revealed that the resident required two person assist for toileting. The staff member shared that the resident was toileted at their request. Most times when the resident asked for assistance their product was already wet. PSW #119 shared that there had been a gradual decline in the resident's continence.

During an interview with the Assistant Director of Nursing (ADON) #102 they acknowledged that the resident's continence had declined during the last six months. The ADON #102 indicated that when there was a change in continence the RAI Coordinator would normally initiate a three day voiding diary and based on the results an individualized plan of care to promote bladder continence would be developed and implemented. The ADON #102 confirmed that the resident did not have a voiding diary completed and that an individualized plan of care had not been developed for the identified resident to promote continence. [s. 51. (2) (b)]

2. The licensee has failed to ensure that there was a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

During interviews with four Personal Support Workers #119, #153, #120 and #156 they shared that each wing of the home had a continence product cart. The cart was stocked on each wing from bins that had been filled by students on the previous afternoon. Staff indicated that the bins contained one product change for each resident with the exception of a few residents that were given an extra change on each shift. Each cart had a Resident Profile Worksheet which identified the type of product a resident was to be given on each shift. The worksheet also identified the number of each product on the cart for each resident. Staff reported that if they required additional continence products

for a resident the home's process required them to access a registered staff who had a key to the medication room where they kept an emergency supply. The registered staff recorded the resident name and type of product as part of the process. If the emergency supply had been depleted then they must get a second key from the Registered Nurse for the continence supply cupboard.

Personal Support Worker #120 and #156 shared that they often run out of continence product on their cart. Depending on the time of day the registered staff can be busy with medication or treatments and they wait between 5-15 minutes. Personal Support Worker #119 shared that there have been situations where a resident is already in a lift when they find out they have had a bowel movement and there was no extra product for a second change. They then have to lower the resident, one staff stay with the resident and the other go to find a registered staff to obtain another product from the medication room. During this period the resident is left to wait in a wet or soiled product and the staff cannot respond to other resident concerns. Personal Support Worker #120 and #153 reported that because of the sometimes lengthy process to get a second product, they have given residents a different product that is available on the cart. Personal Support Worker #120 and #153 indicated that when the Ministry of Health visits the home they seem to always have additional continence products on their cart, however, when they leave the amount of product returns to the usual levels.

Record review revealed that the Resident Profile Worksheets dated April 26, 2016 for Cedar, Ash and Balsam wings identified that in total there were 62 incontinent residents. The worksheet for each wing of the home identified the resident, the number and the type of continence product to be used for the resident one each shift. Of the 62 incontinent residents there were just eight residents that were were identified as having more than one continence product change on each shift provided on the cart.

During interviews with two Registered Practical Nurses, #115 and #123 they shared that extra supply of continence products were kept in the medication room and the continence supply cupboard. If the med room supply was depleted they would need to get the key from the Registered Nurse to access continence products in the supply room. They were required to complete the Tena Emergency Sign Out Form with the resident name, product type and date of request. RPN #115 reported that they get frequent requests for continence products, particularly on the evening shift. The greater number of requests come from Balsam wing. RPN #123 indicated that requests vary from day to day. Some shifts they have quite a few and on others they have none. Both RPN's reported that the time to get an extra product varies depending on their availability. If they are not in the

middle of a medication pass or treatment then they can access the product quickly but otherwise there may be a five to ten minute wait. RPN #115 reported that there have been situations when they run low on certain products toward the end of the week. RPN #123 indicated that it was rare that they would run out of product but there have been a few occasions when they have had to go outside to purchase certain products.

Review of the purchase orders for continence products during the period of January 1, 2016 and April 30, 2016 compared with the assigned product usage identified on the Resident Profile Worksheets for the same period revealed the following:

- 1884 day light liners were purchased and 3120 day light liners would have been used
- 9752 day regular liners were purchased and 10,800 would have been used
- 2480 day plus liners ordered and 2400 used
- 2064 night super liners ordered and 2040 used
- 480 extra large briefs orders and 480 used
- 1280 large briefs ordered and 1320 used
- 320 medium briefs ordered and 240 used

The usage numbers did not include any extra product used for residents in the home during the period of January 1, 2016 and April 30, 2016.

Interview with an identified resident revealed that staff assist them with toileting. The resident reported that they wear a continence product because sometimes they have accidents. Depending on the day, when they need another product staff have sometimes substituted it with a different product that was not as comfortable. Staff are very good but there are occasions when they have had to wait if they don't have the available continence product.

Interview with a resident's substitute decision maker (SDM) revealed that for some time they have been purchasing continence products. The SDM was concerned that the resident would not get sufficient changes to remain dry and since that time had been supplying the home with continence products to allow for more frequent changes.

During an interview with the Director of Nursing Care (DONC) #116 and the Assistant Director of Nursing Care (ADONC) #102 they indicated that product orders were based on the Resident Profile Worksheets taking into consideration any product that was available from the previous month. The DONC #116 reported that to her knowledge over the last five months they had not run out of product. They were surprised to learn, based

on this inspectors review, that the product ordered was not sufficient in some lines for the expected usage identified by the Tena Profile Worksheet. The DONC #116 identified that there were a couple of situations where they ran low and they went out and purchased extra product. The DONC #116 and ADONC#102 indicated that they have had problems with staff using different products than what was assigned on the Tena Profile Worksheets. They seem to have a surplus of the day light liners which they believed was related to staff replacing this product with a different one. When asked if they had a process for staff to request a different product, the DONC#116 indicated that they do not currently have a formalized process for this. Staff tend to just pop in and let her know verbally or leave a note on her desk. The DONC #116 and ADONC #102 were asked if they tracked the requests for extra product in terms of numbers and trends and they indicated that to date this had not been done.

The licensee failed to ensure that there was a range of continence products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes. [s. 51. (2) (f)]

3. The licensee has failed to ensure that the resident who requires continence care products have sufficient changes to remain clean, dry and comfortable.

During an interview with an identified resident's substitute decision maker (SDM) they shared that care staff had advised them that they only had one product change per shift for the resident. The SDM reported that they had come in to visit the resident recently and found them soaked in urine sitting on their chair. Not only was the product soaked but their clothing as well as the chair. The SDM expressed being upset at finding the resident in this situation.

Interview with another resident's SDM revealed that they visit the resident on a regular basis. On several occasions of late the SDM reported that they found the resident soaked right through their product and into their clothes. The chair and pad that they were sitting on was also wet. The SDM indicated that given the degree of wetness they feel that the resident had not been changed or toileted in some time. The situation was very upsetting for both her and the resident.

A third resident's SDM shared with the inspectors that they have come into the home and found their loved one soaked through with urine. The SDM indicated that the staff are sometimes not persistent enough or do not have the time to re-approach to change the resident when they are resistive to care. The SDM recognized that many times they are

working short staffed.

During an interview with Personal Support Worker #120 and #153 they reported that if they are unable to change a resident more than once then there can be problems with some of the residents in terms of leakage onto their clothing or the linens. Depending on the type of product they are using and if they are short staffed it can be difficult to keep the resident dry. The majority of residents were provided with one continence product change per shift and if they require more then staff have to go to the registered staff who then have to go to the med room or supply room to retrieve the extra product. This process takes away valuable time from resident care.

The licensee has failed to ensure that the resident who requires continence care products have sufficient changes to remain clean, dry and comfortable. [s. 51. (2) (g)]

4. The licensee has failed to ensure that residents are provided with a range of continence care products based on their individual assessed needs.

a) During observations on a specified date at 1100 hours it was noted that an identified resident's pants were wet from their bottom to half way down their thigh. Staff were alerted and the resident was changed. Personal Support Worker #128 acknowledged that the resident had been incontinent. The staff member shared that when they went to change the resident they were not wearing a continence product.

On a second day at approximately 0850 hours the identified resident approached inspector #137 and asked if they could help them. The resident pointed to their wet pants extending from the groin area to just above the knees. The resident was able to identify their room and the Assistant Director of Nursing #102 was notified that the resident needed to be changed.

During interviews with Personal Support Workers #131 and #156 they indicated that the identified resident was not in the right product. The resident often removed their product without staff knowledge. Both staff shared that they felt the resident would be better in a different product.

Record review indicated that in 2015 a trial of this different product was initiated for the identified resident at the direction of the Director of Nursing Care. There was no documentation as to the resident's response to the use of this continence product. In January 2016 progress notes identified that the resident was removing their continence

product. Staff were instructed to use a different product. In May 2016 staff were instructed by the Assistant Director of Nursing to put the resident in a different product following an episode of incontinence. Review of the Resident Profile Worksheets for continence products for the period of January through April 2016 indicated that the identified resident was to wear their usual product.

b) The Resident profile Worksheet dated April 26, 2016 identified that the resident wore their own product as per their choice.

During an interview with the resident's substitute decision maker (SDM) they indicated that when their family member was admitted to the home more than one year ago they were wearing a continence product. The home advised the SDM that they would not be able to supply this type of continence product. Since that time the SDM reported they have been supplying continence products to the home.

c) The Resident profile Worksheet identified that the resident used their own product according to their choice.

During an interview with the resident's SDM they expressed concern about their family member being left in wet products. The SDM shared that they attended the home not long ago and found the resident sitting in their chair soaked in urine. The chair pad and chair were also soaked. The SDM indicated that some time ago they were advised by care staff that they only had one continence product change for each resident per shift. The SDM was concerned that their family member might be left in a wet product so they started buying continence products and leaving them for staff.

d) The Resident Profile Worksheet identified that the resident used their own product as per their choice.

The identified resident's SDM reported that they had been providing continence products for their family member since they were admitted to the home. The SDM indicated that on admission to the home they were advised that their continence products included a variety of liners as well as a product with tabs that opened like a diaper. They were told by the home that they did not provide the type of continence product the resident was currently using and if they wished to continue using this product they would have to supply it.

e) The Resident Profile Worksheet identified that two residents used their own

continence product as per their choice.

There was no documented individualized assessment related to the choice of continence product or the resident's response to the use of the product for the two residents.

Review of the home's admission package revealed that there was no information pertaining to the type and range of continence products offered to residents in the home.

The Director of Nursing Care #116 confirmed that they had not completed a formal continence product assessment for the identified residents and that resident's had not been offered a range of products based on their assessed care needs. Record review revealed that on April 26, 2016 there were 62 out of 81 residents that were incontinent. The Resident Profile Worksheet indicated that seven of those residents that were identified as being incontinent were using their own products. [s. 51. (2) (h) (i)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are offered a minimum of a snack in the afternoon and evening.

During stage 1 of the Resident Quality Inspection an identified resident reported that snacks were not always available in the afternoon and evening. Another residentshared that they were not offered a snack in the evening. Interview with a third resident revealed that often they were not offered a snack in the afternoon and evening when they brought around beverages.

During interviews with two Personal Support Workers #148 and #153 they shared that up until a couple of weeks ago they often did not have a snack on the afternoon and evening cart to offer to residents. The staff indicated that residents had asked for a snack but all they had to offer were beverages. The last two weeks they have seen a change and there had been snacks provided on the cart.

During an interview with the Food and Nutrition Manager they acknowledged and confirmed that until recently residents were not always being offered a snack in the afternoon and evening. [s. 71. (3) (c)]

2. The licensee has failed to ensure that planned menu items were offered and available at each meal and snack.

Record review revealed that during the week beginning Monday May 2, 2016 the home was on week one of the menu cycle. The snack menu for week one indicated that on Tuesday May 3, 2016 the afternoon snack would be bran crunch cookies or assorted cookies. On Wednesday May 4, 2016 the snack was to be mini donuts and assorted cookies. The therapeutic option for both days was identified as pureed cookies and mini donuts respectively.

During observations on Tuesday May 3, 2016 the snack being offered to residents in the afternoon on Ash, Balsam and Cedar wing was a choice of either a banana, orange or pear. There were no bran crunch or assorted cookies on the snack carts. On Wednesday May 4, 2016 the residents were being offered mini donuts as their afternoon snack. On both afternoons there were also pre-packaged and labelled snacks for specific residents, as well as a pudding and yogurt.

During interviews with three Personal Support Workers #142, #148, and #153 they indicated that residents on a therapeutic diet including pureed texture were usually offered either a pudding or yogurt for their snack if they didn't already have a pre-packaged snack. The staff shared that the snack carts were not stocked with different

textures of the planned menu snack item. Personal Support Worker #148 confirmed that there was no pureed mini donut on the May 4, 2016 afternoon snack cart.

The Food and Nutrition Manager confirmed that it was the home's expectation that planned snack menu items would be offered to residents in the different diet textures. The licensee failed to ensure that planned menu items were offered and available at each snack. [s. 71. (4)]

3. The licensee failed to ensure that an individualized menu was developed for the resident if their needs could not be met through the home's menu cycle.

Interview with an identified resident during the lunch meal service indicated they had concerns that they were unable to eat any of the food items offered on the menu for that meal. They indicated that they had special diet needs related to their diagnoses and also had multiple food dislikes and intolerances.

During a follow-up interview with the resident they shared that about a week ago they were advised by the Food and Nutritional Manager that they were being changed to a regular diet. The resident reported that they had a hard time picking food items from the menu as there were many items they disliked and could not eat. The resident expressed that on a regular basis they were not able to eat both main entrée choices on the menu.

Review of the home's policy titled "Therapeutic Menus" last reviewed date March, 2015, identified "consulting on-site Dietitian is responsible to prepare individualized spread sheets from existing therapeutic templates for resident with specialized diet needs".

During an interview with the Food Nutritional Manager (FNM) #110 they identified that the home did not have any residents on individualized menus and special interventions were listed on the "Dietary Database" for staff reference during meals and snacks. They confirmed that an individualized menu had not been tried for the resident and that it was difficult to meet the residents needs for a specialized diet and multiple food dislikes with the regular diet. The FNM confirmed that it was the expectation in the home that an individualized menu would be provided to residents whose needs could not be met through the regular menu.

The Corporate RD #111 confirmed via email that it was the expectation in the home that residents with specialized diet requirements that could not be met by the regular menu would be on an individualized menu developed by the RD in the home. [s. 71. (5)]

Additional Required Actions:

CO # - 004 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 to ensure that residents are offered a minimum of a snack in the afternoon and evening; and that an individualized menu is developed for residents if their needs are not met through the home's menu cycle, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident bedroom occupied by more than one resident had sufficient privacy curtains to provide privacy.
Observations during the Resident Quality Inspection revealed the following:
a) Privacy curtains for an identified resident, who resided in a semi-private room, were not sufficient to provide privacy because when they were pulled closed the privacy curtain was short leaving an approximate three foot gap with no curtain.

b) Privacy curtains for an identified resident were not sufficient to provide privacy because when they were pulled the privacy curtain became stuck on the tracking, leaving an approximate three to four foot gap with no curtain. The resident resided in a four bed room.

c) Privacy curtains for an resident were not sufficient to provide privacy as when the split privacy curtain was pulled around the bed it separated leaving an approximate ten inch gap between the curtains at the foot of the bed.

d) Privacy curtains for an identified resident, residing in a four bed room, were not sufficient to provide privacy as when they were pulled the privacy curtain became stuck on the tracking, leaving an approximate eight foot gap between the curtains.

The Director of Nursing Care #116 was shown privacy curtains for four identified residents and confirmed that they did not provide sufficient privacy. [s. 13.]

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 every resident bedroom occupied by more than one resident had sufficient privacy curtains to provide privacy, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home

Record review of a Critical Incident report submitted by the home revealed that they initiated and conducted an investigation pertaining to an incident of alleged abuse. The alleged incidents all took place during a dining service and involved one staff member.

The first incident identified that Personal Support Worker (PSW) #138 was observed to throw down a utensil and respond to an identified resident in a rude manner when they made a request related to their meal.

During the same period of time, two other identified residents each made requests of PSW #138. PSW #138 responded rudely to both residents indicating that they could not help them with their requests.

Later in the dining service an identified resident asked another staff member to go to the toilet. This staff member responded by saying that the resident would have to wait or could go in their product. PSW #138 indicated that they had toileted the resident prior to lunch by getting them to go in their product.

An identified resident reported that at the completion of the dining service they had asked PSW #138 to assist them to their room because they were experiencing some pain. The resident stated that PSW #138 responded by saying "No, you're quite capable".

Residents involved were interviewed, details of the incident were documented by staff and police were notified. Interviews with three of the residents involved revealed that the accused employee was generally always rude to residents and it was upsetting.

The licensee failed to ensure that residents four residents were protected from abuse by anyone. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to minimize the restraining of residents was complied with.

Review of Caressant Care Nursing and Retirement Homes Ltd., policy and procedure titled Safety Plan-Resident, dated May 2015, under part B- use of restraints, stated that a task would be added to Point of Care (POC) for every one hour (q1h) charting by staff and the every two hour (q2H) change of position for each restraint used.

Review of an identified resident's Point of Care documentation that asks if the physical device was applied properly and reposition resident, was reviewed for the period of April 1 to April 28, 2016 with the Director of Nursing Care (DONC) #116 and the Assistant Director of Nursing Care (ADONC) #102. The DONC # 116 and the ADONC #102 agreed that the documentation was done prior to the care being provided. They expressed that the documentation for the physical device was to be done when the care was provided and not before.

The licensee failed to ensue that the home's policy Safety Plan - Resident was complied with. [s. 29. (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 the home's written policy to minimize the restraining of residents is complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

During the Resident Quality Inspection an identified resident was observed on two occasions with two physical devices applied

Record review indicated that the resident utilized bed rails as a Personal Assistance Services Device (PASD). The bed rails were used for bed mobility and positioning. The plan of care indicated that the resident used a secondary device for fall prevention when in their wheelchair.

During an interview with Personal Support Worker #114 they shared that the resident had bed rails raised when in bed. The PSW indicated that the tilt wheelchair was used for offloading when the resident was sitting up but they were unsure of the purpose of the secondary device.

The DONC confirmed that there was no documentation as to the assessment of the secondary device as a PASD or if alternatives had been considered prior to its application. [s. 33. (4) 1.]

2. The licensee has failed to ensure that the use of a PASD had been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

During the Resident Quality Inspection the identified resident was observed on two occasions with two physical devices applied.

During an interview with the Director of Nursing Care (DONC) #116 they indicated that the resident had two devices applied to enhance positioning and they were both considered PASDs. The DONC #116 indicated that they do not use written consents for PASD's. Instead, they will discuss the implementation of the device with the SDM and obtain verbal consent, which is then documented in the Point Click Care progress notes. The DONC #116 confirmed that there was no documentation that consent had been obtained for the resident's secondary device.[s. 33. (4) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living., to be implemented voluntarily.

WN #9: 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, the following element:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

During the Resident Quality Inspection, Personal Support Worker #132 was observed standing and assisting an identified resident to drink their beverage. The resident was seated in their wheelchair and PSW #132 was standing next to the resident holding the glass to resident #041's mouth and encouraging them to drink.

The same day, PSW #132 was observed standing giving a resident their fluids. The resident was sitting in their wheelchair near the home's front entrance at the side of the nursing station. Registered Practical Nurse #123 had a brief conversation with PSW #132 while they were standing giving the resident their beverage. RPN #123 went back to the nursing station. Registered Nurse #136 at the desk saw PSW #132 standing and advised RPN #123 to give PSW #132 a chair and to sit down. PSW #132 then sat down and resumed giving the resident their beverage.

During an interview with Registered Nurse #136 they confirmed that they had observed PSW #132 standing to give a resident their fluids and had instructed PSW #132 to sit down. RN #136 confirmed that the identified resident was a choking risk. Registered Nurse #136 confirmed that PSW #132 should have been sitting to assist two residents with their beverages. [s. 73. (1) 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 to ensure that the home has a dining and snack service that included, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance., to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the required information was 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.
(k) copies of the inspection reports from the past two years for the long-term care home.

On March 16, 2016 and April 20, 2016, during tours of the home it was noted that there were some inspection reports missing.

On May 5, 2016, a review of the posted inspection reports in the black binder on the wall by the Director of Nursing office was reviewed. The following reports were noted to be missing from the binder:
a) RQI inspection report 2014_226192_0038 with inspection start date of November 13, 2014.
b) Critical Incident System inspection report 2014_258519_0030 with inspection start date of September 12, 2014.
c) Complaint inspection report 2014_258519_0029 with inspection start date of September 11, 2014.
d) Complaint inspection report 2014_271532_0027 with inspection start date of August 7, 2014.
e) Critical Incident System inspection 2014_271532_0028 with inspection start date of August 7, 2014.
f) Complaint inspection 2014_258519_0016 with inspection start date of June 24, 2014.
g) Complaint inspection 2014_271532_0020 with inspection start date of June 10, 2014.

The Long Term Care Home (LTCH) Licensee Confirmation Checklist-Admission Process that was signed on March 16, 2016 by the Administrator covering in the home #100 and signed on May 5, 2016 by the Administrator #104 indicated that copies of the inspection reports and orders by an inspector or the Director that are in effect or that have been made in the past two years were posted.

On May 5, 2016, the Administrator #104 stated that they had not had a chance to review the posted items and stated that they were not sure where the reports were. [s. 79. (3) (k)]

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 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. This would include copies of the inspection reports from the past two years for the long term care home, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Family interviews during stage one of the Resident Quality Inspection (RQI) revealed to Inspector # 155 that, there was often a strong odour of urine in the hallways, and to Inspector # 630 that, every time they walk in the halls the smell is terrible. One family indicated that they had been in other Long Term Care Homes and there wasn't such a bad smell.

Observations made on April 26, 27, 28, 2016 in the three home areas revealed that there were often lingering odours in the hallway of one of the resident home areas.

Observations on April 26, 2016 at 1030 hours revealed there were lingering odours on one resident home area and the peri cloth bin bag (mesh) was full. This peri cloth bag remained in the hallway, full, until later in the afternoon at 1530 hours.

During an interview with Housekeeper #121 they stated that the Personal Support Workers (PSWs) were responsible for emptying the peri cloth bags and garbage bags once a shift. They also stated that the floors were mopped once every day. If a resident urinates on the floor the PSWs clean the urine and then housekeeping will come and spot clean the area with disinfectant.

During observations made on April 27, 2016 at 1000 hours, on one resident home area, it was noted that there was no peri cloth bag present, however ,there was still an odour of feces throughout the hallway.

During an interview with Housekeeper # 124 they reported being aware of the resident on this home area that would often urinate on the floor. They used to put an air freshener near this resident's bed side but had to take it down due to Corporate "No Scent" policy.

Observations made on April 28, 2016, at 0950 hours, on one resident home area revealed lingering odours of feces throughout the hallway. The peri cloth bin was noted to be an orange cloth bag that day (not mesh), and was noted to be half full. It was positioned in the home area hallway along with the garbage bin.

The home's policy titled, "Odour Control", revised April 2016, stated under #8: "Ensure lids are placed on laundry hampers and soiled garbage bins and store them in the soiled utility room".

The Director of Nursing Care (DONC) #116 confirmed that there were lingering odours on one home area and that laundry hampers and garbage bins were not being stored as per the home's policy. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the organized program of housekeeping under clause 15(1)(a) of the Act, that procedures were developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff release the resident from the physical device and reposition at least once every two hours.

During the Resident Quality Inspection an identified resident was observed with a physical device applied. Interview with Personal Support Worker # 131 revealed that the resident had the device applied when up in their wheelchair.. PSW #131 shared that

they check the resident hourly while the device is applied and they release the device and reposition the resident every two hours and at any other time as needed.

The identified resident was observed over a two and a half hour period on April 27, 2016 and the resident's device was not released nor was the resident repositioned during this time period.

The resident was observed on May 2, 2016 with a physical device applied while sitting in their wheelchair. During a two hour and thirty five minute period the resident was not observed to have their device removed nor were they repositioned. PSW #131 acknowledged that the resident had not had their physical device released nor had they been repositioned during the more than two hour period.

Record review revealed that the identified resident was to have a physical device applied when up in wheel chair. The plan of care stated apply device and remove or readjust every one hour. Complete documentation as per home policy and procedure.

Review of Caressant Care Nursing and Retirement Homes Ltd. policy and procedure titled "Safety Plan-Resident", dated May 2015, stated that at least once every two hours, staff were required to release/reapply the restraint and reposition the resident. A task would be added to Point of Care for every one hour (q1h) charting by staff and the every two hour (q2h) change of position for each restraint used.

Interview with the Director of Nursing Care # 116 and the Assistant Director of Nursing Care #102 revealed that the documentation did not identify when the resident was repositioned or when the restraint was removed. They expressed that the documentation for the device needed to be done at the time of release and repositioning.

The licensee failed to ensure that staff released the identified resident from the physical device and repositioned the resident at least once every two hours. [s. 110. (2) 4.]

2. The licensee has failed to ensure that the documentation included the person who applied the device and the time of the application.

During the Resident Quality Inspection, the identified resident was observed with a physical device applied when sitting in their wheelchair. During an interview with Personal Support Worker # 131 they acknowledged that the resident was to have a physical device applied when up in their wheelchair. PSW #131 shared that they check

the resident hourly when the device is applied and it is released and the resident is repositioned every two hours and any other time as needed.

Record review revealed that the identified resident had a physical device applied when up in their wheel chair. The plan of care stated apply physical device and remove or readjust every one hour. Complete documentation as per home policy and procedure.

Review of Caressant Care Nursing and Retirement Homes Ltd. policy and procedure titled "Safety Plan-Resident", dated May 2015, stated that at least once every two hours, staff were required to release/reapply the restraint and reposition the resident. A task would be added to Point of Care for every one hour (q1h) charting by staff and the every two hour (q2h) change of position for each restraint used.

Review of the documentation revealed that there was no documentation that included the time as to when the physical device was applied.

The Director of Nursing Care # 116 and the Assistant Director of Nursing Care #102 revealed that the documentation did not include the time of the application of the device. They expressed that the documentation for the physical device needed to be done at the time of the application of the device.

The licensee failed to ensure that the documentation included the person who applied the device and the time of the application. [s. 110. (7) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff release the resident from the physical device and reposition at least once every two hours, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Record review of a Critical Incident report submitted by the home revealed that an investigation of the incident was initiated by the Home's Administrator. The Home's Regional Manager was notified and a report made to the police. An entry on the Critical Incident report indicated that the investigation was continuing.

There was no documentation on the Critical Incident (CI) report and/or subsequent amendments to the CI report indicating that an investigation was completed. In addition, there was no documentation on the CI report and/or subsequent amendments to the CI as to the outcome and/or conclusions drawn from the investigation, and communication of the outcome to the Director.

The Home's Policy and Procedures, for Communication of Adverse Events, dated February, 2015 outlined the following under Procedures:
4. The Administrator and/or Director of Nursing will facilitate further discussion and disclosure of all details concluded as a result of the investigation process.
7. The Adverse Event will be documented through the facility reporting process and reviewed with the Quality Improvement and Professional Advisory Committee.
8. The Administrator will arrange for a follow-up meeting and de-briefing with all concerned parties.

Interview with the Director of Nursing Care #116 revealed the absence of supporting documentation among the Home's records of the actual investigation, the outcome and/or conclusions drawn from the investigation, and communication of the outcome to the Director.

During an interview with the Administrator #104 they confirmed that the results of the investigation pertaining to the identified CI were not communicated to the Director. [s. 23. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee of a long-term care home has failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

On March 16, 2016, at 1030 hours during an initial tour of the home it was noted that there were small empty shampoo bottles sitting on the shelf in the Balsam wing tub room, Cedar wing tub room, and Ash wing supply room. This was confirmed by Registered Practical Nurse # 159.

On March 16, 2016, interview with Personal Support Workers #149 and #120 revealed that there were no big shampoo bottles in the home for the past week. PSW #149 reported that the home purchased large oversize shampoo bottles and the staff on night shift filled the smaller bottles with shampoo. The staff explained that the home was short on shampoo supplies for the past week. They reported that the staff were using resident's own stock that family provided or soap from the soap dispenser (hand soap) to wash the residents. They further shared that the staff had had informed management that they were out of shampoo but they remained short.

On March 16, 2016, at 1400 hours another observation of the Ash wing supply room and other tub rooms were made. It was discovered that a large sized pink colored shampoo bottle was sitting in the tub room.

Interview with PSW #120 on March 16, 2016 revealed that the shampoo was provided from the retirement home. The staff member shared that the retirement home used the pink colored shampoo bottle while the Long Term Care side used the blue colored shampoo. When the home was short they borrowed supplies from the retirement home.

Interview with Registered Nurse #160 on March 16, 2016 revealed that they had worked Sunday March 13, 2016, on night shift and there were no reports of the home being short

on supplies.

On March 16, 2016, at 1400 hours the Assistant Director of Nursing Care #102 confirmed that pink shampoo was borrowed from the retirement home as the home was out of shampoo. The ADONC #102 explained that they were not made aware that the home was out of shampoo and they were not the person responsible for ordering the supplies. ADONC #102 indicated that the DONC had advised her that supplies had been ordered before they went on holidays the week prior. The ADONC #102 further reported that since being informed that they were short of shampoo they had placed an order for additional supplies.

The ADONC #102 confirmed that supplies were not readily available at the home to meet the nursing and personal care needs of residents. [s. 44.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion

Record review of the a Critical Incident report, revealed that an investigation of the incident was initiated by the Home's Administrator. The Home's Regional Manager was notified and a report made to the police. An entry on the Critical Incident report indicated that the investigation was continuing.

There was no documentation on the Critical Incident (CI) report and/or subsequent amendments to the CI report indicating that an investigation was completed. In addition, there was no documentation on the CI report and/or subsequent amendments to the CI as to the outcome and/or conclusions drawn from the investigation, and communication of the outcome to the resident and the resident's substitute decision-maker.

Interview with the Director of Nursing Care #116 revealed the absence of supporting documentation among the Home's records of the investigation, the outcome and/or conclusions drawn from the investigation, and communication of the outcome to the resident and the resident's substitute decision-maker.

During an interview with the Administrator #104 they confirmed that the resident and the resident's substitute decision-maker, were not notified of the results of the investigation pertaining to the identified CI. [s. 97. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was secure and locked.

On April 28, 2016 the Director of Nursing Care's office was observed to be open and no one in the office. The DONC #116 was in meetings being held in the dining room. The vaccine fridge was observed in the Director of Nursing Care's office and there was no lock noted on the vaccine fridge.

On May 2, 2016, Director of Nursing Care # 116 confirmed that the vaccine fridge was not locked but indicated that they usually locked their office when they went for lunch or when they are not in the immediate vicinity.

On May 3, 2016 at 1215 hours, the Director of Nursing Care's office was open and no one in attendance. The vaccine fridge was noted to be in the office and not locked. An identified resident was noted to be wandering in the hallway and in and out of the dining room. At 1240 hours, the Director of Nursing Care returned to the office and confirmed that the vaccine fridge was not locked and contained vaccines.

The licensee failed to ensure that the vaccines were stored in an area or a medication cart, that was secure and locked. [s. 129. (1) (a)]

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

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Issued on this 11th day of July, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	DOROTHY GINTHER (568), AMIE GIBBS-WARD (630), CHARLES SMITH (635), MARIAN MACDONALD (137), NUZHAT UDDIN (532), SHARON PERRY (155), SHERRI GROULX (519)
Inspection No. / No de l'inspection :	2016_325568_0010
Log No. / Registre no:	007526-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 8, 2016
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE ARTHUR NURSING HOME 215 ELIZA STREET, P.O. BOX 700, ARTHUR, ON, N0G-1A0
	LISA CANADA

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

Name of Administrator /
Nom de l'administratrice ou de l'administrateur :

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_171155_0015, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that there is a written plan of care that sets out clear directions to staff and others who provide direct care related to toileting for resident #040 and any other resident on a toileting plan.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Record review of an identified resident's care plan indicated that they were incontinent. The resident was to be toileted before meals or after meals, before bed and when necessary (PRN). The resident's Kardex indicated that the resident was to be toileted every two hours.

During an interview with care staff they revealed that the identified resident was to be toileted every two hours.

Interview with the Director of Nursing Care # 116 and Assistant Director of Nursing Care # 102 revealed that the resident was to be toileted every two hours. The Assistant Director of Nursing Care # 102 confirmed that the care plan did not provide clear direction to staff who provide direct care to the identified resident.

This area of noncompliance was previously issued as a compliance order with a compliance date of September 21, 2015. The severity was a level two with a potential for harm and the scope was isolated. (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) 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. 31 (3).

Order / Ordre :

The home shall prepare, submit, and implement a plan to ensure that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and includes a back up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work

The plan must include what immediate and long term actions will be undertaken to ensure there is a process in place to monitor ongoing compliance as well as who will be responsible, specifically related to the monitoring of call bell response times, provision of personal care including bathing, nail care and toileting routines, and the monitoring of coverage of Personal Support Worker shifts.

Please submit the plan in writing, to Dorothy Ginther, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Ave., 4th Floor, London ON, N6A 5R2, by email, to Dorothy.Ginther@ontario.ca by June 24, 2016

Grounds / Motifs :

1. The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

A review of staff schedules and payroll records identified that the home worked short personal care staff, between February 29 – March 12, 2016, for 16.56 shifts; March 13 – March 26, 2016, for 29.7 shifts; March 27 – April 9, 2016, for 25.7 shifts and April 10 – April 23, 2016, for 12.7 shifts.

The 2016 Residents' and Family Council meeting minutes identified staff shortages and call bells not being responded to which resulted in residents not being toileted and increased episodes of incontinence. A review of the bathing report, on Point Click Care (PCC), revealed on March 4, 5 and 8, 2016, due to staff shortages, 13 residents received a bed bath rather that their preferred shower or tub bath. Of those residents, 11/13 (84.6 per cent) did not have his/her hair washed and 4/13 (30.8 per cent) did not receive nail care. On March 14, 16, 19, 20, 21, 22, 23, 24 and 25, 2016, due to staff shortages, 28 residents received a bed bath rather than their preferred shower or tub bath. Of those residents, 18/28 (64.3 per cent) did not have his/her hair washed and 10/28 (35.7 per cent) did not receive nail care.

During a review of the bathing report, the Director of Nursing Care # 116 confirmed, that due to staff shortages, residents received a bed bath rather than their preferred shower or tub bath. Some residents did not have their hair washed and/or nail care was not provided, on the identified days during the month of March 2016.

During interviews with three identified residents, they shared that the home was frequently short staffed and due to having to wait a long time to go to the washroom they ended up having accidents. The residents also shared that they had received either a bed bath or no bath at all rather than their preferred shower or tub bath, due to staff shortages. Negative outcomes identified by residents and family included missed tub baths/showers, hair not being washed, oral and nail care not provided, and residents not being toileted and changed. The licensee failed to ensure that the staffing plan provided a staffing mix that was consistent with resident's assessed care and safety needs.

The scope of this area of noncompliance was widespread and the severity of harm was a level two with potential for actual harm. The compliance history was a level three indicating one or more related noncompliance in the last three years.
(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 12, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

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

(iv) promote continued independence wherever possible, and

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

Order / Ordre :

The licensee shall ensure that:
1. There is a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.
2. Resident #051, #022, #008 and any other resident requiring continence care products have sufficient changes to remain clean, dry and comfortable
3. Resident #081, #051, #022 and #008 and any other resident requiring continence care products are assessed and provided with continence products based on their individual assessed needs as outlined in the regulations, including a pull up style product
4. Residents and/or families are made aware of the range of continence products available to them at no cost. Staff in the home communicate with Resident #016, #051, #022, #037, #005 and any other resident currently providing their own continence product to ensure they are aware that a range of continence products are available to them at no cost.
5. Conduct an audit of all residents, who have resided in the home in the years of 2015 and 2016 to determine if they had used or are using a pull up style continent product:
i. when a pull up product was/is used the home will determine, when the product was provided by the home, if the resident/representative was providing the product and if the product is/was an assessed need.
ii. when the product was provided by the resident/representative the licensee will reimburse all actual or estimated expenses incurred by the resident/representative in 2015 and 2016, for the full cost of the products used by August 1, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

During interviews with four Personal Support Workers #119, #153, #120 and #156 they shared that each wing of the home had a continence product cart. The cart was stocked on each wing from bins that had been filled by students on the previous afternoon. Staff indicated that the bins contained one product change for each resident with the exception of a few residents that were given an extra change on each shift. Each cart had a Resident Profile Worksheet which identified the type of product a resident was to be given on each shift. The worksheet also identified the number of each product on the cart for each

resident. Staff reported that if they required additional continence products for a resident the home's process required them to access a registered staff who had a key to the medication room where they kept an emergency supply. The registered staff recorded the resident name and type of product as part of the process. If the emergency supply had been depleted then they must get a second key from the Registered Nurse for the continence supply cupboard.

Personal Support Worker #120 and #156 shared that they often run out of continence product on their cart. Depending on the time of day the registered staff can be busy with medication or treatments and they wait between 5-15 minutes. Personal Support Worker #119 shared that there have been situations where a resident is already in a lift when they find out they have had a bowel movement and there was no extra product for a second change. They then have to lower the resident, one staff stay with the resident and the other go to find a registered staff to obtain another product from the medication room. During this period the resident is left to wait in a wet or soiled product and the staff cannot respond to other resident concerns. Personal Support Worker #120 and #153 reported that because of the sometimes lengthy process to get a second product, they have given residents a different product that is available on the cart. Personal Support Worker #120 and #153 indicated that when the Ministry of Health visits the home they seem to always have additional continence products on their cart, however, when they leave the amount of product returns to the usual levels.

Record review revealed that the Resident Profile Worksheets dated April 26, 2016 for Cedar, Ash and Balsam wings identified that in total there were 62 incontinent residents. The worksheet for each wing of the home identified the resident, the number and the type of continence product to be used for the resident one each shift. Of the 62 incontinent residents there were just eight residents that were were identified as having more than one continence product change on each shift provided on the cart.

During interviews with two Registered Practical Nurses, #115 and #123 they shared that extra supply of continence products were kept in the medication room and the continence supply cupboard. If the med room supply was depleted they would need to get the key from the Registered Nurse to access continence products in the supply room. They were required to complete the Tena Emergency Sign Out Form with the resident name, product type and date of request. RPN #115 reported that they get frequent requests for continence

products, particularly on the evening shift. The greater number of requests come from Balsam wing. RPN #123 indicated that requests vary from day to day. Some shifts they have quite a few and on others they have none. Both RPN's reported that the
time to get an extra product varies depending on their availability. If they are not in themiddle of a medication pass or treatment then they can access the product quickly but otherwise there may be a five to ten minute wait. RPN #115 reported that there have been situations when they run low on certain products toward the end of the week. RPN #123 indicated that it was rare that they would run out of product but there have been a few occasions when they have had to go outside to purchase certain products.

Review of the purchase orders for continence products during the period of January 1, 2016 and April 30, 2016 compared with the assigned product usage identified on the Resident Profile Worksheets for the same period revealed the following:
- 1884 day light liners were purchased and 3120 day light liners would have been used
- 9752 day regular liners were purchased and 10,800 would have been used
- 2480 day plus liners ordered and 2400 used
- 2064 night super liners ordered and 2040 used
- 480 extra large briefs orders and 480 used
- 1280 large briefs ordered and 1320 used
- 320 medium briefs ordered and 240 used

The usage numbers did not include any extra product used for residents in the home during the period of January 1, 2016 and April 30, 2016.

Interview with an identified resident revealed that staff assist them with toileting. The resident reported that they wear a continence product because sometimes they have accidents. Depending on the day, when they need another product staff have sometimes substituted it with a different product that was not as comfortable. Staff are very good but there are occasions when they have had to wait if they don't have the available continence product.

Interview with a resident's substitute decision maker (SDM) revealed that for some time they have been purchasing continence products. The SDM was concerned that the resident would not get sufficient changes to remain dry and since that time had been supplying the home with continence products to allow

for more frequent changes.

During an interview with the Director of Nursing Care (DONC) #116 and the Assistant Director of Nursing Care (ADONC) #102 they indicated that product orders were based on the Resident Profile Worksheets taking into consideration any product that was available from the previous month. The DONC #116 reported that to her knowledge over the last five months they had not run out of product. They were surprised to learn, basedon this inspectors review, that the product ordered was not sufficient in some lines for the expected usage identified by the Tena Profile Worksheet. The DONC #116 identified that there were a couple of situations where they ran low and they went out and purchased extra product. The DONC #116 and ADONC#102 indicated that they have had problems with staff using different products than what was assigned on the Tena Profile Worksheets. They seem to have a surplus of the day light liners which they believed was related to staff replacing this product with a different one. When asked if they had a process for staff to request a different product, the DONC#116 indicated that they do not currently have a formalized process for this. Staff tend to just pop in and let her know verbally or leave a note on her desk. The DONC #116 and ADONC #102 were asked if they tracked the requests for extra product in terms of numbers and trends and they indicated that to date this had not been done.

The licensee failed to ensure that there was a range of continence products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.
(568)

2. The licensee has failed to ensure that the resident who requires continence care products have sufficient changes to remain clean, dry and comfortable.

During an interview with an identified resident's substitute decision maker (SDM) they shared that care staff had advised them that they only had one product change per shift for the resident. The SDM reported that they had come in to visit the resident recently and found them soaked in urine sitting on their chair. Not only was the product soaked but their clothing as well as the chair. The SDM expressed being upset at finding the
resident in this situation.

Interview with another resident's SDM revealed that they visit the resident on a

regular basis. On several occasions of late the SDM reported that they found the resident soaked right through their product and into their clothes. The chair and pad that they were sitting on was also wet. The SDM indicated that given the degree of wetness they feel that the resident had not been changed or toileted in some time. The situation was very upsetting for both her and the resident.

A third resident's SDM shared with the inspectors that they have come into the home and found their loved one soaked through with urine. The SDM indicated that the staff are sometimes not persistent enough or do not have the time to re-approach to change the resident when they are resistive to care. The SDM recognized that many times they were working short staffed.

During an interview with Personal Support Worker #120 and #153 they reported that if they are unable to change a resident more than once then there can be problems with some of the residents in terms of leakage onto their clothing or the linens. Depending on the type of product they are using and if they are short staffed it can be difficult to keep the resident dry. The majority of residents were provided with one continence product change per shift and if they require more then staff have to go to the registered staff who then have to go to the med room or supply room to retrieve the extra product. This process takes away valuable time from resident care.

The licensee has failed to ensure that the resident who requires continence care products have sufficient changes to remain clean, dry and comfortable.
(568)

3. The licensee has failed to ensure that residents are provided with a range of continence care products based on their individual assessed needs.

a) During observations on a specified date at 1100 hours it was noted that an identified resident's pants were wet from their bottom to half way down their thigh. Staff were alerted and the resident was changed. Personal Support Worker #128 acknowledged that the resident had been incontinent. The staff member shared that when they went to change the resident they were not wearing a continence product.

On a second day at approximately 0850 hours the identified resident approached inspector #137 and asked if they could help them. The resident pointed to their wet pants extending from the groin area to just above the knees.

The resident was able to identify their room and the Assistant Director of Nursing #102 was notified that the
resident needed to be changed.

During interviews with Personal Support Workers #131 and #156 they indicated that the identified resident was not in the right product. The resident often removed their product without staff knowledge. Both staff shared that they felt the resident would be better in a different product.

Staff were instructed to use a different product. In May 2016 staff were instructed by the Assistant Director of Nursing to put the resident in a different product following an episode of incontinence. Review of the Resident Profile Worksheets for continence products for the period of January through April 2016 indicated that the identified resident was to wear their usual product. Record review indicated that in 2015 a trial of this different product was initiated for the identified resident at the direction of the Director of Nursing Care. There was no documentation as to the resident's response to the use of this continence product. In January 2016 progress notes identified that the resident was removing their continence

b) The Resident profile Worksheet dated April 26, 2016 identified that the resident wore their own product as per their choice.

During an interview with the resident's substitute decision maker (SDM) they indicated that when their family member was admitted to the home more than one year ago they were wearing a continence product. The home advised the SDM that they would not be able to supply this type of continence product. Since that time the SDM reported they have been supplying continence products to the home.

c) The Resident profile Worksheet identified that the resident used their own product according to their choice.

During an interview with the resident's SDM they expressed concern about their family member being left in wet products. The SDM shared that they attended the home not long ago and found the resident sitting in their chair soaked in urine. The chair pad and chair were also soaked. The SDM indicated that some time ago they were advised by care staff that they only had one continence product change for each resident per shift. The SDM was concerned that their

family member might be left in a wet product so they started buying continence products and leaving them for staff.

d) The Resident Profile Worksheet identified that the resident used their own product as per their choice.

The identified resident's SDM reported that they had been providing continence products for their family member since they were admitted to the home. The SDM indicated that on admission to the home they were advised that their continence products included a variety of liners as well as a product with tabs that opened like a diaper. They were told by the home that they did not provide the type of continence product the resident was currently using and if they wished to continue using this product they would have to supply it.

e) The Resident Profile Worksheet identified that two residents used their own continence product as per their choice.

There was no documented individualized assessment related to the choice of continence product or the resident's response to the use of the product for the two residents.

Review of the home's admission package revealed that there was no information pertaining to the type and range of continence products offered to residents in the home.

The Director of Nursing Care #116 confirmed that they had not completed a formal continence product assessment for the identified residents and that resident's had not been offered a range of products based on their assessed care needs. Record review revealed that on April 26, 2016 there were 62 out of 81 residents that were incontinent. The Resident Profile Worksheet indicated that seven of those residents that were
identified as being incontinent were using their own products.

The scope of this area of noncompliance was widespread and the severity a level two with potential for actual harm. The compliance history was a level three with one or more related noncompliance identified in the last three years. (568)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 12, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the planned menu items for all diet textures are offered and available at each meal and snack.

Grounds / Motifs :

1. The licensee has failed to ensure that planned menu items were offered and available at each meal and snack.

Record review revealed that during the week beginning Monday May 2, 2016 the home was on week one of the menu cycle. The snack menu for week one indicated that on Tuesday May 3, 2016 the afternoon snack would be bran crunch cookies or assorted cookies. On Wednesday May 4, 2016 the snack was to be mini donuts and assorted cookies. The therapeutic option for both days was identified as pureed cookies and mini donuts respectively.

During observations on Tuesday May 3, 2016 the snack being offered to residents in the afternoon on Ash, Balsam and Cedar wing was a choice of either a banana, orange or pear. There were no bran crunch or assorted cookies on the snack carts. On Wednesday May 4, 2016 the residents were being offered mini donuts as their afternoon snack. On both afternoons there were also pre-packaged and labelled snacks for specific residents, as well as a pudding and yogurt.

During interviews with three Personal Support Workers #142, #148, and #153 they indicated that residents on a therapeutic diet including pureed texture were usually offered either a pudding or yogurt for their snack if they didn't already have a prepackaged snack. The staff shared that the snack carts were not stocked with different
textures of the planned menu snack item. Personal Support Worker #148

confirmed that there was no pureed mini donut on the May 4, 2016 afternoon snack cart.

The Food and Nutrition Manager confirmed that it was the home's expectation that planned snack menu items would be offered to residents in the different diet textures.

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

The scope of this area of noncompliance was widespread and the severity a level two with potential for harm. The compliance history was identified as a level three; one or more related noncompliance issued in the last three years. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
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 8th day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dorothy Ginther

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