Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue 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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 22, 2019	2018_598570_0013 (A1)	005363-18, 007888-18	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 Lindsay Nursing Home
240 Mary Street West LINDSAY ON K9V 5K5

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

Amended by SAMI JAROUR (570) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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Compliance orders #002 and #003 were amended to extend the compliance date from April 30, 2019 to June 30, 2019.

Issued on this 22nd day of March, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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Amended by SAMI JAROUR (570) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 30, 31, August 1, 2, 3, 7, 8, 9, 10, 13, 14, 15, 16 and 17, 2018

The following intakes were inspected concurrently during the RQI inspection:

Log #024004-17 - Complaint related to refusal of admission of a resident.

Log #011949-18 - Complaint related to care issues, allegations of abuse of a resident.

Log #016087-18 - Complaint related to temperature at the home.

Log #009113-18 - Complaint related to safety at the home.

Log #025011-17 - Critical Incident Report related to an allegation of resident to resident abuse.

Log #026694-17 - Critical Incident Report related to an allegation of resident to resident abuse.

Log #028104-17 - Critical Incident Report related to fall of a resident with injury.

Log #029123-17 - Critical Incident Report related to fall of a resident with injury.

Log #012362-18 - Critical Incident Report related to allegation of improper care of a resident.

Log #000667-18 - Critical Incident Report related to allegation of neglect of a resident.

Log #002181-18 - Critical Incident Report related to allegation of neglect of a resident.

Log #004983-18 - Critical Incident Report related to allegation of neglect of a resident.

Log #005013-18 - Critical Incident Report related to allegation of neglect of a resident.

Log #007888-18 - Follow Up: CO#001 related to medication administration, s.114. Compliance due date June 18, 2018.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Nursing (DON), Environmental Services Manager (ESM), Activity Director, Nutrition Manager, Resident Care Coordinators (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Ward Clerk (WC), Maintenance Worker (MW), housekeeping staff, Behavioural Support Staff, Dietary Aide, Activity Aide, Personal Support Workers (PSW), Laundry Aides, president of the Residents' Council, Chair of the Family Council, residents and family members.

In addition, during the course of the inspection, the inspector(s) toured the home, observed staff to resident and resident to resident interactions, medication administration and infection control practices. The inspector(s) reviewed clinical health records, Resident Council meeting minutes, Family Council's newsletters and e-mail documents, medication incident reports, medication management meeting minutes, the licensee's internal investigation records and policies related to monthly weights, falls prevention, skin and wound care, resident safety and zero tolerance of abuse and neglect.

Inspector Miko Hawken #724 was shadowing.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Family Council
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
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **28 WN(s)**
- **10 VPC(s)**
- **6 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. 114. (1)	CO #001	2018_591623_0003	554

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 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 :

The licensee failed to ensure that residents are protected from abuse by anyone.

Pursuant to O. Reg. 79/10, s. 2 (1) – For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,

'emotional abuse' means (b) any threatening or intimidating gestures, actions,

behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

The licensee's policy, 'Abuse and Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff' (dated February 2018) indicates that Caressant Care believes in and is committed to the prevention of abuse. Caressant Care believes in the provision of a safe environment for residents. Abuse, in any form, is a direct violation of this intrinsic right and will not be tolerated.

Related to Intake #025011-17 and Intake #026694-17:

The following Critical Incident Reports were submitted to the Director:

RCC #104 submitted a CIR, Intake #025011-17, to the Director related to a witnessed incident of resident to resident alleged abuse involving resident #036 towards resident #009. The CIR indicated that on an identified date and time, Activity Aid (AA) #132 witnessed resident #036 display a specified responsive behavior towards resident #009. AA #132 indicated resident #009 was trying to get resident #036 to stop. AA #132 indicated that resident #009 indicated that resident #036's behaviour was unwelcome. AA #132 reported the incident to RPN #114.

RPN #114 indicated to Inspector #554 that resident #009 indicated that the actions of resident #036, were upsetting and unwelcome. RPN #114 indicated that the incident was reported to RCC #104.

RCC #128 submitted a CIR, Intake #026694-17, to the Director related to a witnessed incident of resident to resident alleged abuse involving resident #036 towards resident #009. The CIR indicated that on an identified date, resident #009 and resident #036 were in an identified common area when resident #036 approached resident #009 and displayed a specified responsive behaviour. The CIR indicated that the responsive behaviour was not consensual.

RPN #114 indicated to Inspector #554, being aware of the second alleged abuse incident involving resident #009 and resident #036. RPN #114 indicated that resident #009 had indicated that resident #036 displayed a specified responsive behaviour which was upsetting and unwelcomed. RPN #114 indicated that the

incident was reported to them by RPN #160 who had witnessed the incident. RPN #114 indicated being uncertain if RPN #160 had reported the abuse incident to either one of the RCCs on the date of the incident. RPN #114 indicated not reporting the incident of abuse to either RCC, as it was RPN #160 who witnessed it.

While inspecting the two CIRs related to alleged abuse involving resident #036 towards resident #009. The clinical health records for both residents were reviewed.

Resident #009:

The clinical health record, for resident #009, documented the following:

- On identified date and time, a PSW notified RCC #104 that resident #036 had displayed a specified responsive behaviour towards resident #009. Documentation was written by RCC #104.

The written care plan for resident #009, in effect at time of incident, directed the following:
- Identified responsive behaviour: Goal of care is indicated as 'decrease episodes of identified responsive behaviour'. Interventions include (but not limited to) 'resident #036 appears to search out resident #009, wanting to be in the same area as resident; document each incident. There was no new intervention specific to the identified responsive behaviour related to interaction with resident #036.

Resident #036:

The clinical record, for resident #036, directed the following:

Written Care Plan (for two identified quarters)
- Mobility: resident uses a mobility aid independently.
- Identified responsive behaviour: Goal of care is indicated as 'reduction of incidents'. Interventions include, resident will search out resident #009, wanting to be in the same area as resident. Staff to monitor interactions with resident #036 and resident #009; distract resident if possible; document each incident; remove resident from public area when presenting identified responsive behaviour. There was no new intervention specific to the identified responsive behaviour or resident #036's interactions with resident #009.

PSW #151 indicated to Inspector 554, being aware that resident #009 is bothered by the actions of resident #036. PSW indicated that resident #036 is 'always looking for resident #009'. PSW indicated resident #036 will display this responsive behaviour towards resident #009, and indicate desire to seek out resident #009. PSW #151 indicated that staff attempt to distract resident #036 or remove resident away from resident #009 but that the redirection only escalates resident #036's behaviours. PSW #151 indicated that resident #009 voiced frustrated with resident #036 and indicated that resident #036's actions were unwelcomed by resident #009.

RN #100 indicated to Inspector #554, being aware of the alleged abuse incidents by resident #036 towards resident #009. RN #100 indicated that 'resident #036 is obsessed with resident #009'. RN #100 indicated that resident has been known to display a specified responsive behaviour towards resident #009. RN indicated that resident #036 will seek out resident #009. RN #100 indicated that resident #036 is often difficult to direct or redirect when resident is focused on resident #009, indicating that resident #036 will become verbally and physically aggressive with staff direction; RN indicated that often resident #036 is left to 'self-console' (settle on their own). RN #100 indicated being aware that resident #009 is frustrated with the actions of resident #036. RN indicated that the display of this specified responsive behaviour by resident #036 towards resident #009 are unwelcomed by resident #009. RN #100 indicated that resident #009 will often stay in their room with the door closed to avoid resident #036. RN #100 indicated that resident #036's exhibited responsive behaviour has been a challenge to staff and remains an upsetting/frustrating situation for resident #009. RN #100 indicated 'feeling sad for resident #009'.

The ED indicated to Inspector #554, being aware of the alleged abuse incidents involving resident #036 towards resident #009. The ED indicated that the incidents have lessened but do occasionally occur. The ED indicated that staff and managers were aware that resident #009 is upset by the actions of resident #036 and indicated knowing that resident #036's actions were unwelcome to resident #009. The ED indicated that staff do attempt to keep resident #036 away from resident #009 but indicated staff can't be with resident #036 all the time. The ED indicated 'resident #009 is tolerant of resident #036'.

Resident #009 indicated to Inspector #554, being upset by the actions of resident #036. Resident #009 indicated that resident #036's actions, specifically the

display a specified responsive behaviour towards them was 'emotionally exhausting' and unwelcome. Resident #009 indicated to Inspector #554 'I stay in my room most of the time with the door closed to avoid resident #036.' Resident indicated avoidance of activity programs and or sitting in communal lounges to avoid resident #036. Resident indicated voicing frustration to staff on several occasions but indicated that the actions of resident #036 continue. Resident indicated 'feeling trapped in the home.'

The licensee has further failed to comply with:

- LTCHA, 2007, s. 20 (1), by ensuring the written policy that promotes zero tolerance of abuse and neglect of residents was complied with. (as indicated in Written Notification (WN) #17)

- LTCHA, 2007, s. 24 (1) 2, by ensuring the person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. (as indicated in WN #19)

- O. Reg. 79/10, s. 104 (2), by ensuring a report is made to the Director within 10 days of becoming aware of an alleged, suspected or witnessed incident of abuse of a resident by anyone. (as indicated by WN #26)

The licensee has failed to ensure that residents are protected from abuse by anyone.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the initial tour of the long-term care home (LTCH), the following was observed, by Inspector #554:

In a specified wing, resident home area (RHA):
- Toilet – dark brownish-black staining was observed around the base of the toilet stool, and the flooring. The debris could be easily scraped loose with Inspector's pen. This was observed in the tub-shower rooms on both hallways of the RHA. Dark staining around toilet stools and flooring was observed in nine identified residents' rooms.
- Flooring – tiled flooring in the tub-shower room was observed to have debris (grout) between the tiles along the wall/flooring and at the threshold of the entrance/exit of the tub-shower room. The tub-shower room was located on an identified hallway.
- Exhaust Fan – observed to have thick, dark grey debris on the exhaust fan cover and visible blades of the fan. This exhaust fan was located in a specified tub-shower room.
- Oscillating Fan - observed to have thick, dark grey debris visible blades of the fan. This fan was located in the north hall tub-shower room.
- Floors – in resident washrooms were observed heavily soiled with dark debris (grout) between flooring tiles in nine identified residents' rooms.

In other identified wing, RHA:
- Flooring – the vinyl sheet flooring in the tub room was observed torn, dark debris was visible on the sub-flooring. Dark brownish-black staining was visible

throughout the room, but the flooring was heavily stained along the wall/flooring, at the door and along the threshold entry/exit to the room.
- Toilet – dark brownish-black staining was observed around the base of the toilet stool, and the flooring. The toilet was located in the tub room of the RHA.
- Tub – observed to have a brownish staining along the tub edges, and white film, and debris along the underside of the faceplate of the tub (housing tub-controls). The tub was observed in the tub room of the RHA.

In another identified wing, RHA:
- Toilet – dark brownish-black staining was observed around the base of the toilet stool, and the flooring. The toilet was located in the tub and shower rooms of the RHA.
- Tub – observed to have a brownish staining along the tub edges, and white film, and debris along the underside of the faceplate of the tub (housing tub-controls). The tub was observed in the tub room of the RHA.
- Flooring – the vinyl sheet flooring in the tub room was observed to have dark brownish-black visible throughout the room, but the flooring was heavily stained along the edges of the wall/flooring, at the door and along the threshold entry/exit of the tub room.
- Flooring – vinyl sheet flooring was observed to have whitish film throughout the shower stall in the shower room.

Additionally, windows in multiple identified common resident areas, were observed to have dust and debris covering the window pane; the window panes appeared 'foggy'.

The above identified areas, staining around toilets, on floors in tub-shower rooms, and resident washrooms, and along tub surface was, also, observed on four different dates.

Housekeeping Staff (HSK) #120, who works on an identified Wing, indicated to Inspector #554 that windows in the home are cleaned twice yearly, by an external service, but cleaned in between by housekeeping staff with thorough cleans. HSK #120 indicated that the stains in the tub rooms on the identified Wing are permanent. HSK #120 indicated that there should not be stains around the toilet stool and flooring in resident rooms or tub-shower rooms. HSK #120 indicated that the tub in the tub room is not cleaned by housekeeping staff but is to be cleaned by nursing staff.

HSK #119, who works on other identified Wing, indicated to Inspector #554 that there should not be stains around the toilet stool and flooring in resident rooms and or tub-shower rooms. HSK #119 indicated that flooring in resident's rooms are old and flooring tiles have separated allowing debris to build up.

Environmental Services Manager (ESM) indicated, to Inspector #554 that:
- Windows in the LTCH are cleaned twice yearly by an external contractor, and that housekeeping staff are expected to clean the windows monthly as part of their 'thorough cleans'. ESM indicated that they believe that contracted window cleaning was last done in June or July 2018, but indicated it was their belief that the job completed was not done well.
- Cleaning around the toilets in tub-shower rooms, as well as resident's washrooms is done daily. ESM indicated there should be no staining around the toilet stools and the flooring in resident rooms and or tub-shower rooms.
- The tiled flooring in resident rooms and washrooms are the original flooring in most rooms, and agreed that debris is building up between separated floor tiles. ESM indicated that resident rooms, which includes adjoining washroom are wet mopped daily and thoroughly cleaned as part of the monthly schedule. ESM indicated the flooring in resident rooms and washrooms should not be stained, and should be kept clean.
- Flooring in the tub rooms on two identified Wings should not be stained, but then indicated that they believe that the stains maybe permanent. ESM indicated that they could place a call to a supplier to see if they have a chemical to remove the stains.
- The tub, itself, is not cleaned by housekeeping staff, but is part of the nursing duties. ESM indicated that the tub should be cleaned following resident use.

The ESM, as well as the ED indicated that the LTCH should be clean.

The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]

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

i) The licensee's policy, 'Principles Functions of the Maintenance Department' (dated October 2014) directs that maintenance services will ensure all internal and external maintenance concerns are addressed in a timely manner.

The licensee's policy, 'Maintenance Requisitions' (dated December 2009) that maintenance concerns will be addressed in a timely manner. Identified maintenance concerns waiting on parts or awaiting a contractor will be identified as such and an expected completion date will be identified on the maintenance requisition in the maintenance binder at the applicable nursing station.

Related to Intakes #009113-18 and #011949-18:

Intakes for inspection indicated that the 'home was falling apart inside and outside' and voiced concern for the safety of residents residing in the long-term care home.

During the initial tour of the LTCH the following maintenance concerns were observed by Inspector #554:

On an identified Wing - RHA:
- Air Conditioning (AC) window unit – was observed leaking in an identified common area, water was pooling onto the floor;
- Ceiling Tiles – were ceiling tiles in an identified hallway were observed to have brownish staining. The tiled ceiling, in this same hallway, was observed to be sloping;
- Tub-Shower Room – a hole, measuring approximately 30 cm irregular diameter, was observed in the ceiling above the tub, in the north hallway tub-shower room;
- Ceiling Exhaust Fan – observed covered in dark gray debris;
- Tub – acrylic finish on the inside of the tub was chipped in three to four areas and appeared as if the acrylic finish on the tub had been previously repaired. The exposed surface was porous in nature, which poses potential infection control problems. This tub is located in the north hall of the RHA;
- Tiled Flooring – four to five flooring tiles were observed chipped and or portions of the tiled floor were missing, adjacent by to the threshold of the A-wing door closet to the nursing station.
- Flooring – tiled flooring was observed uneven around a floor drain in the east hallway, adjacent to an identified resident room and common area room; the area presented a potential trip/fall hazard for residents;
- Door Locking Mechanism – the coded door mechanism on the tub-shower room was observed to be dysfunctional. Inspector #554 was unable to enter the tub-shower room, as well as PSW #102 and HSK #119. PSW #102 indicated to Inspector #554, that the door mechanism has 'been a problem' for some time. PSW #102 indicated it is often difficult to 'get into the room' when PSW's are

ringing for assistance with a resident;
- Furniture – faux leather surface on the love seat and chairs, located in a common area, was observed peeling or missing in areas along the seating and arms of the furniture;
- Wall – the wall, adjacent to a common area, was observed cracked along the upper wall edging and ceiling, the area measured approximately 60 cm. The paint on this wall was observed chipped and lifting.
- Window Screens – the window screens of all three windows in an identified common area were observed loose and bent.

In other identified Wing - RHA:
- Walls – in the television lounge were observed scuffed and chipped in areas;
- Flooring – the laminate flooring in the tub room was observed torn, an area measuring approximately 60 cm was observed to the left of the door as you entered the room, smaller areas measuring 2.5cm to 3 cm were observed in front of the door, the sub-flooring and debris were visible beneath the torn flooring. Water (from the bathtub) was observed leaking through the torn flooring and onto the sub-flooring. The flooring in the tub room was heavily stained with dark brown-black staining; the flooring was observed separating from the floor and the wall to the right of the tub, this area measured approximately 50 cm;
- Shower Room – a strong 'sewage like' odour was present in the room;
- Nursing Station – laminate was observed chipped in several areas on the outer aspect, facing the hallway and dining room, of the nursing station;
- Tiled Flooring – the flooring in the hallways were observed worn in areas;
- Window Screens – the window screens of two of the four windows in the activity room/chapel, as well as one of the two windows overlooking the enclosed patio were observed loose and bent.

In another identified Wing - RHA:
- Ceiling Tile – were observed ajar, exposing the ceiling wiring, adjacent to the tub room and an identified resident room;
- Tub – acrylic finish on the inside of the tub was chipped in two areas and appeared as if the acrylic finish on the tub had been previously repaired; the exposed surface was porous in nature, which poses potential infection control problems;
- Flooring – was observed heavily stained, with dark brown-black staining, in the tub room and shower room;
- Window Screens – the window screens of one of the two windows overlooking the enclosed balcony were observed loose and bent.

Outside of the LTCH:
- Sidewalk – the concrete sidewalk, outside of identified door, was observed cracked, chipped, and having loose and or missing areas of concrete along its pathway. The sidewalk was observed cracked and sloped inward toward the building (outside of activity department) and had a hole, was present in the concrete, measuring approximately one foot width and depth.
- Sidewalk – the concrete sidewalk, outside of identified door, was observed uneven in areas and having a raised area. The raised area measured approximately one inch.
- Patio and Ramp Access – the concrete/interlocking brick patio and access ramp, outside of identified Wing door, was observed cracked, missing concrete and uneven in several areas. Residents walking and in wheelchairs were observed maneuvering the uneven concrete patio and ramp.
- Patio – the concrete patio, was observed cracked and missing areas of concrete.

Uneven sidewalks, the access ramp and patios present a potential trip/fall hazard for residents and or others using them.

- Parapet Wall – seven to eight blocks, from the block facing, were observed missing and loose in areas of the parapet wall outside of an identified Wing - RHA. Five blocks were observed on the grass, outside of another identified Wing - RHA. Blocks were observed missing from the parapet wall at the corner of the building. Caution tape was haphazardly lying on the ground.

Falling bricks/blocks present a potential safety hazard for residents and others.

During this inspection, the following was observed by Inspector #554:
- Identified resident room – the tile flooring in the washroom was observed chipped and cracked, involving approximately four floor tiles;
- Identified resident room – the laminate finish on the counter-top vanity and cupboards were observed chipped. The left cupboard door was missing a piece of laminate measuring approximately 10 cm, the plywood under the laminate was exposed; the window screen was loose and bent;
- Identified resident room – there was no lid observed on the toilet tank in the washroom; the counter-top vanity and cupboards in the washroom was chipped, orange tape was holding the outer side of the cupboard (left side) together;
- Identified resident room – the tiled flooring in the washroom was heavily stained,

between the toilet and the wall; thick dark debris (grout) was visible between the flooring tiles; there was no lid on the toilet tank in the washroom;
- Identified resident room – the wall-base guard along the entire length of the wall, from the door to the window, was observed loose and or hanging from the wall; the wall, above the wall-base guard, was observed scuffed and chipped in areas; the wall, adjacent to the closet for identified bed, was observed chipped and had visible holes in the dry wall; the tiled flooring adjacent to the threshold separating the room and washroom was chipped;
- Identified resident room – the tiled flooring in the washroom was chipped and cracked in areas around the toilet, involving three tiles, the sub-floor was visible beneath and heaving laden with dark debris; the exhaust fan in the washroom was ¾ off and hanging from the ceiling;
- Identified resident room – the laminate finish on the counter-top vanity and the cupboards in the washroom were observed chipped; the exhaust fan in the washroom was ¾ off and hanging from the ceiling; the window screen was observed bent and loose;
- Identified resident room – the tiled flooring in the washroom had thick dark debris between the tiles; the exhaust fan in the washroom was ¾ off and hanging from the ceiling;
- Identified resident room – the tiled flooring in the washroom was heavily soiled, between the toilet and the wall; thick dark debris was visible between the flooring tiles; the laminate on the cupboard in the washroom was chipped and or missing on the left cupboard door and corner of the cupboard; the finish on the mirror in the washroom was worn and missing in areas (on the right side); the wooden bathroom door was scuffed and gouged; the wall, to the left, as you enter the washroom was scuffed and gouged; the toilet in the washroom was heard 'running' on multiple dates;
- Identified resident room – the window screen was observed loose and bent, there was duct tape on the sides of the screen's metal frame.

Outside of the LTCH:
- The eaves troughs, and down spouts, along the front of the LTCH, were observed loose (coming away from the building), bent, cracked and or missing in areas. The soffit panels, within the same area, were observed cracked and coming loose from the fascia, the plywood beneath, the soffit panels, was observed exposed to the elements.
- The asphalt shingles on the roof, at the front of the LTCH, were observed cracked and lifting in areas.

HSK #119, HSK #120, PSW #101, WC #103 and RN #100 indicated to Inspector #554, that any items identified as needing repair by maintenance are placed into the 'maintenance binders' located at the nursing stations on all RHA's.

The maintenance binder on all three RHA's were reviewed by Inspector #554. The maintenance binder identified window screens being loose and bent in an identified common area. Other maintenance issues identified by Inspector #554 were not documented as needing repair and or replacement in any of the maintenance binders on RHA's.

The ESM indicated to Inspector #554 that the maintenance binders on all RHA's are reviewed daily and repairs are prioritized. ESM indicated repairs and or replacement are completed in collaboration with MW. ESM indicated that the maintenance department relies on staff to identify maintenance concerns and document the concern(s) in the maintenance binders. ESM indicated that needed repairs within the LTCH are done as soon as possible and indicated that any repairs waiting on parts or contractors are identified in the maintenance binder with date and expected completion. The ESM indicated that the maintenance department is doing it's best to keep up with the repairs in the LTCH.

The ESM indicated the following:
- awareness of the conditions of washrooms on A-wing RHA, specifically washroom floors, cupboards and counter-tops. ESM indicated being recently approved to repair and or replace flooring and counter-tops in ten resident washrooms per year. ESM indicated that two identified resident rooms were not on the list for 2018. ESM indicated that the 'plumbing was causing the toilet to leak in identified resident room' and therefore causing the staining on the washroom floor. ESM indicated that at this time, there was no plan in place to address the plumbing issues in identified resident room/washroom.
- being aware that the acrylic finish inside the tubs on identified two Wings were chipped. ESM indicated that a product had been used to fill the chipped acrylic but must have come loose again.
- no awareness of window screens in the LTCH being bent or loose.
- awareness of the heavily stained flooring in two identified Wings tub-shower rooms and awareness of the torn flooring in an identified Wing's tub room. ESM indicated that the flooring in the tub room has been in the same condition for approximately four years and indicated being aware that water, from the bathtub, was leaking onto the sub-flooring beneath the laminate flooring. ESM indicated being directed, by corporate office's ESM Lead, to fill it with caulking. ESM

indicated that the 'caulking was a bandage solution' and indicated that the caulking 'continues to break down and has been ineffective'. ESM indicated at this time, there is no plan to address the torn flooring in the tub room on identified Wing.
- awareness of the concrete issues on sidewalks, patios and ramp access around the exterior of the LTCH. ESM indicated that quotes had been obtained and forwarded to corporate office in 2017 and 2018 identifying that the sidewalks and access ramp pose a 'serious trip hazard' for residents and others. ESM indicated being told by corporate office that the 'repairs would not be done in 2017 and in 2018', ESM stated no reason was given.
- awareness of the damaged eaves trough and downspouts around the exterior of the LTCH. ESM indicated that quotes had been obtained and forwarded to corporate office in 2015 and 2017. ESM indicated being told by corporate office that the 'repairs would not be done in 2015 and in 2017', ESM stated no reason was given.
- awareness of the damaged parapet wall on the exterior of the LTCH. ESM indicated that quotes had been obtained and forwarded to corporate office in 2015. ESM indicated being told by corporate office that the 'repairs would not be done in 2015' despite the repair being marked as 'urgent' and indicating that a section of the wall was coming away from the building. ESM stated no reason was given why the repair to the parapet wall was not approved for repair. ESM indicated in an identified date in 2018, blocks started to fall from the wall. ESM indicated that the 'falling blocks were a safety concerns' and this was communicated to corporate office; and ESM was directed to obtain a second quote for the repair of the parapet wall. ESM indicated that the quote was forwarded to corporate office on an identified date and indicated that approval was granted for the repair of the wall. ESM indicated that the parapet wall should have been repaired in 2015 when the wall was identified as coming away from the building.

The ED indicated to Inspector #554, being aware of maintenance issues on identified Wing - RHA, ED indicated that the washrooms in the identified Wing are old and falling apart. ED indicated that they had approval to fix ten washrooms this year (2018). ED indicated being aware of maintenance concerns on the exterior of the LTCH, specifically uneven concrete on sideways, patios, access ramps, damaged eaves troughs and downspouts and damage to the parapet wall. The ED indicated that quotes for repairs had been forwarded to corporate office over the past four years, as indicated by ESM. The ED indicated that the quotes for needed repairs had not been approved by corporate office and indicated that

no reason was provided.

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

ii) On identified date, Inspector #554 was standing at an identified Wing nursing station when the fire alarm sounded. Inspector #554 observed that one of the fire doors on one hallway did not automatically close.

Ward Clerk (WC) #103 and RN #100 indicated that the fire door should close automatically when the fire alarm is activated. Both WC and RN indicated that there had been issues with the fire door not closing for some time and indicated that Environmental Services Manager is aware of the fire door not closing.

The ESM indicated to Inspector #554, that the fire door, located on the north hall on an identified Wing - RHA, had been dysfunctional for approximately three weeks. ESM indicated that an identified contractor had been to the LTCH approximately two weeks ago to service the dysfunctional fire door, but indicated that the representative of the contractor indicated that the issue with the door was not related to the 'meg lock mechanism' but related to the 'automatic door closure arm', which did not fall under their services. ESM indicated being aware that a door company needed to be called to install a new door closure arm and indicated that the repair of the fire door had not been arranged but should have been.

Following discussion with Inspector #554, required repair of the fire door was arranged by the ESM. On identified date, the fire door was repaired, and operational.

The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, specifically the maintenance of fire separation doors in the LTCH. Dysfunctional fire doors jeopardize the safety of residents and others in the long-term care home.

iii) On identified date, the automatic door closure arm on the fire door, leading to identified area, was observed not attached to the door. The Maintenance Worker (MW) #105 indicated to Inspector #554 being told by ESM that the fire door was not closing properly and needed repair. MW indicated being unaware of who removed the door closure arm. MW indicated that the door closure arm should not have been removed as the door was a fire door and the door closure arm

functions to automatically close the door when the fire alarm sounds.

The FSS indicated to Inspector #554 that the fire door in an identified area had not been closing properly for some time and that the door closure arm was removed by the ESM.

The ESM indicated to Inspector #554 awareness that the fire door in the identified area was dysfunctional. ESM indicated removing the door closure arm at some point. ESM indicated that the identified area was 'not high traffic' so the repair was not deemed urgent. ESM indicated that the 'door closure arm was ordered but the repair had been forgotten' until Inspector #554 questioned fire door operations in the LTCH following fire drill on identified date, when another fire door was not closing.

The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, specifically fire separation doors in the LTCH. Dysfunctional fire doors will jeopardize the safety of residents and others in the long-term care home. [s. 15. (2) (c)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a resident-staff communication and response system available in every area accessible by residents.

During the initial tour of the long-term care home, Inspector #554 did not observe a resident-staff communication and response system available in the following areas:

- Identified sitting area where residents and visitors were observed sitting in the area;
- Identified area, located outside of identified Wing doors. Residents were observed sitting in the smoking area;
- In an identified Patio area.

WC #103, RPN # 112 and RN #100 indicated to Inspector #554 that the identified sitting area, and identified patios are resident accessible areas. The WC #103, RPN #103 and RN #100 indicated that the sitting area and patios do not have a resident-staff communication and response system available to residents. WC #103 and RN #100 indicated that there has been incidents where residents have fallen outside in an identified area and have had to wait until staff noticed they had fallen or other residents and/or visitors alerted staff of the incident.

The ESM indicated to Inspector #554, being aware that the identified sitting area and the two patios had no accessible resident-staff communication and response system. The ESM indicated being unaware that the outside patios required an accessible resident-staff communication response system. The ESM indicated that all three areas are resident accessible areas.

The licensee has failed to ensure that the resident-staff communication and response system was available in every area accessible by residents. [s. 17. (1) (e)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written hot weather related illness prevention and management plan that meets the needs of the residents, is developed in accordance with evidence-based practices and, if there is none, in accordance with prevailing practices, and is implemented when required to address the adverse effects on residents related to heat.

The licensee policy, 'Hot Weather Plan-Residents' (effective date May 2018) indicates that Caressant Care will make every attempt to keep our residents comfortable and well during the hot weather season. The season typically between May 01 and September 30. The Hot Weather Plan-Residents policy indicates that keeping residents comfortable and well will be accomplished from a multi-disciplinary approach, every department has an important role to play. The policy, Hot Weather Plan-Residents directs:

The Administrator will;

- ensure the indoor temperatures and humidex levels are monitored and recorded at the specified times; (refer to policy and procedure entitled Hot Weather Plan-Taking of Humidity and Temperature Readings).
- ensure the humidex level is communicated to staff and residents.
- ensure all staff have been educated to the signs and symptoms of heat related illness.
- implement policies and procedures for the prevention and management of heat related illness.
- monitor and assess the need to declare heat related emergency.

Nursing Department will;
- assess the need for additional fluids to residents 24 hours a day, seven days per week based on assessed needs.
- assess and implement body cooling strategies as required.
- assess and provide additional skin care in response to hygiene requirements of each resident.
- monitor residents for signs and symptoms of heat related illness.
- encourage residents to spend time in the air conditioned lounges.
- during the night, open the doors to the air conditioned lounges, to release the cool air into the corridors.

Housekeeping Department will;
- ensure shades, drapes, blinds and window coverings are kept closed during the warmest parts of the day.

Maintenance Department will;
- ensure lights remain on.

The licensee's policy, 'Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents' (effective May 2018) indicates that Caressant Care will monitor the indoor temperature and humidity levels so that staff can be on heightened alert for signs and symptoms of resident distress due to heat.

Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents policy indicates that a thermal hygrometer is placed in every corridor which is frequented by residents. For a specified period every year, the humidex will be recorded at the start of every shift and more frequently if deemed necessary.

The supervisor and or charge nurse shall;

- refer to the hygrometer for the temperature and the humidity level. Both of these readings are recorded on the 'Hot Weather Plan-Indoor Humidex Recording Form'.
- then refer to the humidex chart, align the air temperature with the temperature column (far left) and the humidity level with the humidity row across the top. The humidex value is where the two numbers meet on the chart.
- record the humidex level on the humidex recording form.
- refer the humidex reading to the legend, if the humidex is between 30-39, the Executive Director will communicate this to the staff and the hot weather guidelines will be put into effect.
- the hot weather guidelines will remain in effect until the humidex falls below 30.

Related to Intake #016087-18:

There are 124 residents residing at Caressant Care-Lindsay. The long-term care home (LTCH) has three resident home areas (RHA).

The ED indicated to Inspector #554 that the licensee has policies specific to 'Hot Weather' which included the monitoring of residents for heat related illness and monitoring of indoor temperatures and humidity. The ED indicated that registered nursing staff take air temperatures in the LTCH during their assigned day, evening and night shifts and indicated that air temperatures are recorded for all RHAs. The ED indicated that the LTCH is equipped with designated cooling areas for residents and indicated that resident accessible cooling areas are located in the following areas of the LTCH:

In an identified Wing RHA;
- Four identified areas.

In other identified Wing RHA;
- Three identified areas.

In another identified Wing RHA;
- Two identified areas.

On identified date and time, Inspector #554 observed the following:

- approximately 5-6 residents sitting in wheelchairs and chairs adjacent to the nursing station, on an identified Wing RHA, resident's faces were observed

flushed, three of the residents were asleep in their wheelchairs.
- resident #043's face was observed flushed, damp with sweat and resident's shirt (back portion) was observed 'wet', as resident walked down the hallway.
- one resident was observed sitting in an identified common area, the door to the area was closed and the window air conditioning (AC) unit was on.
- there were no residents observed in the other identified common area, which is located on an identified Wing, door to the room was open and the AC window unit was not observed to be turned on.
- the dining rooms on an identified Wing, which have AC, were locked and not accessible to residents outside of meal times.
- the hallway lights of an identified Wing, were observed turned off.
- Six identified resident rooms and one identified common area windows were observed to be open
- the dining rooms on identified Wings, which have AC, were observed locked and not accessible to residents outside of meal times.

Resident #002 indicated to Inspector #554, that the temperature in the LTCH was 'unbearable', and that the temperature worsens as the late afternoon and evening approach.

On identified date and time, the following temperatures and humidity readings were taken by Inspector #554, using licensee owned hygrometers in the hallways of the RHAs:
- In two areas of an identified Wing – 25 Celsius (C) / humidity 65 and – 28 C / humidity 60.
- In two areas of other identified Wing – 25 C / humidity 70 and – 25 C / humidity 74.
- In one area of other identified Wing – 24 C / humidity 80.

Referencing the licensee's policy, Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents, to determine the humidex within the LTCH. Inspector #554 referenced the humidex chart within the policy which indicated the humidex in RHA's hallways was 31-35.

RPN #122, who was the designated Charge Nurse (CN) on identified date, indicated, to Inspector #554, that the CN routinely takes the air temperatures in the hallways and records it on the 'Air/Water Temperature Daily Log'. RPN #122 indicated air temperatures are taken on all shifts. RPN #122 indicated that registered nursing staff do not take humidity readings. RPN #122 indicated being

unaware of what the air temperature in the LTCH was to be. RPN #122 indicated that as the CN on the assigned shift on identified date, there has been no communication to staff as to the Hot Weather Plan being in place. RPN #122 indicated that there has been no direction, by nursing management or the Executive Director, to take additional air temperature readings. RPN #122 indicated being unaware of the licensee's policies, specific to, Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents and or Hot Weather Plan-Residents. RPN #122 indicated being unaware when the Hot Weather Plan is to take effect and or who is to communicate that the plan is in effect. RPN #122 further indicated that the windows in the home are open to allow air into the LTCH, and indicated that the dining room doors are only unlocked during meal times.

Subsequent air temperatures and humidity readings were taken on five identified dates by Inspector #554. Inspector used referenced the humidex chart the Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents policy to determine the humidex in the LTCH on the identified dates, the following was determined:
- temperatures in multiple areas in the home were between 24 to 28 Celsius.
- recorded humidity readings ranging between 60 to 72.

The humidex level in the long-term care home was identified by Inspector #554 to be 30-39.

Further observations on five identified dates identified that hallway lights of an identified wing, were turned off; windows in six identified resident rooms and one common area were open; the dining rooms on all wings were locked and not accessible to residents outside of meal times; the AC unit in a common area in identified wing was on, the door was open, and there were residents in the area; one to two residents were in the other common area; and five to seven residents were seated, in wheelchairs, in the hallway adjacent to the nursing station, and residents faces were observed flushed.

RN #100 and RN #130, who are CN's, indicated to Inspector #554 that hallway air temperatures are taken by the CN on each shift and recorded on a form entitled Air/Water Temperature Daily Log. RN #100 and RN #130 indicated that humidity readings are not taken, nor does the Air/Water Temperature Daily Log have a space for humidity readings to be recorded. RN #100 and RN #130 indicated being unaware of how to determine the humidex level in the LTCH. Both RN's

indicated being unaware when the Hot Weather Plan is to take effect and or who communicates that the plan is in effect. RN #100 and RN #130 indicated being unaware of the licensee's policies, specific to, Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents and or Hot Weather Plan-Residents, both indicated never seeing either policy.

PSW #131, RPN #122, RN #100, #130, #134 and RCC #104 indicated, to Inspector #554, being unaware if the Hot Weather Plan was in affect during their shift on these dates. PSW, RPN and RN's indicated that the dining rooms are routinely locked between meals and not accessible to residents.

PSW #151 indicated to Inspector #554, being unfamiliar with the term 'Hot Weather Plan' was. PSW #151 indicated 'when it is hot inside, we open windows in resident rooms and lounges'. PSW #151 indicated that if 'residents were hot, they would have dry lips and I would give them water'. PSW #151 indicated that residents are routinely offered fluids during meals, and during the morning, afternoon evening snack cart. PSW #151 indicated being unaware of the Hot Weather Plan policies.

RCC #104, who indicated being the Interim DOC, indicated to Inspector #554, being 'unfamiliar' with the contents of the licensee's policies, Hot Weather Plan-Residents and Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents. RCC #104 indicated being unaware of how to determine the humidex level and indicated being unaware of when the Hot Weather Plan would be activated and or by whom.

During a second interview, the ED indicated being unaware of the contents of the Hot Weather Plan-Residents and Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents policies. The ED indicated that the policies 'must have changed at some point' and indicated that changes with the policies 'had not been communicated' to the LTCH by Caressant Care Corporate Office. The ED indicated being unaware that registered nursing staff were to be taking humidity readings, were to be using the form entitled 'Hot Weather Plan-Indoor Humidex Recording Form', was unsure how to determine the humidex level in the home and indicated, being unaware when the Hot Weather Plan was to be communicated to staff and residents and by whom. The ED further indicated that the nursing staff were correct, dining rooms are locked outside of mealtimes.

The licensee has failed to ensure that the written hot weather related illness

prevention and management plan that meets the needs of the residents was implemented. [s. 20. (1)]

2. The 'Guidelines for the Prevention and Management of Hot Weather Related Illness in Long-Term Care Home' (dated July 2012) indicates that the 'guidelines reflect multiple sources of evidence-based practices' and 'consistent with requirements outlined under O. Reg. 79/10, s. 20 (1).

The Guidelines for the Prevention and Management of Hot Weather Related Illness in Long-Term Care Home indicate that, in order to respond appropriately to hot weather conditions, LTCH's should prepare in advance of the hot weather season and review and update annually a plan that will be in effect during the hot weather season. The Guideline specifically direct the following:

The Administrator will;
- Develop a communication protocol to convey hot weather action plan (including humidex readings) to residents, staff, volunteers, family, visitors and others as required.
- Implement annual staff education and training program on prevention and management of heat related illness and hot weather plan.

All Staff will;
- Attend annual staff education and training program on prevention and management of heat related illness.
- Review policies and procedures for heat related emergencies.

The licensee policy, 'Hot Weather Plan-Residents' (effective May 2018) indicated the Administrator will, ensure that the humidex level is communicated to staff and residents and will ensure that all staff have been educated to the signs and symptoms of heat related illness.

The licensee's policy, 'Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents' (effective May 2018) directs that the ED will communicate to staff if the humidex is between 30-39 and that the hot weather guidelines will be put into effect. The policy directs that the hot weather guidelines will remain in effect until the humidex falls below 30.

Related to Intake #016087-18:

Caressant Care employs approximately 160 staff and seven managers within the LTCH.
The ED indicated, to Inspector #554 on an identified date that staff and managers are informally aware of the licensee's Hot Weather policies and procedures. The ED indicated informally meant 'word of mouth' at morning huddles. ED indicated staff do not receive formal training specific to the Hot Weather Plan.

On six identified dates, the humidex level in the long-term care home was identified by Inspector #554 to be 30-39. The licensee's hot weather plan was not communicated to staff and residents.

RPN #122, who was the designated CN, indicated to Inspector #554 being unaware of the Hot Weather Plan policy, when the plan is to take effect and who communicates that the plan is in effect.

RN #100 and RN #130, who are both CN's, indicated to Inspector #554, being unaware of the Hot Weather Plan policy, when the plan is to take effect and who communicates that the plan is in effect.

PSW #131 and PSW #151 indicated, to Inspector #554, being unfamiliar with the Hot Weather Plan policy. PSW #151 indicated that staff would open windows if the building was too hot and indicated, if resident's lips were dry staff would give residents water.

RN #159, who is a contracted agency staff, indicated to Inspector #554, being unaware of the licensee policy and or procedures specific to the Prevention and Management of Hot Weather Related Illness.

RCC #104, who indicated being the Interim DOC, indicated to Inspector #554, that his role, as RCC, included Staff Education. RCC #104 indicated that approximately thirty-nine nursing staff were provided education specific to 'Hydration during Hot Weather'. RCC #104 indicated the staff had not been provided education specific to the licensee's Hot Weather Plan. RCC #104 indicated being unaware that staff are to receive annual education specific to the Hot Weather Plan. RCC #104 indicated being unaware of the contents of the licensee's policies related to the Hot Weather Plan.

During a follow up interview, the ED indicated being unaware of the contents of the licensee's policies, Hot Weather Plan-Residents and Hot Weather Plan-

Taking of Humidity and Temperature Readings-Residents.

The licensee has failed to ensure that the written hot weather related illness prevention and management plan that meets the needs of the residents, was implemented when required to address the adverse effects on residents related to heat, specifically the licensee failed to ensure that staff are provided education related to the Hot Weather Plan. [s. 20. (1)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that drugs are stored in an area or a medication cart that is secured and locked.

During the initial tour of the long-term care home, Inspector #554 observed the following:
- Two medication cups containing an identified amount of medication were observed on top of a medication cart. The medication cart was located outside of an identified Wing RHA dining room. There was no registered nursing staff in attendance at the time of the observations. RPN #101 returned to the medication cart approximately three minutes later.
- An opened container of identified medication was observed sitting on top of a medication cart in the hallway of another identified wing RHA. The medication cart was observed unlocked and unattended. Residents were observed walking past the medication cart.

RPN #101 indicated to Inspector #554, that the medication cups had an identified medication. RPN #101 indicated pre-pouring the medication 'for ease' and indicated being aware that medication was not to be left unattended.

RN #100 indicated to Inspector #554, that medications were not to be left unattended at any time. RN #100 indicated that medications are to be stored inside medication carts and medication carts are to be locked when registered nursing staff are not in attendance.

Further Observations:
- Multiple observation on identified date, Inspector #554 observed an opened container of identified medication on top of a medication cart outside the dining room on identified wing RHA. RPN #122, who was the assigned medication nurse, nor any other registered nursing staff were in attendance. Resident #039, as well as other residents were observed wandering past the medication cart.
- On an identified date and time, opened container of identified medication and a container of another identified medication were observed sitting on top of a medication cart, outside the dining room of an identified wing RHA. RPN #123, who was the assigned medication nurse, nor any other registered nursing staff were observed in attendance.
- On identified date, during the morning medication pass, an opened container of identified medication was observed on top of the medication cart, adjacent to the nursing station on identified wing RHA. No registered nursing staff were observed in attendance. The medication cart was observed unlocked. Residents were observed wandering past the medication cart.
- On identified date, during the morning medication pass, an opened container of

identified medication was observed on top of the medication cart, outside the dining room on identified wing RHA. The medication cart was observed unlocked. RPN #112, who was the assigned medication nurse, was observed in the dining room with back to the medication cart.
- On identified date, during the morning medication pass, a container of identified medication was observed on top of a medication cart, outside the dining room on idnetified wing RHA. No registered nursing staff were observed present.

RPN #122 indicated to Inspector #554, being aware that medications were not to be left unattended.

RCC #104 indicated to Inspector #554, that registered nursing staff are aware that medications are not to be left unattended and medication carts are to be locked when staff are not in attendance. RCC indicated being aware that the registered nursing staff are leaving medications unattended and medication carts unlocked and indicated that all registered nursing staff had been provided education recently. RCC #104 indicated that RPN #101, RPN #112, RPN #122 and RPN #123 had signed off education and had acknowledged awareness following the education. RCC #104 indicated awareness that medications being left unattended continues to be an issue of concern in the long-term care home and indicated being 'unsure how to get staff to be compliant with practice and policies'. RCC #104 indicated that the Executive Director, DOC and Corporate Office is aware of concerns surrounding the safety of medications.

The Executive Director indicated to Inspector #554, being unaware that registered nursing staff were leaving medications unattended or medication carts unlocked. The ED indicated that medications were not to be left unattended.

The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secured and locked. [s. 129. (1) (a)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

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

While inspecting upon compliance order under O. Reg. 79/10, s. 114, compliance due date of June 18, 2018, the following was identified.

Resident #003 has an identified diagnosis.

Physician orders indicated resident #003 was prescribed the following:

- Identified medication (an identified dosage) to be administered at two identified times. The physician's order indicated that the medication was depending on the result of an identified test, and indicated that the physician was to be called. This physician's order was effective until an identified date.
- Identified medication to be administered as directed. The physician's order directed that the physician was to be contacted following administration of the medication or if registered nursing staff were unsure that the medication should be administered.

The clinical health record indicated the following for an identified month:
- Identified tests results at specified dates and times were documented in the eMAR, at below specified level on multiple dates.
- On identified date and time, CN-RN #134 documented in the eMAR, indicated the physician prescribed an identified medication to be held due to specified test results. There is no documentation to indicate that the test was repeated by RN #134 or another registered nursing staff and There is no supporting documentation indicating the physician was notified.
- On identified date and time, the eMAR documentation indicated that the results of a specified test were at an identified level and indicated that the prescribed identified medication dose was administered by an RPN. There is no supporting documentation indicating that the physician was notified of the tests results.
- On identified date and time, the eMAR documentation indicated that the results of a specified test were at an identified level. There is no indication that an identified medication was administered as prescribed. At an identified time, the documentation indicated that a specified tests results were at specified level. The eMAR indicated that resident was not administered the identified medication. There is no documentation in the clinical health record indicating the physician was notified of the test results and that the medication was not administered.
- On identified date and time, the eMAR documentation indicated that the results of a specified test were at an identified level. The eMAR indicated that the identified medication was held. There is no documentation in the clinical health record indicating the physician was notified of the test results and that the medication was not administered.
- On identified date and time, the eMAR documentation indicated that the results of a specified test were at an identified level. The eMAR indicated that the identified medication was held. There is no documentation in the clinical health record indicating the physician was notified of the test results and that the medication was not administered.
- On identified date and time, the eMAR documentation indicated that the results of a specified test were at an identified level and an identified medication was administered. There is no supporting documentation to indicate that the physician was contacted following administration of the drug.

RN #100 and RPN #155 indicated to Inspector #554, that drugs are to be administered according to the directions by the physician.

The Physician indicated being unaware that resident #003 had not been

administered drugs according to the physician's orders on four identified dates and indicated not being aware that resident's identified test results were below certain level. The Physician indicated that physician's orders for resident #003 were 'clear' indicating registered nursing staff were to contact doctor (MD) if the specified test results were under specified level. The Physician indicated that physician's orders are to be followed unless otherwise indicated by the physician. The physician indicated being unaware that an identified medication was administered on an identified date.

On an identified date, the physician's order were reviewed and a specified dose of identified medication was prescribed to be administered at a specified time.

The clinical health record indicated the following:

- On an identified date, the eMAR for an identified medication was signed and coded as '5' meaning 'hold/see nurses notes'. A progress note, documented by RPN #161 indicated 'resident's specified test result was at a specified level. RPN #161 and CN-RN #130 decided to hold the medication.
- On an identified date, the eMAR for an identified medication was signed and coded as '2' meaning 'drug refused'. A progress note, dated documented by CN-RN #140 indicated resident #003 was exhibiting responsive behaviours when registered nursing staff attempted to administer the medications. Documentation indicated resident was not administered the medication due to responsive behaviour. There is no documentation to indicate medication administration was attempted again.

- On an identified date, the eMAR for an identified medication was signed and coded as '5'. There was no progress notes to correspond with the identified medication not being administered as prescribed by resident #003's physician.

- On an identified date, the eMAR for an identified medication was signed and coded as '5'. A progress note, documented by an RN indicated a specified test results was at a specified level.

The clinical health record for the above identified four dates, fails to provide support that the physician for resident #003 was contacted when registered nursing staff did not administer an identified medication in accordance with physician's directions, nor is there a physician's order, during an identified month, directing that an identified medication be held or not given to resident #003.

The ED indicated to Inspector #554, that registered nursing staff are to follow physician's direction related to the administration of drugs.

The Physician, for resident #003, indicated, being unaware that registered nursing staff were not administering an identified medication as prescribed. The physician indicated that the medication was not to be held and/or not administered unless directed otherwise by a physician. The Physician for resident #003 indicated frustration with registered nursing staff not following physician's orders.

The Director of Regional Operations indicated to Inspector #554, that physician's orders are to be followed as indicated by the physician.

The licensee has failed to ensure that drugs were administered to resident #003 in accordance with the directions for use as specified by the prescriber. [s. 131. (2)]

2. The licensee failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

A Medication Incident was reviewed by Inspector #554. The incident identifies the following:

-On an identified date, RPN #122 prepared physician prescribed medications, two identified medications, for resident #031. RPN #122 placed the two medications into a glass of identified supplement. RPN #122 gave the supplement containing the medications to a PSW to administer to resident #031. RPN #122 returned to find the glass containing the nutritional supplement and medications empty. PSW indicated to RPN #122 that resident #031 had not received the supplement and or the medications. PSW indicated to RPN being unaware of who consumed the nutritional supplement containing the medications. The medication incident indicated that there were three other residents at dining room table with resident #031. All four residents are cognitively impaired and were unable to recall who drank the nutritional supplement containing the medications.

RPN #122 indicated to Inspector #554, at the time it had been the practice to leave medications in supplements with PSW to give to residents.

RCC #104 indicated to Inspector #554, being aware of the medication incident. RCC indicated being in the LTCH and being called to come to the RHA where the incident occurred. RCC #104 indicated RPN #122 indicated preparing the medication for resident #031 according to physician's orders; RPN #122 indicated putting the physician two identified medications into a supplement, and leaving the medication with a PSW to administer to resident #031. RCC #104 indicated that RPN #122 indicated that leaving nutritional supplements containing medications with PSWs had been the practice in the home.

The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. [s. 131. (3)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for resident #016, sets out the planned care for the resident.

Related to resident #016:

During stage one of the RQI, the use of a specified device by resident #016 was triggered as a potential restraint.

A review of clinical records for resident #016 indicated the resident was admitted to the home on an identified date with multiple diagnoses that affects cognition and mobility.

During observations on two identified dates, Inspector #570 observed resident #016's bed with specified device in use.

In an interview with Inspector #570, the resident indicated that they use the specified device to assist them to get up. The resident further indicated that they have been using the device for transfer since they were admitted to the home.

The current written plan of care for resident #016 was reviewed by Inspector #570. The plan of care review did not indicate that the resident used the specified device.

During an interview, PSW #125 indicated to Inspector #570 that resident #016 had a specified device to assist in transfer out of bed.

During an interview, RPN #114 indicated to Inspector #570 that resident #016 had a specified device to assist in bed mobility. RPN #114 confirmed to Inspector #570 that the use of the specified device was not included in resident #016's plan of care.

During an interview, the resident care coordinator RCC #104 indicated to Inspector #570 that it is an expectation that when specified devices are used by a resident, they should be included in the resident's written plan of care.

The licensee did not ensure that the written plan of care for resident #016 set out the planned care for the resident, specific to the use of a specified device. [s. 6. (1)]

2. The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for resident #039.

Related to Resident #039:

Resident #039 was observed, by Inspector #554 to have unclean hands and nails on nine different dates. Resident's nails were heavily soiled with brownish debris.

Resident #039 was observed eating independently in the dining room on three occasions, resident's nails were observed soiled with brownish debris.

The written plan of care indicated that resident #039 is cognitively impaired, and is dependent on staff for extensive assistance with hygiene, bathing and toileting. Resident #039 is able to eat independently with supervision. The goals of care include that resident is to be clean.

Progress notes provided details of resident #039 exhibiting an identified responsive behaviour related to hygiene on three different occasions.

The written plan of care for resident #039 does not include planned care related to nail care for the resident, nor does it provide planned care related to identified responsive behaviour.

RPN #112 indicated to Inspector #554, that resident is known to have a specified responsive behaviour and will end up to have unclean hands.

PSW #157 indicated to Inspector #554, that resident #039 is dependent on staff for hygiene, bathing and toileting. PSW #157 indicated that residents routinely receive nail care with their baths twice weekly, and that resident's nails are not cleaned by staff during morning care, bedtime care and or prior to meals. PSW #157 indicated being aware that resident #039 has a specified responsive behaviour that would soil their hands.

The licensee failed to ensure that there was a written plan of care for resident #039 that sets out the planned care for the resident, specifically related to nail care, and an identified responsive behaviour. [s. 6. (1) (a)]

3. The licensee failed to ensure that the care set out in the plan of care had been

provided to resident #034 as specified in the plan, specifically related to toileting and continence care and bowel care management.

Related to Intake #002181-18:

RCC #104 submitted a Critical Incident Report (CIR) to the Director, on identified date and time, specific to an alleged incident of neglect of care involving resident #034.

The clinical health record for resident #034 was reviewed by Inspector #554, the following was documented:

On identified date, a progress note, written by RN #140, indicated that resident #034 was found by PSW on a toileting device at specified time. PSW's working during that time, indicated that they had not placed resident #034 on the toileting device. PSWs indicated being unaware of how long resident #034 had been on the toileting device, and indicated that the previous shift left their assigned shift at identified date and time. Resident #034 had no recall of the incident. Resident #034 was assessed, by RN #140, to have no injury.

The written plan of care for resident #034 directs the following:
- Toileting – resident #034 requires assistance of staff to get onto and off of a toileting device, provision of hygiene, continence product changes, clothing adjustments related to physical limitations. Interventions include, total dependence on staff; resident uses a specified toileting device.
RN #140 indicated, to Inspector #554, that they interviewed all three PSWs working on a specified shift on identified date, and that all PSWs indicated they had not assisted resident #034 onto the specified toileting device that shift. RN #140 indicated resident #034 had been placed onto the specified toileting device by previous shift PSWs and that staff from the previous shift had not communicated that resident was on the specified toileting device. RN #140 indicated that resident #034 had been left on the specified toileting device for an identified period of time.

The ED indicated, to Inspector #554, that during the licensee's investigation it was determined that a PSW from previous identified shift on identified date, had left resident #034 on the specified toileting device. The ED indicated PSWs are to communicate when a resident is on a specified toileting device, if they (the staff) are leaving their assigned shift so the next shift's staff can provide assistance to

the resident. ED indicated resident #034 is dependent on staff to get onto and off of the specified toileting device.

The licensee has failed to ensure that the care set out in the plan of care had been provided to resident #034 as specified in the plan, specifically related to toileting and continence care and bowel care management. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care for each resident, sets out the planned care for the resident and that the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with its "Monthly Weights" policy, a part of the Nutrition and Hydration Policy.

Under Ontario Regulations. 79/10, s. 68 (2) (c) every licensee of a long-term care home shall ensure that the nutrition and hydration programs include a weight monitoring system to measure and record residents weight with respect to each resident.

According to the licensee Policy "Monthly Weights," part of the nutrition and hydration policy, with effective date of January 12, 2012, reviewed on June 2018, the policy states:
- All residents are to be weighed monthly by the Health Care Staff on the first bath day of the month.
- If a resident has lost or gained 2.5 kg over a month, a re-weigh must be obtained by the Health Care staff immediately or within 48 hours.
- All residents' weights are to be entered in 'kilograms' into Point Click Care under the 'Weights and Vitals Tab' by the 10th of the month by the Nurse Clerk.
- Once the weights have all been entered, the Consulting Dietitian will review the weight exceptions on Point Click Care. The Consulting Dietitian will follow up with all Residents who have lost or gained a significant amount of weight.
- Determining, taking action and documenting weight variance concerns is the responsibility of the multidisciplinary care team including the FNM, Registered Nursing Staff and the Consulting Dietitian.
- The Registered Nursing Staff are responsible for weighing all residents by the 10th of the month and will enter the weights into Point Click Care. The Consulting Dietitian must follow-up on all Residents with a weight variance.
- Any weight change (up or down) of 2.5 kg must be re-weighed and entered into Point Click Care. The initial weight is struck out and the new weight recorded.
- All weight exceptions must be cleared by the end of the month by the Consulting Dietitian.

Related to resident #010:

During stage one of the Resident Quality Inspection (RQI), resident #010 was identified for no plan low body mass index (BMI).

During a review of the health records conducted, by Inspector #570, the following was documented for resident #010's weights entered into Point Click Care (PCC):
- On identified date, recorded weight indicated a weight difference of -8.7% over one month period, compared to previous month weight. The records review did not indicate that resident #010 was re-weighed following the identified weight

variance over the one month period.
- On identified date, the following month, recorded weight indicated a weight difference of 12.4% over one month period. The records review did not indicate that resident #010 was re-weighed following the identified weight variance over the one month period until three weeks later.
- On identified date, two month after above date, recorded weight indicated a weight difference of -6.5% over one month period. The records review did not indicate that resident #010 was re-weighed following the identified weight variance over the one month period.

During an interview by Inspector #570, RPN #114 indicated that all residents' weight should be taken and entered in PCC by the 10th of each month. If there is a weight difference of 2.5 kg, then the resident is to be reweighed within 48 hours. The RPN indicated that resident #010 should have been reweighed when the resident's weight dropped in identified month.

During an interview by Inspector #570, the Registered Dietitian (RD) indicated that resident #010 had a weight change and remains within their adjusted body weight (ABW) range of identified range. The resident was receiving a nutritional intervention to augment or boost their intake. The RD further indicated the resident should have been reweighed when their weight changed by an identified weight variance, immediately and their weight recorded by the first week of the month.

During an interview by Inspector #570, the resident Care Coordinator (RCC) #104 indicated to Inspector #570 that residents' weights are done from the 1st day to the 10th day of every month; PSW staff are to take residents' weights; if they see 2.5 kg gain or loss they have to reweigh the resident immediately; furthermore, the RPNs are to input the weights into PCC and if they see a weight variance of 2.5 kg (gain or loss) they should request a reweigh. Upon review of the resident #010's weight history, the RCC indicated that the resident should have been reweighed when their weight dropped in two identified months.

The licensee did not ensure that the "Monthly Weights" Policy had been complied with when resident #010 was not reweighed when the resident had a weight variance over 2.5 kg had over a one month period. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to Skin and

Wound Care Program.

Pursuant to O. Reg. 79/10, s. 50 (1) - The skin and wound care program must, at a minimum, provide for the following, the provision of routine skin care to maintain skin integrity and prevent wounds; strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents; strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids; and treatments and interventions, including physiotherapy and nutrition care.

The licensee's policy, 'Skin and Wound Program' (dated March 2018) indicated that each home will implement a quality, standardized program of skin and wound care management through a collaborative interdisciplinary approach based on best practice guidelines. The Skin and Wound Program directs the following:

PSW Staff will:
- Observe for skin integrity issues during resident care, including bath time and report any issues to registered nursing staff.

Related to resident #009:

Resident #009 was observed, by Inspector #554, to have altered skin integrity on identified date and time. Resident's identified body part has an area of altered skin integrity measuring approximately 5cm, the area surrounding the area was red.

Resident #009 indicated to Inspector #554, having just returned from a tub bath. Resident #009 could not recall any injury to a specified body part.

RN #100, who is the Lead for the Skin and Wound Care Program, indicated to Inspector #554, being unaware of resident #009 having an altered skin integrity. RN #100 indicated resident #009 is dependent on staff for activities of daily living due to both cognitive and physical limitations.

The clinical health record, for resident #009, was reviewed. The clinical health record failed to document resident #009 as having an identified problems with altered skin integrity over the past two weeks. Point of Care (POC) documentation, which is part of the clinical health record, identified that resident

#009 was bathed that morning of identified date. There is no documentation by PSWs as to resident having altered skin integrity.

The written care plan identifies that resident #009 requires extensive assistance of staff for personal hygiene, bathing and dressing.

On an identified date and time, RN #100 documented, in a progress note within the clinical health record, that the SDM for resident #009 was notified of resident's altered skin integrity. RN #100 documented that the SDM indicated visiting four days earlier and observed resident's identified body part to have an altered skin integrity. SDM indicated resident #009 indicated 'bumping their body part on a wheelchair'.

PSW #117 indicated to Inspector #554, that any altered skin integrity is to be immediately reported to registered nursing staff so that assessment and treatment can be initiated.

RN #100 indicated that the PSW who had completed resident #009's bath on the morning of identified date as well as PSWs who had completed morning and bedtime care should have communicated the altered skin integrity so that resident could be assessed by registered nursing staff, a treatment initiated and residents SDM could be notified of a change in resident's health condition.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to Skin and Wound Care Program. [s. 8. (1) (b)]

3. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to medication management systems.

Pursuant to O. Reg. 79/10, s. 114 (1) - Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Pursuant to O. Reg. 79/10, s. 114 (2) - The licensee shall ensure that written policies and protocols are developed for the medication management system to

ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee's policy, 'Diabetes/Hyper/Hypoglycemia' (dated July 2010) indicates that hypoglycemia is defined by The Canadian Diabetes Association (CDA) as a blood glucose (blood sugar) of less than 4.0 mmol/L or the development of autonomic or neurogylcopenic signs and symptoms and/or symptoms which respond to the administration of a carbohydrate.

The licensee's procedure, 'Algorithm for Management of Hypoglycemia' indicated:

If a resident's blood sugar is less than 4.0 mmol/L or showing one or more signs and symptoms of hypoglycemia the following is directed:

If conscious and blood sugar is under 4.0 mmol/L give 15 grams of carbohydrate:
- 3 packages of sugar dissolved in water OR 175 millilitres (mLs) of juice or regular pop (3/4 cup) OR 4 dextrose tablets OR 1 dextrose gel (15 mL) * (*use for swallowing difficulty).
- Retest blood glucose in 15 minutes. If blood glucose is less than 4.0 mmol/L then give another 15 grams of carbohydrate.
- If blood glucose is above 4.0 mmol/L and next meal is less than an hour away, set up next meal as soon as possible and document intake. If next meal is more than an hour away given protein plus carbohydrate snack (1 slice of bread with peanut butter, or 6 crackers and 1 ounce (oz) of cheese, or ½ (half) a sandwich, or 1 pudding cup, or 1 muffin with 1 oz of cheese, or 125 mL of Resource. Notify the Physician/Prescriber/Registered Dietician/Pharmacist.

If conscious and blood sugar is less than 2.8 mmol/L give 20 grams of carbohydrate:
- 4 packages of sugar dissolved in water OR 250 mL of fruit juice or regular pop OR 5 dextrose tablets OR 1 dextrose gel (15 mL)*.
- Retest blood glucose in 15 minutes. If blood glucose is less than 4.0 mmol/L then give another 15 grams of carbohydrate.
- If blood glucose is above 4.0 mmol/L and next meal is less than an hour away, set up next meal as soon as possible and document intake. If next meal is more than an hour away given protein plus carbohydrate snack (1 slice of bread with peanut butter, or 6 crackers and 1 ounce (oz) of cheese, or ½ (half) a sandwich, or 1 pudding cup, or 1 muffin with 1 oz of cheese, or 125 mL of Resource. Notify

the Physician/Prescriber/Registered Dietician/Pharmacist.

RCC #128, DOC (former), ED and the Director of Regional Operations indicated to Inspector #554, on identified dates, that all registered nursing staff have been provided education regarding the management of hypoglycemia and are aware of the 'Algorithm for Management of Hypoglycemia' which was developed and implemented as a result of a Compliance Order (CO) dated March 19, 2018.

Related to Intake #007888-18:

A Compliance Order (CO) was issued to the licensee on March 19, 2018, under Inspection Report #2018_591623_0003 and pursuant to O. Reg. 79/10, s. 114 (1). Compliance was due by June 18, 2018. Compliance with O. Reg. 79/10, s. 114 was identified by Inspector #554 during this Resident Quality Inspection (RQI).

While inspection upon the licensee's compliance with the CO pursuant to O. Reg. 79/10, s. 114, Inspector #554 identified the following documented in the clinical health record for resident #003.

The physician's order for resident #003 directs:

- Identified medication, two specified doses to be administered at two identified times daily. Hold if a specified test is below specified target and call physician. (Note: this physician's order was discontinued on identified date)

- Other identified medication, to administer a specified dose three times daily before eating. Hold if resident refuses to eat. (ordered on a specified date).

- Identified medication, administer (identified dosage) at identified time. ordered on a specified date).

- Identified medication, administer as directed for specified symptoms and notify physician after the medication has been given or if you are unsure if it should be administered.

Progress Notes:

- On identified date and time, RPN #155 documented that resident #003's results

of a specified test were identified and the resident was lethargic but responsive to verbal and physical stimuli. Resident was given a specified medication with a large glass of juice. RN #162 attempted to give resident more juice and specified medication but resident refused. Specified test was done and the prescribed medication was held and not administered to resident #003 during the morning of identified date. Documentation in the health record indicated that the physician was notified of the specified symptoms incident during physician rounds later that morning.

- On identified date and time, resident #003's specified test was done, resident refused juice and was given 1 package of honey by RN #162. Specified test was redone and the resident given 1 package of honey; specified test was redone after specified period of time. The eMAR indicated that the physician prescribed identified medication was held and not administered to resident #003 at specified date and time. There is not documentation to support that the physician for resident #003 was notified of the specified symptom incident.

- On identified date and time, resident #003's specified test was done and the resident given a large glass of juice, two packets of honey, and a specified medication by RPN #155. Resident's specified test was redone and the resident was given a specified medication. Resident's specified test was redone at three different times. Resident's specified medication was held at specified time. Documentation, by another registered nursing staff, at identified time indicated resident #003's specified test was done and the RN administered orange juice with one honey package, resident took only a quarter of the glass of the juice. Resident was administered a specified medication but did not finish it either. Resident became physically and verbally aggressive with RN. Staff to monitor. There is no documentation to support that the physician for resident #003 was notified of the specified symptoms incident.

- On identified date and time, resident #003's specified test was done, RN #162 indicated that resident refused a glass of orange juice. Resident #003 was administered two packages of honey by registered nursing staff. Resident's specified test was redone at specified time. Resident refused to go for meal. There is no documentation to support that the physician for resident #003 was notified of the specified symptoms incident.

- On identified date and time, resident #003's specified test was done. The resident refused to have juice and was given chocolate milk by registered nursing

staff. Resident's specified test was redone. RN #100 documented that the Nurse Practioner was notified of resident's specified tests results.

Registered Nurse #100 indicated to Inspector #554, awareness of the Algorithm for Management of Hypoglycemia. RN #100 indicated that if a resident is hypoglycemic, registered nursing staff are to follow the algorithm, retake the resident's blood sugar in 15 minutes and repeat the procedure directed in the algorithm as indicated. RN #100 indicated that the physician is to be notified of individual resident's experiencing hypoglycemic incidents, indicating that registered nursing staff notify the physician by placing a note of the incident in the physician's binder and the physician reviews the binder during weekly rounds.

Registered Practical Nurse #155 indicated to Inspector #554, awareness of the Algorithm for Management of Hypoglycemia. RPN #155 indicated that if a resident is hypoglycemic, registered nursing staff are to follow the algorithm, retake the resident's blood sugar in 15 minutes and repeat the procedure directed in the algorithm as indicated. RPN #155 indicated that the hypoglycemic incident is reported to the Charge-RN by the RPN and the RN would determine if a call to the physician is required.

Inspector #554 reviewed documentation in the clinical health record, with RPN #155, for two identified dates. RPN #155 indicated adding honey to the orange juice is to sweeten it. RPN #155 indicated that adding honey to the orange juice is not a procedure indicated in the licensee's Algorithm for Management of Hypoglycemia, but is a method used by registered nursing staff in the home when dealing with incidents of hypoglycemia.

RCC #128 indicated to Inspector #554, that if a resident is assessed, by registered nursing staff, to be hypoglycemic, the nurse is to follow the Algorithm for Management of Hypoglycemia. RCC #128 indicated that registered nursing staff are to administer one of the carbohydrates indicated in the algorithm not all of them.

The Medical Director, who is also the Attending Physician for resident #003, indicated to Inspector #554, that the Algorithm for Management of Hypoglycemia was developed to direct registered nursing staff on how to manage incidents of hypoglycemia. The Physician indicated it is an expectation that registered nursing staff will follow the algorithm and physician's orders when managing residents experiencing hypoglycemia. The Physician indicated frustration that Algorithm for

Management of Hypoglycemia, as well as the physician's orders are not being followed consistently by all registered nursing staff working within the LTCH, indicating 'unsure how much more clear it can be'.

Director of Regional Operations indicated to Inspector #554, that registered nursing staff are to follow the Algorithm for Management of Hypoglycemia and indicated that they are to administer only one of the carbohydrates indicated in the algorithm not all of them.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, related to medication management systems, specifically the Algorithm for Management of Hypoglycemia. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the licensee's policies on monthly weights, medication management systems and skin and wound program are complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict access to those areas by residents, and are locked when they are not being supervised by staff.

During the initial tour of the long-term care home, Inspector #554, observed the following:

- An open door leading to a room, the room appeared to be a storage/laundry/office space. The room was adjacent to kitchen and the dining area in an identified wing (residential home area). The room was observed to contain laundry carts, mattresses, storage cupboards, tools, electrical cords, a caulking gun and caulking, boxes, a desk and a computer. The door handle on the door, of the room, had no visible locking mechanism. Staff were not observed to be present in the identified room, nor in the dining room. A resident was observed in the identified room during this observation.

Dietary Aide (DA) #107 indicated to Inspector #554, that the room (identified above) was a 'free for all storage space'. DA #107 indicated that the room is not considered a resident accessible area. DA #107 indicated that the room is used for storage, and is also an office space for the ESM. DA #107 indicated that the door to the room is always open.

RPN #112 and RN #100 indicated to Inspector #554, that the identified room adjacent to the dining room on an identified wing, is a storage space and used as an office for the ESM. Both indicated that the room is not considered a residential area, but some residents have been known to wander into the room when they enter the dining room during meal times. RN #100 indicated that the door to the room is never closed and/or locked.

The ED indicated that the room, identified by Inspector #554, is not a resident accessible space, and indicated that the room is used for storage and the ESM's office. ED indicated being uncertain as to why the door was not closed, and indicated further not knowing why the door had no locking mechanism. ED indicated being aware that non-residential

Upon further observations on six different occasions, the door to the identified room was observed open and unlocked. Residents were observed, by Inspector #554, entering the unlocked room on four occasions. No staff were present during these observations.

The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict access to those areas by residents, and are locked when they are not being supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are equipped with locks to restrict access to those areas by residents, and are locked when they are not being supervised by staff, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opens to the outdoors is accessible to residents has a screen and cannot be opened more than fifteen centimeters.

On an identified date, Inspector #554 observed the following:

- Identified Resident Room – one of the two windows in this resident room was observed open to the outside. The measurement of the window opening was measured to be twenty-five centimeters. The screen on this window was observed loose, bent and extended beyond the window frame to the outside approximately one inch.
- Identified Resident Room – one of the two windows in this resident room was observed open to the outside. The measurement of the window opening was measured to be approximately eighty centimeters. The screen on this window was observed hanging from the open window, duct tape was observed on the framed edge of the screen.
- Identified residents common area lounge– three windows in this room were observed to have no screens, all three windows were observed open approximately ten centimeters.

The two identified residents' rooms, as well as residents' common area lounge are located on an identified wing (resident home area) within the LTCH.

Residents, including resident #039 were observed in the vicinity of the hallways were the opened windows and/or windows without screens were observed.

RPN #122 indicated to Inspector #554, that there are two residents residing in the long-term care home (LTCH) that are known to exit seek, one resident being resident #039. RPN #122 indicated having no awareness that the windows in two identified resident rooms were of concern. RPN #122 indicated being unaware why the windows in the residents' common area lounge had no screens. RPN #122 indicated being unaware of the legislative requirement for window openings and or necessity of screens.

The maintenance binder at an identified wing was reviewed by Inspector #554. The review, of the maintenance binder, failed to identify that the window opening for the window in two identified resident rooms were an area identified as a

concern, nor was there documentation to indicate that three window screens in the common area lounge were not on the windows. The maintenance binder did identify that the screens on the windows in the common area lounge were bent, and indicated further that a 'resident had tried to escape' from the windows, this entry was written by HSK #158.

ESM indicated to Inspector #554, not being aware that the windows in two identified resident rooms opened beyond the legislated requirement. ESM indicated that there are locking mechanisms on the windows but 'staff and families are rough when opening the windows and have been known to bend or break the locking mechanism'. ESM indicated that windows are checked by themself every other month. ESM indicated reliance on staff to alert them that there is an issue. ESM indicated that the screens in the common area lounge had been removed as the screens were bent and new ones had to be made. ESM indicated that the screens are normally on all windows in the home.

The ED indicated to Inspector #554, that it is an expectation that windows in the long-term care home meet legislative requirements specific to the window opening and that windows are to have screens.

Windows, within the common area lounge, were observed to be open, and without screens during observation son four different dates.

The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than fifteen centimeters. [s. 16.]

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 window in the home that opens to the outdoors is accessible to residents has a screen and cannot be opened more than fifteen centimeters, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee' policy, Use of a Sit Stand Lift (SSL)' (dated May 2018) directs that when using a SSL with a resident, two staff members are required. The policy further directs the staff are to detach sling, from the SSL, and remove the lift, once the resident is lowered and appropriately positioned.

RCC #104, who is the Lead for the Falls Prevention Program, indicated, to Inspector #554 on August 09, 2018, that policy that directs that 'two staff are required for all mechanical lifts', as well as the mention in the policy that 'residents are not to be left attached to mechanical lifts' while on the toilet has been in place prior to starting their position in 2015.

Related to Intake #000667-18:

The ED submitted a Critical Incident Report (CIR) on identified date and time specific to an alleged staff to resident neglect involving resident #032. The alleged incident occurred on a specified date and time.

The following is documented on the CIR:

A PSW found resident #032 sitting on the toilet at identified time, attached to a

transfer device. Resident #032 had been left on the toilet by staff of identified shift until that shift was concluded at identified time.

The clinical health record, reviewed for the dates of identified period, identifies that resident #032 is cognitively impaired, requires extensive assistance for all activities of daily living, is transferred and toileted by two staff using a specified device, and that resident is at known risk for falls.

RN #140 indicated, to Inspector #554, being the assigned Charge Nurse on the date of the incident. RN #140 indicated that the alleged neglect incident involving resident #032 had been reported by a RPN at specified time. RN #140 indicated that resident #032 was found on the toilet, attached to a transfer device and that resident #032 had no call bell within their reach. RN #140 indicated that staff who discovered the resident had not placed resident #032 onto the toilet. RN #140 indicated that resident #032 should not have been left on the toilet, and should not have been left attached to a transfer device while on the toilet. RN #140 indicated that the incident placed resident #032 at risk of harm.

RCC #104 indicated the incident, on identified date had been investigated and concluded that not only was resident #032 left on the toilet with the transfer device attached by staff from the previous shift, and without a call bell within the resident's reach, but further indicated that during the investigation it was found that PSW #142 had transferred resident #032 onto the toilet using a transfer device without the assistance of second staff. RCC indicated that PSW #142's actions placed resident #032 at risk of harm.

The ED indicated, to Inspector #554, that PSW #142 actions, not only constituted neglect of care, but also failure of PSW to follow safety in transferring a resident.

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, specifically resident #032.

2. Related to Intake #004983-18:

A RCC submitted a Critical Incident Report (CIR) on identified date and time specific to an alleged staff to resident neglect involving resident #032. The alleged incident occurred on identified date and time (Note: This is the second incident of a similar nature involving resident #032. Reference Intake #000667-18)

The following is documented on the CIR:

A PSW found resident #032 sitting on the toilet at specified time, attached to a transfer device. Resident #032 had been left on the toilet by staff on specified shift. Resident #032 was assessed to have redness to their skin as a result of this incident.

The clinical health record, reviewed for specified period, identifies that resident #032 is cognitively impaired, requires extensive assistance for all activities of daily living, is transferred and toileted by two staff using a transfer device, and that resident is at known risk for falls.

RN #140 indicated, to Inspector #554, that they were the assigned Charge Nurse of specified date. RN #140 indicated that the alleged neglect incident involving resident #032 had been reported by a PSW at specified time. RN #140 indicated that resident #032 was found on the toilet, attached to a transfer device. RN #140 indicated that staff who discovered the resident had not placed resident #032 onto the toilet. RN #140 indicated that resident #032 should not have been left on the toilet, and should not have been left attached to a transfer device while on the toilet. RN #140 indicated that the incident placed resident #032 at risk of harm.

RCC #104 indicated the incident, had been investigated and concluded resident #032 was left on the toilet with a transfer device attached by staff from specified shift. RCC indicated staff actions had placed resident #032 at risk of harm.

ED indicated, to Inspector #554, that the actions of an evening PSW, not only constituted neglect of care, but also failure of a PSW to follow safety in transferring a resident.

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, specifically resident #032. [s. 36.]

3. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee' policy, Use of a Sit Stand Lift (SSL)', and 'Use of a Total Lift' (both reviewed May 2018) direct that residents may NEVER be transported from one area of the home to another in any mechanical lift. The policies direct that two staff must be present when using a mechanical lift.

Related to Resident #033:

On specified date and time, Inspector #554 observed PSW #129 pushing a transfer device down a corridor on specified wing with resident #33 sitting on the transfer device. A second staff was not observed to be present during this observation. This observation was reported to RCC #104.

Resident #033 did not sustain injury as a result of the actions of PSW #129.

RN #100, who was the Charge Nurse, indicated, to Inspector #554, that staff are expected to have two staff present when using and operating a transfer device. RN #100 further indicated that staff are not to transport residents down corridors using a transfer device.

RCC #104, who is the Lead for the Falls Prevention Program, as well Staff Educator for the long-term care home (LTCH), indicated, to Inspector #554, that all staff are aware that residents are not to be transported throughout the LTCH using any transfer devices.

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents have their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within forty-eight hours of admission and in the case of new items, of acquiring.

During the initial tour of the long-term care home (LTCH), the following was observed, by Inspector #554:

Identified wing, resident home area (RHA):

- Tub-shower room – five sets of nail clippers, and a brush were observed in an open cupboard in the room. The items were observed used, and all were unlabeled, on three different dates.
- A bag of personal care items, including shampoo, conditioner, body wash, combs and brushes were observed on the floor, adjacent to the shower. The bag and the items were used and unlabeled.

Other identified wing, RHA:

- Tub room – two brushes, a hair pick, a comb and a set of nail clippers were observed lying on a shelf adjacent to the tub. The items observed were used, and all were unlabeled, on three different dates.

Further Observations, by Inspector #554:

- Identified resident room – a comb was observed on the counter-top vanity in the washroom. The comb was unlabeled. Resident #001 was unable to identify if the comb belonged to them.
- Identified resident room – a comb was observed on the counter-top vanity in the

washroom. The comb was unlabeled. Resident #003 was unable to identify if the comb belonged to them.
- Identified resident room – a comb was observed on the counter-top vanity in the washroom. The comb was unlabeled. This is a shared resident room. When asked, by Inspector #554, resident #007 was unable to identify who the comb belonged to.
- Identified resident room – a brush and a denture cup were observed on the counter-top vanity in the washroom. The items were observed unlabeled and used. This is a shared resident room. When asked, by Inspector #554, resident #008 was unable to identify who the items belonged to.

PSW #117 and PSW #121 indicated, to Inspector #554, that personal care items, such as combs, brushes nail clippers and denture cups, are to be labeled for individual resident use. PSW #117 and PSW #121 indicated personal care items are to be labeled on admission and when resident receives a new one. PSW #117 indicated that normally night PSW's check to ensure items are labeled.

RN #100, as well as Resident Care Coordinator (RCC) #104 indicated that personal care items are to be labeled for individual use. Both indicated that personal care items are to be labeled on admission, and as resident receives a new item.

RCC #104 indicated that staff have been reminded, on more than one occasion in staff meetings, about labeling of personal care items and new items such as combs, brushes and nail clippers are to be labeled.

The licensee has failed to ensure that residents have their personal items labelled within forty-eight hours of admission and in the case of new items, of acquiring. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents have their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within forty-eight hours of admission and in the case of new items, of acquiring, to be implemented voluntarily.

WN #13: 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 procedures are developed and implemented for addressing incidents of lingering offensive odours.

The licensee's policy, 'Odour Control' (dated January 2010) indicates that 'every reasonable effort to provide an environment free of unpleasant odours'. The policy indicates:
- Control of odours are dependent on the co-operative effort of all departments. Nursing staff will ensure optimum resident hygiene practices, promptly upon discovering that a resident has been incontinent. The initial clean-up of soiled floors will be undertaken by the nursing staff.
- Provision of air fresheners in areas particularly affected by odour is the responsibility of the housekeeping staff.
- Use of disinfectant cleaning agents will control the growth of odour causing organisms.
- Ensure toilets are flushed.
- Ensure lids are placed on laundry hampers and soiled garbage bins, and store them in the soiled utility room.

During the initial tour of the long-term care home, offensive odours were detected,

by Inspector #554, in the following areas of the home:

- In one identified wing resident home area (RHA) communal resident washroom. The odour in this room was indicative of 'urine'. In identified hallway outside of three identified resident rooms, the odour resembled the smell of urine.
- In other identified wing RHA communal resident washroom, located adjacent to the dining room; shower room, the odour in this room was similar to a sewage like odour. Tub room, the odour in this room was fecal like. Inspector #554 noted a continence product in the waste receptacle in the tub room. The waste receptacle did not have a lid.

During resident interviews and room observations lingering offensive odours were detected in three identified resident rooms/washrooms over two dates at multiple times.

Additionally lingering offensive odours, strongly resembling 'urine' were identified to be present on twelve different dates, throughout the day in the following areas:
- Identified wing RHA communal resident washroom, located in one specified hallway and outside of two identified resident rooms in other specified hallway.
- Five identified resident rooms/washrooms. The flooring in the washroom of identified resident room was laden with staining around the toilet during all identified dates.

HSK #119 and HSK #120 indicated to Inspector #554, that resident rooms and communal resident areas are cleaned daily. Both HSKs indicated that if odours are detected then they will try to determine where the odour is emitting from. HSK #119 and #120 both indicated that odours in the home are normally due to nursing staff leaving soiled continence products in waste receptacles in the room, from nursing staff or residents not flushing the toilets, and from nursing staff leaving urine on the floors in resident rooms. HSK #119 and HSK #120 indicated they will use a 'spray' air freshener if odours are detected but such is a short term solution to resolving odours. Both indicated, that at times, the ESM will purchase air freshening sponges for problematic rooms but such are not always available for use.

HSK #120 indicated that the odour in identified wing RHA shower room is 'believed' to be coming from the drain in the floor of the shower room. HSK #120 indicated that the odour is a long-standing issue. HSK #120 indicated that when they notice the odour becoming bad, they (the HSK) will notify the ESM and the

ESM will pour hot water down the drain. HSK #120 indicated that not noticing that the shower room had a lingering offensive odour during the past few days.

HSK #119, who routinely works in an identified wing RHA, indicated being unaware of any lingering offensive odours within resident rooms or common areas of the identified wing. HSK #119 indicated that they may have not noticed the lingering offensive odours in the identified wing RHA communal washroom, or in identified five resident rooms as they become accustomed to the odour.

HSK #108, who routinely works in identified wing RHA, indicated to Inspector #554, that the odour in three identified resident rooms is an issue and indicated that daily cleaning and use of spray air fresheners has not been effective in controlling the lingering offensive odour.

Another staff member indicated that the lingering offensive odours are present daily in four identified resident rooms as well in the identified wing RHA communal resident washroom.

ESM indicated, to Inspector #554, that they are aware that there are lingering offensive odours within the LTCH. ESM indicated that odours are generally related to resident hygiene, nursing staff leaving soiled continence products in waste receptacles or nursing staff not cleaning up urine spill as they occur. ESM indicated being aware of lingering offensive odours in three identified resident rooms. ESM indicated the following:
- Identified resident room - 'believes there is a drain problem with the toilet', and indicated that there is currently no plan in place to address the drain issue, and indicated that the flooring in the room most likely needs replacing to.
- Identified resident room – the odour in the room has been an ongoing issue for some time. The flooring in the room was replaced last year, resident continues to spill urine from their catheter bag onto the floor, and nursing staff leave the urine on the floor for housekeeping staff to clean up. ESM indicated that it was their belief that the flooring in the washroom again needs replacement, but indicated that there is no plan in place at this time for flooring replacement.
- Three identified resident rooms and the communal identified wing washroom – indicated not being aware of an odour problem in these rooms.
- In other identified wing RHA shower room – believes the odour to be a drain problem. ESM indicated they will pour warm water down the drain, if told by staff that the odour has returned.

ESM indicated that they will occasionally purchase air freshening sponges to mask odours in resident rooms and common areas, but indicated that they have not purchased them in a while. ESM indicated that they could reach out to a contracted supplier to see if there is a chemical to reduce or eliminate odours within the LTCH, but has not done this as this time.

The licensee has failed to ensure that procedures are implemented for addressing incidents of lingering offensive odours, specifically in five identified resident rooms and the communal washroom and shower room in identified wings. [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 procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or the operations of the home, that the complaint is investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint and where the complaint alleges harm or risk of harm to one or more residents that an investigation commences immediately.

Related to Intake #005013-18:

Resident #035 was admitted to the long-term care home (LTCH) in an identified date. Resident has a medical diagnosis which includes cognitive impairment.

Substitute Decision Maker (SDM) for resident #035, indicated to Inspector #554, submitting a written complaint to the ED's Assistant on identified date. SDM indicated that concerns raised were related to the care of resident #035 and the operations of the long-term care home. SDM indicated that one of the concerns mentioned in the letter of complaint was that resident #035 was missing two identified personal properties that were in the possession of resident #035 when resident was admitted to the LTCH. SDM indicated that both of the items went missing after on an identified date. SDM indicated that 'no attempt had been made to locate the missing items'. SDM indicated not being told of the licensee's investigation specific to the missing items, and was only told the process to follow if a resident had lost clothing and or property.

The ED indicated to Inspector #554, that a written letter of complaint was received from the SDM for resident #035 on identified date. The ED indicated that the ED Assistant had received the initial written complaint and had in turn forwarded the complaint (to ED) the same day. The ED indicated that the written complaint from SDM was related to care of resident #035, as well as concerns specific to the operations of the LTCH.

The ED indicated that one of the concerns mentioned in the letter of complaint was that resident #035 was missing two identified items. The ED indicated not investigating the missing items. The ED indicated response to the complainant on identified date, but that the written response did not include what had been done to investigate the complainant's concerns, and or resolution. The ED indicated interpreted the letter of complaint as an inquiry and in turn communicated to the complainant the licensee's processes around the communication of lost property

and to which manager this information should be directed.

SDM, for resident #035, indicated as of this time, the items remain missing, and unaccounted for.

The licensee failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or the operations of the home, that the complaint is investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint. [s. 101. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or the operations of the home, that the complaint is investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint and where the complaint alleges harm or risk of harm to one or more residents that an investigation commences immediately, to be implemented voluntarily.

WN #15: 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. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.

On identified date and time, Inspector #554 alerted Inspector #570 that resident #038 was sliding in their mobility device with a restraining device applied. Inspector #570 observed resident #038 sliding from their mobility device with restraining device noted above the resident's waist. The resident was repositioned in the mobility device by the Activity Director and another staff and the restraining device was reapplied. During the observation, Inspector #570 noted the resident had a specified restraining device in place while using their mobility device. The restraining device was noted to be loose and not appropriately applied; this observation was confirmed by the Activity Director.

During an interview, the Activity Director indicated to Inspector #570 that resident #038 was not able to undue the restraining device due to cognitive decline.

During an interview, Physiotherapy Assistant (PTA) #163 indicated to Inspector #570 that the restraining device used for resident #038 was loose as they could insert at least three fingers between the resident and the restraining device. The PTA indicated that the resident would not be able to undue the restraining device on command and that the resident always had the restraining device in use.

During an interview, PSW #133 indicated resident #038 had a restraining device to prevent sliding from the mobility device. PSW #133 indicated that they repositioned the resident few times this day as the resident was sliding from their mobility device with the restraining device on; the restraining device was catching the resident's abdomen from preventing them from sliding further. PSW indicated

no awareness of any manufacture instructions regarding the use of the restraining device. PSW indicated that the restraining device should be snug enough that you can slide your hand in and out.

During an interview, RPN #114 indicated resident #038 had a specified device used as a personal assistance services device
(PASD) for positioning in the mobility device; the resident could release the device when asked. The RPN indicated they had no access to manufacturer's instructions pertaining to the use of restraining device and that for instructions regarding the use of restraining device they would refer the resident to the physiotherapist.

During an interview, Physiotherapist (PT) #164 indicated that resident #038 had a specified device used as a PASD. PT indicated the device should be applied around the resident's waist and should be two to three fingers between the resident and device.

A review of the mobility aid manufacturer's manual for the mobility device used by resident #038. The manual was provided to the Inspector by the Executive Director (ED). Page #30 of the manual directed that the positioning device can be adjusted for operator comfort. The positioning device is designed to support the operator so that the operator does not slide down or forward in the seat. To adjust the positioning device for operator comfort:
1. once seated, insert the metal tab on one side of the belt into the plastic housing on the opposite side until you hear a click.
2. Pull the excess strap attached to the metal tab until it is secure, but not so tight to cause discomfort.

During an interview, Executive Director (ED) indicated that the device used by resident #038 is considered as a restraint as the resident was unable to undue the device. The ED confirmed that the restraining device used by resident #038 was not applied as per manufacturer instructions as noted in the mobility device manual.

The licensee did not ensure that the restraining device used for resident #038 was applied in accordance with the manufacturer`s instructions. [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to Intake #011949-18:

During this inspection, an unidentified family member indicated observing soiled continence products on floors throughout the long-term care home (LTCH) during their visits. Family member could not provide specific dates, but indicated that they have observed soiled continence products on the floors in the hallways during evening and weekend visits.

The following was observed, by Inspector #554:

- On identified date – soiled clothing, towels, washcloth and a soiled continence

product, were observed on the floor outside of two identified resident rooms. Continence products were both observed open, with excrement exposed. Flies were observed flying landing and/or flying off of the continence products in identified wing RHA.
- On identified date – soiled bedding (white sheet), and a soiled continence product was observed on the floor in the communal tub room, which was located on identified wing (resident home area).
- On identified date – soiled clothing, towels, washcloths and a soiled continence product was observed on the floor outside of identified resident room.
- On identified date – three to four soiled washcloths were observed on the floor in the hallway, outside the tub room of identified wing (resident home area).
- On identified date – a soiled continence product was observed on the floor in the communal tub room, which was located on identified wing (resident home area).

PSW #117 and PSW #121 indicated to Inspector #554, that soiled clothing, linens and continence products are not to be put on floors in resident rooms, hallways or in tub-shower rooms. Both PSWs indicated that staff are to utilize linen and waste receptacles.

RCC #104, who is the lead for the Infection Prevention and Control Program, indicated to Inspector #554, that staff are aware that soiled clothing, linens and continence products are not to be placed on the floors as such is unsanitary.

The ED indicated to Inspector #554, that nursing staff have been told in the past not to place soiled clothing, linens and continence products on the floors.

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program, specific to the appropriate handling and/or disposal of soiled clothing, linen and continence products.

2. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program, specific to hand hygiene and use of PPE.

The licensee's policy, 'Hand Hygiene' (dated April 2018) indicates that 'hand hygiene is considered the most important and effective infection prevention and control measure to prevent the spread of health care associated infections'. The policy states that 'all staff are required to participate in the hand hygiene program, and perform effective and safe hand hygiene'.

The Hand Hygiene policy indicates that hand hygiene must be performed at indicated times, including:
- Before initial contact with the resident and before entering the resident`s room
- After care involving contact with body fluids of a resident
- After contact with a resident or items in their immediate surrounding when leaving

On identified date, during identified medication/treatment observation at specified time, on identified wing (resident home area) the following was observed:

- RN #134 was observed performing specified test on resident #041, who's body part continued to bleed following having their specified test. RN #134 assisted resident in controlling the bleeding. RN #134 did not don gloves and or perform hand hygiene before or after this observation. RN #134 was observed performing specified test on residents #027, #037, and #042, following resident #041. RN #134 performed specified test without donning gloves, and or performing hand hygiene before or after resident contact. RN #134 was observed to touch the treatment cart opening and closing drawers, touched resident test devices, touched the computer screen and keyboard at the nursing station, and assisted an unidentified resident in a wheelchair, while performing specified test on the four residents.

RN #134, who is a Charge Nurse, indicated to Inspector #554, that they do not normally don (put on) gloves when performing a specified test. RN #134 indicated being aware that they are in contact with residents bodily fluids, but indicated 'I'm careful'. RN #134 indicated being aware of the need to perform hand hygiene between residents, and indicated that they must have forgotten to perform hand hygiene earlier that day.

RCC #104, who is the lead for the Infection Prevention and Control Program, indicated to Inspector #554, that staff are aware that they are to perform hand hygiene before and after resident contact, and when in contact with bodily fluids. RCC #104 indicated that it would be an expectation that staff use gloves when doing specified test as there is the potential to come in contact with bodily fluids. RCC #104 indicated that all staff in the LTCH have been provided education specific to 'the four moments of hand hygiene' and use of personal protective equipment (PPE).

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program, specific to hand hygiene and use of PPE.

3. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program, specific to personal use equipment.

The licensee's policy, 'Cleaning Guidelines-Personal Use Equipment' (dated April 2018) indicated that bedpans, basins, and urinals will be reserved for use by a single resident. The policy states that on admission, appropriate residents will be given a urinal or bedpan for use. Bedpans and urinals will be labeled and are to be used only for the specified resident. Bedpans and urinals will be cleaned to ensure all debris is removed.

On three identified dates, the following was observed by Inspector #554:

- Identified resident room – a specified toileting device was observed on the floor between the wall and the toilet. The device was observed used, containing brownish residue. This is a shared resident room. The device was not labeled.
- Identified resident room – two specified devices used to promote continence were observed on the floor, adjacent to the toilet. The one device was observed to have residue in the bottom of it. This is a shared resident room. The devices were not labeled.
- Identified resident room – a urine collection device was observed on the back of the toilet, and a toileting device was observed on the floor adjacent to the toilet. Both items had residue in the bottom of them. This is a shared resident room and the items were all unlabeled.
- Identified resident room – a urine collection device was observed on the back of the toilet, on identified date. This is a shared resident room and the item was not labeled.

PSW #117 and PSW #121 indicated to Inspector #554, that toileting devoices are to be removed from resident rooms following use, taken to the soiled utility rooms and cleaned. Both PSW's indicated that toileting devices are not labeled as items are for communal use, but to be cleaned between residents. PSW #117 indicated that urine collection devices are not shared items, but are to be disposed of, in the soiled utility room, following use.

RCC #104 indicated to Inspector #554 that specified toileting devices are not

shared items. RCC #104 indicated being unsure if specified toileting devices are labeled, but indicated that such should be labeled. RCC #104 indicated that specified toileting devices are to be emptied following use, taken to the soiled utility room and cleaned. RCC #104 indicated that toileting devices are not stored in resident rooms and or washrooms, but stored in soiled utility room until required for use. RCC indicated that urine collection devices are not to be stored in resident rooms, especially shared rooms.

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program, specific to personal use equipment. [s. 229. (4)]

Additional Required Actions:

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

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

The licensee's policy, 'Abuse and Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff' (dated February 2018) indicated that Caressant Care believes in and is committed to the prevention of abuse. Caressant Care believes in the provision of a safe environment for residents. Abuse, in any form, is a direct violation of this intrinsic right and will not be tolerated.

The policy directs that all situations of suspected or actual abuse is to be reported

to the Executive Director and/or the Director of Care. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify management staff on call. After receiving notice of the abuse, the DOC/Manager on call will immediately notify the Executive Director.

Related to Intake #026694-17:

RCC #128 submitted a CIR to the Director on identified date, related to a witnessed incident of resident to resident abuse involving resident #036 towards resident #009. The abuse incident occurred on identified date.

The CIR indicated that on an identified date, resident #009 and resident #036 were in an identified common area when resident #036 approached resident #009 and displayed a specified responsive behaviour. The CIR indicated that the responsive behaviour was not consensual.

RPN #114 indicated to Inspector #554, being aware of incident involving resident #009 and resident #036. RPN #114 indicated that resident #009 had indicated that
resident #036 displayed a specified responsive behaviour toward resident #009, which was upsetting and unwelcomed by resident #009. RPN #114 indicated being told of the incident by RPN #160 who witnessed it. RPN #114 indicated being uncertain if RPN #160 had reported the abuse incident to either RCC's, but indicated an RCC would have been working in the LTCH. RPN #114 indicated being aware of the licensee's policy regarding the reporting of abuse. RPN #114 indicated not reporting the abuse incident to a supervisor or management.

RCC #128 indicated to Inspector #554, being unaware of the abuse incident until the following day during morning report.

The ED indicated to Inspector #554, being aware of the abuse incident the next day during morning report. The ED indicated that the abuse incident should have been immediately reported to a supervisor and then to the ED or DOC.

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, specific to the reporting of abuse on November 03, 2017. [s. 20. (1)]

2. The licensee failed to ensure that the written policy that promotes zero

tolerance of abuse and neglect of residents is complied with.

The licensee's policy, 'Abuse and Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff' (dated July 2018) indicates that Caressant Care believes in and is committed to the prevention of abuse and neglect of residents. The policy directs that staff must report situations of suspected or actual abuse to the Executive Director and/or the Director of Care.

The policy, 'Abuse and Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff' directs that all cases of suspected or actual abuse must be reported immediately to the Director of Care and/or the Executive Director. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify management staff on call. The policy directs, that after receiving the notification of abuse, the Director of Care or the manager on call will immediately notify the Executive Director.

The ED indicated that the 'reporting structure' specific to suspected or actual abuse has been the policy and practice of the licensee prior to the policy which is dated July 2018.

Related to Intake #004983-18:

The RCC submitted a Critical Incident Report (CIR) on specified date and time specific to an alleged staff to resident neglect involving resident #032. The alleged incident occurred on identified date and time.

The following is documented on the CIR:

A PSW found resident #032 sitting on the toilet at identified time, attached to a transfer device. Resident #032 had been left on the toilet by the previous shift staff. Resident #032 was assessed to have redness to their skin as a result of this incident.

RN #140 indicated, to Inspector #554, that the alleged neglect incident involving resident #032 had been reported by a PSW at identified time. RN #140 indicated that the incident did constitute neglect of care by staff, and such placed resident #032 at risk of harm. RN #140 indicated reporting the neglect of resident #032 to the On Call Manager on same date. RN #140 indicated being unable to recall who the On Call Manager or the time of the notification. RN #140 indicated not

contacting the Director as registered nursing staff have been directed to call the On Call Manager, and are not permitted to contact the Ministry of Health and Long-Term Care (MOHLTC) directly.

The Activity Director indicated, to Inspector #554 being the On Call Manager on specified date. The Activity Director indicated being contacted by RN #140 as to the alleged neglect of resident #032. The Activity Director indicated being contacted by RN #140 the following day. The Activity Director indicated that RN #140 should have immediately contacted them of the alleged neglect of resident #032. The Activity Director indicated reporting the alleged neglect, of resident #032, to the DOC upon arrival to work.

The ED indicated, to Inspector #554, that abuse and or neglect of residents is to be immediately reported to the management, and in turn the on call manager is to contact the DOC and or the ED.

A Critical Incident Report was submitted to the Director on the following date.

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

3. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The licensee's policy, 'Abuse and Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff' (dated July 2018) indicates that Caressant Care believes in and is committed to the prevention of abuse, and has adopted a policy to promote the zero tolerance of abuse and neglect of residents.

The licensee's policy directs that all cases of suspected or actual abuse/neglect must be reported immediately to the Director of Care (DOC) and/or Executive Director. In the absence of management staff, concerns should be immediately reported to the Charge Nurse, who will notify management on call. After receiving the notice of abuse, the DOC / manager on call will immediately notify the Executive Director.

The ED indicated, to Inspector #554, being unable to locate the licensee's policy, 'Abuse and Neglect – Staff to Resident, Family to Resident, Resident to Resident,

Resident and/or Family to Staff' which was in place prior to identified date. The ED indicated that the licensee's 'practice has always been that the Charge Nurse is to notify the On Call Manager immediately of abuse/neglect of residents'.

Related to Intake #002181-18:

RCC #104 submitted a Critical Incident Report (CIR) to the Director, on identified date and time, specific to an alleged incident of neglect of care involving resident #034.

The clinical health record for resident #034 documents the following:

On identified date and time, a progress note, written by RN #140, indicates that resident #034 was found by PSWs on a specified toileting device. PSWs discovered the resident indicated that they had not placed resident on the toileting device. PSWs from previous identified shift had left their assigned shift at specified date and time. Resident #034 had no recall of the incident. Resident #034 was assessed, by RN #140, to have no injury.

On identified date and time, a progress note, written by RN #140, indicates that the on call manager was paged to inform them of the incident; the on call manger, who was the Activity Director returned call at specified time.

RN #140 indicated, to Inspector #554, notifying the On Call Manager of the neglect incident on specified date. RN #140 indicated being unable to recall the exact time when the On Call Manager was called regarding the incident. RN #140 indicated that abuse and or neglect of a resident is to be immediately reported to the DOC and/or ED, or to the on call manager if after hours.

The Activity Director indicated, to Inspector #554, being the On Call Manager on identified date. Activity Director indicated being notified by RN #140 of the neglect incident involving resident #034 until specified time after the incident. Activity Director indicated that RN #140 should have notified them immediately of the alleged neglect of care involving resident #034. The Activity Director indicated communicating the alleged neglect to RCC #104, at identified time that same.

The ED indicated to Inspector #554, that abuse and or neglect of a resident is to be immediately reported to management during business hours and or to the On Call Manager after hours.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with, specifically the alleged neglect of resident #034 on specified date. [s. 20. (1)]

4. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall contain an explanation of the duty under section 24 of the Act to make mandatory reports.

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

During this inspection, Inspector #554 inspected four intakes related to abuse/neglect of residents by staff and or others.

The licensee's policy, 'Abuse and Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff' (dated July 2018) was reviewed by Inspector #554.

The licensee's policy directs that the Executive Director / Director of Care who has reasonable Grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1) Improper care or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3) Unlawful conduct that resulted in harm or a risk of harm to a resident.
4) Misuse or misappropriation of a resident's money.
5) Misuse or misappropriation of funding provided to the home under the Long

Term Care Homes Act, 2007.

The licensee's policy fails to contain an explanation of the duty under Section 24 to make mandatory reports, specifically fails to explain that 'any person who has reasonable grounds to suspect that any of the following has (see above) occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director'.

The Executive Director (ED) reviewed the licensee's policy, Abuse and Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff' (dated July 2018) on specified date. ED indicated that they do not see an explanation of the duty to report under Section 24 in the policy.

The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports. [s. 20. (2)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to immediately forward any written complaints, to the Director that had been received concerning the care of a resident or the operations of the home.

Related to Intake #005013-18:

Substitute Decision Maker (SDM) for resident #035 submitted a written complaint to the ED's Assistant on identified date. The written complaint, by SDM, was related to care of resident #035 and the operations of the long-term care home (LTCH). The SDM indicated that the letter of concern was related to, a missing two personal items, management of resident's pain, care of resident #035 including missed baths, continence care management, bedding/linen changes, laundry services, and activation.

The ED indicated to Inspector #554, being aware that written complaints regarding care of a resident or the operations of the home are to be immediately submitted to the Director. The ED indicated receiving the written complaint, of SDM, directly from the ED Assistant on identified date. The ED indicated that the written complaint, from SDM, related to care of resident #035 and the operations of the LTCH. The ED indicated submitting a Critical Incident Report (CIR) to the Director on identified date and time. The ED indicated that the CIR was submitted specific to 'neglect' of resident #035, and indicated that the CIR referenced that a letter of complaint had been received from SDM of resident #035 which involved multiple issues. ED indicated that they did not immediately notify the Director as they wanted to speak with the management team first. The Executive Director indicated that the actual written complaint received, from SDM of resident #035, had not been forwarded to the Director, as it was their understanding, through Corporate Office that the process for reporting had changed.

The licensee has failed to immediately forward any written complaints received concerning the care of a resident or the operations of the home to the Director, specifically a written complaint from the SDM of resident #035, which was received on specified date. [s. 22. (1)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may occur, immediately report the suspicion and the information upon it was based to the Director.

Pursuant to O. Reg. 79/10, s. 2 (1) – For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,

'emotional abuse' means (b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Related to Intake #025011-17:

RCC #104 submitted a Critical Incident Report (CIR) to the Director on identified

date and time related to a witnessed incident of resident to resident abuse involving resident #036 towards resident #009. The abuse incident occurred on identified date.

The CIR indicated that on an identified date and time, Activity Aid (AA) #132 witnessed resident #036 display a specified responsive behavior towards resident #009. AA #132 indicated resident #009 was trying to get resident #036 to stop. AA #132 indicated that resident #009 indicated that resident #036's behaviour was unwelcome. AA #132 reported the incident to RPN #114.

RPN #114 indicated to Inspector #554 that resident #009 indicated that the actions of resident #036, were upsetting and unwelcome. RPN #114 indicated that the incident was reported to RCC #104.

The ED indicated to Inspector #554, being aware of the witnessed abuse incident the next day during morning report. The ED indicated being aware that RPN #114 had reported the abuse incident to RCC #104 on same date. The ED indicated being aware of the reporting requirements under Section 24 but indicated belief that the home could investigate incidents of abuse before reporting them to the Director.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may occur, immediately report the suspicion and the information upon it was based to the Director. A witnessed incident of abuse, involving resident #036 towards resident #009, was not reported to the Director for approximately 23 hours.

Related to Intake #026694-17:

RCC #128 submitted a CIR to the Director on identified date related to a witnessed incident of resident to resident abuse involving resident #036 towards resident #009. The abuse incident occurred on identified date. The CIR indicated that on an identified date, resident #009 and resident #036 were in an identified common area when resident #036 approached resident #009 and displayed a specified responsive behaviour. The CIR indicated that the responsive behaviour was not consensual.

RPN #114 indicated to Inspector #554, being aware of the second alleged abuse incident involving resident #009 and resident #036. RPN #114 indicated that

resident #009 had indicated that resident #036 displayed a specified responsive behaviour which was upsetting and unwelcomed. RPN #114 indicated that the incident was reported to them by RPN #160 who had witnessed the incident. RPN #114 indicated being uncertain if RPN #160 had reported the abuse incident to either one of the RCCs on the date of the incident. RPN #114 indicated not reporting the incident of abuse to either RCC, as it was RPN #160 who witnessed it.

RCC #128 indicated to Inspector #554, being unaware of the abuse incident until the following day during morning report. RCC #128 indicated awareness of the reporting requirements under Section 24. RCC #128 indicated being uncertain as to why the Director was not informed of the abuse of resident #009 until the following day.

The ED indicated to Inspector #554, becoming aware of the abuse incident the next day in morning report. The ED indicated being aware of the reporting requirements under Section 24 but indicated belief that the home could investigate incidents of abuse before reporting them to the Director.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may occur, immediately report the suspicion and the information upon it was based to the Director. A witnessed incident of abuse, involving resident #036 towards resident #009, was not reported to the Director for approximately 23 to 24 hours.

Related to residents #009 and #036:

While inspecting two related incidents of resident to resident alleged abuse (Intake #025011-17 and #026694-17) involving resident #009 and resident #036. The clinical health records of both residents were reviewed.

RCC #104 documented, in the clinical health record for resident #009, the following:
- On identified date and time, a PSW notified RCC #104 that resident #036 had displayed a specified responsive behaviour towards resident #009.

Resident #009 indicated to Inspector #554, being upset by the actions of resident #036. Resident #009 indicated that resident #036's actions, specifically the display a specified responsive behaviour towards them was 'emotionally

exhausting' and unwelcome.

The ED indicated to Inspector #554, being unaware of the alleged abuse involving resident #036 towards resident #009. The ED indicated that staff and managers are aware that resident #009 was upset by the actions of resident #036 and indicated that resident #036's actions were unwelcome to resident #009. The ED indicated that documentation in the clinical record supports that RCC #104 was aware of the alleged abuse involving the two residents. ED indicated RCC #104 should have notified the Director using the after-hours contact number for the MOHLTC and indicated that RCC #104 should have submitted a CIR. The ED confirmed that the Director was not notified of the abuse incident involving the two residents.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may occur, immediately report the suspicion and the information upon it was based to the Director, specific to incident on specified date, involving resident #036 towards resident #009. [s. 24. (1)]

2. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately report the suspicion and the information upon which is was based to the Director.

Related to Intake #011949-18 and #012362-18 (same incident):

The Director of Care submitted a CIR to the Director on identified date related to improper/incompetent treatment of a resident that resulted in harm or risk to a resident. The incident occurred on an identified date, according to documentation in the CIR.

The CIR documented that family of resident #021 reported to a Registered Practical Nurse that resident #021 was 'treated badly by staff, was bossed around and was refused toileting.'

Family of resident #021 indicated to Inspector #554 that they reported an allegation of abuse of resident #021 to a registered nursing staff on identified date, but indicated they could not recall the name of registered nursing staff who

they reported the incident to. Family indicated that resident #021 was 'yelled at by staff, bossed around by staff and was refused toileting'. Family indicated that during the same incident resident #021's 'arm was pulled, causing resident #021 to cry.' The family member indicated that the registered nursing staff whom they spoke with indicated they would report the abuse incident to a RCC.

RCC #104 indicated to Inspector #554, being aware of the allegations reported by the family of resident #021. RCC #104 indicated awareness of the allegations on identified date and indicated RPN #101 reported that an identified family member reported that resident #021 was yelled at, refused toileting and had their arm pulled. RCC #104 indicated that the alleged incident would constitute abuse and neglect of a resident. RCC #104 indicated being aware of the reporting requirements under section 24 of the Act. RCC #104 indicated the allegation was not reported to the Director as the family alleging the abuse/neglect was not the SDM for resident #021. RCC #104 indicated 'I now know I should have reported this allegation to the Director'.

The DOC (former) indicated to Inspector #554, awareness of the abuse/neglect allegation of family of resident #021 on identified date. DOC indicated the incident was reported by RCC #104. DOC indicated that during the investigation it was found that RPN #101 had reported the abuse/neglect allegations to RCC #104 on identified date. DOC indicated that the allegations by the family of resident #021 should have been reported to the Director on same date, and should have been reported as a complaint regarding alleged abuse/neglect of resident #021.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately report the suspicion and the information upon which is was based to the Director, specific to the alleged abuse/neglect of resident #021. [s. 24. (1)]

3. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the license or staff that resulted in harm or risk of harm, occurred or may occur, immediately reports the suspicion and the information upon which it was based to the Director.

Pursuant to O. Reg. 79/10, s. 5 – For the purposes of the Act and this Regulation,

'neglect' means failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Related to Intake #000667-18:

The ED submitted a Critical Incident Report (CIR) on identified date and time specific to an alleged staff to resident neglect involving resident #032. The alleged incident occurred on identified date and time.

The following is documented on the CIR:

A PSW found resident #032 sitting on the toilet at specified time, attached to a transfer device. Resident #032 had been left on the toilet by staff from the previous shift. Resident #032 did not have access to the resident-staff communication and response system (call bell).

RN #140 indicated, to Inspector #554, that the alleged neglect incident involving resident #032 had been reported by an RPN at specified time. RN #140 indicated that the incident did constitute neglect of care by staff, and such placed resident #032 at risk of harm. RN #140 indicated reporting the neglect of resident #032 to the On Call Manager on identified date and time. RN #140 indicated the On Call Manager was the ED. RN #140 indicated not contacting the Director (Ministry of Health and Long-Term Care, (MOHLTC)) as registered nursing staff have been directed to call the On Call Manager, and are not permitted to contact (MOHLTC).

The ED, formerly called Administrator, indicated, to Inspector #554, being aware of the alleged neglect incident, which had occurred on identified date. The ED indicated being contacted by RN #140 specified time (same date). The ED indicated that abuse and or neglect of residents is to be immediately reported to the management, and then management, specifically a RCC, the Director of Nursing or the ED would contact the Director. The ED indicated that 'I must have missed calling MOHLTC' about the alleged neglect of care incident involving resident #032.

The alleged neglect of resident #032 was not reported, to the Director, by the ED for nine hours.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that neglect of a resident by a staff that resulted in harm or risk of harm, occurred or may occur, immediately reports the suspicion and the information upon which it was based to the Director, specific to the alleged neglect of resident #032.

2. Related to Intake #004983-18:

The RCC submitted a Critical Incident Report (CIR) specific to an alleged staff to resident neglect involving resident #032. The alleged incident occurred on identified date an dtime.

The following is documented on the CIR:

A PSW found resident #032 sitting on the toilet at specified time attached to a transfer device. Resident #032 had been left on the toilet by the staff from previous shift. Resident #032 was assessed to have redness to on their skin as a result of this incident. (Note: This is the second incident of a similar nature involving resident #032. Reference Intake #000667-18.

RN #140 indicated, to Inspector #554, that the alleged neglect incident involving resident #032 had been reported to by a PSW at specified time. RN #140 indicated that the incident did constitute neglect of care by staff, and such placed resident #032 at risk of harm. RN #140 indicated reporting the neglect of resident #032 to the On Call Manager. RN #140 indicated that they could not recall who the On Call Manager was. RN #140 indicated not contacting the Director as registered nursing staff have been directed to call the On Call Manager, and are not permitted to contact (MOHLTC) directly.

ED indicated, to Inspector #554 being aware of the alleged neglect incident. The ED indicated that the incident, involving resident #032, on identified date did constitute neglect of care. The ED indicated that the On Call Manager on the date of the incident, was the Activity Director. The ED indicated that abuse and or neglect of residents is to be immediately reported to the management, and then management, specifically a RCC, the DOC or the ED would contact the Director.

The Activity Director indicated, to Inspector #554, being contacted by RN #140 as to the alleged neglect of resident #032. The Activity Director indicated being

contacted by RN #140 on identified date and time. The Activity Director indicated not contacting the Director, incidents of abuse and or neglect are to be reported to the ED or the DOC and they will contact the Director. The Activity Director indicated that the alleged neglect involving resident #032 was reported to the DOC on identified date and time.

The alleged neglect of resident #032 was not reported, to the Director, for approximately eleven hours.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that neglect of a resident by a staff that resulted in harm or risk of harm, occurred or may occur, immediately reports the suspicion and the information upon which it was based to the Director, specific to the alleged neglect of resident #032. [s. 24. (1)]

4. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse by anyone, or neglect of a resident by the licensee or staff had occurred or may occur, immediately report the suspicion and information upon which it was based to the Director.

Pursuant to O. Reg. 79/10, s. 5 – for the purposes of the Act and this Regulation, 'neglect' means the failure to provide a resident with the treatment, care, services or assistance required for the health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Related to Intake #002181-18:

RCC #104 submitted a Critical Incident Report (CIR) to the Director, on identified date and time specific to an alleged incident of neglect of care involving resident #034.

The CIR describes the incident as follows:

Resident #034 was found by a PSW, on identified date and time, on a specified toileting device. PSWs who reported the incident indicated that they had not placed resident on the specified toileting device. Resident #034 had no recall of the incident. Resident #034 was assessed by RN #140 to have no injury.

RN #140 indicated, to Inspector #554 reporting the alleged neglect of care, involving resident #034 to the On Call Manager on identified date. RN #140 indicated that the On Call Manager was the Activity Director. RN #140 could not recall the time of the notification to the Activity Director on the date of the incident.

The Activity Director indicated, to Inspector #554, being notified of the neglect incident by RN #140 at approximately 0630 hours on identified date. The Activity Director indicated telling RN #140 that one of the RCC's would notify of the alleged neglect incident. Activity Director indicated reporting the neglect incident, involving resident #034, to RCC #104 at approximately on identified date and time. Activity Director indicated not contacting the Ministry of Health and Long-Term Care and/or the Director, indicating that such is the responsibility of the RCCs, DOC and or the ED.

The RCC #104 was unavailable to be interviewed during the inspection of this CIR.

The ED indicated to Inspector #554, being aware of the alleged neglect, involving resident #034, when RCC #104 discussed the incident during the morning management meeting, on identified date. The ED indicated that abuse and or neglect of a resident is to be immediately reported to the Director.

The Director was not notified of the alleged neglect of resident #034 for approximately 10.5 hours.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that neglect of a resident by the licensee or staff had occurred or may occur, immediately report the suspicion and information upon which it was based to the Director. [s. 24. (1)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents are bathed, at minimum, twice a week by the method of their choice, including tub baths, showers and full body sponge baths, and more frequently as determined by the residents' hygiene requirements, unless contraindicated by a medical condition.

Related to Intake #011949-18:

Resident #021's family indicated to Inspector #554, that resident was not being provided twice weekly bathing.

RPN #122 and RCC #104 indicated to Inspector #554, that residents are provided bathing twice weekly. RPN and RCC indicated that bathing is scheduled and communicated to nursing staff using the 'bath list' located on each RHA.

The 'bath list' for identified wing RHA indicated that resident is to receive twice weekly bathing. Resident's scheduled two identified bath days.

Documentation in the written plan of care, for resident #021, details the following:

Written Care Plan
- Bathing – requires assistance related to impaired mobility and vision. Goals of care indicated as, neat, clean and odour free. Interventions included, physical assistance of PSW; linen changes on bath days and as needed; prefers bath, see bath schedule for specific day/time.

There is no mention in the written care plan that resident #021 refuses care.

Point of Care (POC) documentation by PSW's indicated the following:

Identified month period:
- Resident #021 was provided bathing by nursing staff on eight occasions during the identified month.
- Resident #021 was scheduled to receive a bath on identified date, documentation in the clinical health record indicated that the care was not provided. Resident was not provided a tub bath, shower or bed bath for specified period until an identified date (six days later).

Identified month period:
- Resident #021 was provided bathing by nursing staff on eight occasions during the identified month.
- Resident #021 was scheduled to receive a bath on identified date of the month, documentation in the clinical health record indicated that the care was not provided. Resident was not provided a tub bath, shower or bed bath for an identified period until identified date (six days later).

Identified month period:
- Resident #021 was provided bathing by nursing staff on seven occasions during the identified month.
- Resident #021 was scheduled to receive a bath on identified date, documentation in the clinical health record indicated that the care was not provided. Resident was not provided a tub bath, shower or bed bath for an identified period until an identified date (six days later).

There is no documentation in the clinical health record to indicate that resident #021 refused bathing on three identified dates during a three months period. The clinical health record fails to provide documentation that an alternate bathing dates were offered to resident #021 during these same dates.

Resident #021 indicated to Inspector #554 no recall if scheduled bathing had been missed during identified three month period.

PSW #133 indicated to Inspector #554 that scheduled bathing is to be completed according to the bath list and to be documented in POC. PSW #133 indicated that if a bathing is not completed, then PSW's are to verbally communicate this to the Charge Nurse.

RCC #104 indicated that POC documentation indicated that resident #021 was not provided bathing on three identified dates.

The DOC (former), who was on-site, indicated to Inspector #554 that all residents are provided twice weekly bathing, unless otherwise indicated. DOC indicated that bathing is scheduled and communicated to nursing staff using the 'bath list' located on each RHA. The DOC indicated that it is an expectation that nursing staff follow the bath list and provide bathing to residents as scheduled and based on each residents care needs. The DOC indicated that any bathing not provided to a resident as scheduled is to be communicated to the Charge Nurse on each RHA and then arrangements will be made reschedule 'missed bathing' that day or the next day. The DOC indicated that if bathing is not documented as being completed in POC, then bathing for that resident was not completed.

The licensee has failed to ensure that resident #021 was bathed, at minimum, twice a week, during identified period of three months. [s. 33. (1)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to Resident #039:

Resident #039 was observed, by Inspector #554 to have soiled hands and fingernails with brownish debris on nine different dates.

Resident #039 was observed eating in the dining room on three occasions with resident's fingernails were observed soiled with brownish debris.

Registered Practical Nurse (RPN) #112 indicated to Inspector #554, that resident is known to have an identified responsive behaviour that would cause the soiled hands

Personal Support Worker (PSW) #157 indicated to Inspector #554, that resident #039 is dependent on staff for hygiene, bathing and toileting. PSW #157 indicated that residents routinely receive nail care with their baths twice weekly and that resident's nails were not cleaned by staff during morning care, bedtime care and/or prior to meals.

The licensee has failed to ensure that resident #039 received fingernail care when visibly soiled. [s. 35. (2)]

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a written response was provided to the Family Council within 10 days of receiving Family Council advice related to concerns or recommendations.

Interview with Family Council Chair #152 and Family member #153 indicated that a letter by the Family Council was provided to the Administrator (currently the Executive Director) via email on identified date, related to the operations of the home. The letter included a list of recommendations requested by the Family Council in consultation with families and friends of Caressant Care. The Family Council Chair further indicated that the Administrator responded to some of their concerns and deferred some to corporate office, but to date there was no response from corporate office to three recommendations that were deferred.

Review of the Family Council letter indicated a list of seven suggestions or recommendations related to the operation of the home. A response from the Administrator was provided within 10 days, to the Family Council. A response letter from the Administrator indicated a response related to the outlined recommendations, except for three listed recommendations related to music and TV, snack areas in the dining room and Tuck Cart. The response to those three recommendations was deferred to corporate office.

The Executive Director provided Inspector #570 a newsletter produced by the Family Council on identified date. The newsletter included the Administrator's response to the Family Council letter except for three recommendations that were deferred to corporate and the Family Council had not heard anything from corporate office.

During an interview, the Executive Director (ED) indicated that they responded to the Family Council letter and deferred other recommendations to corporate office. The ED confirmed to Inspector #570 that there was no written response from corporate to the Family Council to the three deferred recommendations. The ED further indicated that there was no directive how to respond to the Family Council's concerns / recommendations that were deferred to corporate office.

The licensee did not respond in writing within 10 days to all recommendations brought forward by the Family Council. [s. 60. (2)]

WN #23: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee had failed to consult regularly with the Family Council, and in any case at least every three months.

Interview with Family Council Chair #152 and Family member #153, both indicated they did not hear anything from the home at all except for one call from the Activity Director to seek input from Family Council, a very short notice was given and thus a Family Council representative could not attend.

During an interview, the Executive Director (ED) indicated there was no consultation with the Family Council. The ED further indicated that the Activity Director at the home was the liaison with the Family Council.

During an interview, the Activity Director (AD) indicated that they were the contact person for the Family Council. The AD further indicated the most recent communication with the Family Council was a newsletter from the Family Council received via email and that was forwarded to the ED. The AD indicated that the Family Council Chair was contacted to attend a general meeting with the regional director of the home on identified date, but they did not attend.

The licensee did not consult regularly with the Family Council, and in any case at least every three months. [s. 67.]

WN #24: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee had failed to seek the advice of the Family Council, if any, in developing and carrying out the Satisfaction Survey, and acting on its results.

Interview with Family Council Chair #152 and Family member #153, both indicated that the Family Council did not participate in developing and carrying out the annual satisfaction survey. The survey was not presented to the Family Council in advance.

During an interview, the Executive Director (ED) indicated that the Family Council did not participate in developing and carrying out the survey. The ED further indicated that the satisfaction survey is corporately developed; the management team at the home would review and discuss the survey at team meetings

The licensee did not seek at the advice of the Family Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

2. The licensee had failed to ensure the results of the satisfaction survey was made available to the Family Council in order to seek the advice of the Council about the survey.

Interview with Family Council Chair #152 and Family member #153, both indicated that Family Council did not review the results or acted upon those results.

During an interview, the Executive Director (ED) indicated the Family council did not act upon the satisfaction survey results; the results were posted in the home but not made available specifically to the Family Council.

The licensee did not make the results of the satisfaction survey available to the Family Council in order to seek the advice of the Council about the survey. [s. 85. (4) (a)]

WN #25: 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. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within twelve (12) hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a resident.

Related to Intake #002181-18:

RCC #104 submitted a Critical Incident Report (CIR) to the Director, on identified date and time, specific to an alleged incident of neglect of care involving resident #034.

The clinical health record for resident #034, as well as the Risk Management Incident report was reviewed for an identified period.

The health record indicated that RN #140 assessed resident #034 on identified date and time, resident #034 had no visible injuries. RN #140 indicated, in the progress note, that resident #034 did not recall the incident.

RN #140 indicated, to Inspector #554 that the SDM for resident #034 was not notified of the alleged neglect incident during the shift, but indicated communicating the incident to the oncoming shift's registered nursing staff, indicating telling that staff that the incident needed to be reported to resident #034's SDM. RN #140 indicated that notification of a SDM would be documented in the health record sun as in the progress note, if the SDM was notified.

RCC #104 indicated, to Inspector #554, any communication with SDM's are to be documented in the health record such as in the progress note.

There is no documentation in the clinical health record that the SDM for resident #034 had been notified of the alleged neglect of care incident.

The licensee has failed to ensure that resident #034's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within twelve (12) hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident. [s. 97. (1) (b)]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a report to the Director was made within ten days of becoming aware of an alleged, suspected or witnessed incident.

RCC #104 submitted a Critical Incident Report (CIR) to the Director on identified date for an alleged incident of resident to resident abuse involving resident #036 towards resident #009.

While inspecting the CIR regarding the alleged abuse incident involving resident #036 towards resident #009 the clinical health record for both residents were reviewed.

Resident #009's health record was reviewed and the following was documented by RCC #104:
- On identified date and time, a PSW notified RCC #104 that resident #036 had displayed a responsive behaviour toward resident #009.

Resident #009 indicated to Inspector #554, being upset by the actions of resident #036. Resident #009 indicated that resident #036's actions are unwelcome. Resident indicated voicing frustration to staff.

The ED indicated to Inspector #554, being unaware of the alleged abuse involving resident #036 towards resident #009. The ED indicated that documentation supports that RCC #104 was aware of the alleged abuse involving the two residents. The ED indicated that RCC #104 should have notified the Director and should have submitted a CIR regarding the abuse incident. The ED indicated that no CIR had been submitted related to an alleged abuse of resident #009 on identified date.

The licensee has failed to ensure that the report to the Director was made within ten days of becoming aware of an alleged, suspected or witnessed incident which occurred on identified date. [s. 104. (2)]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is, reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending to the resident and the pharmacy service provider.

An identified Medication Incident was reviewed by Inspector #554. The incident identifies the following:

On identified date, RPN #122 prepared physician prescribed two identified medications for resident #031. RPN #122 placed the two medications into a glass of a prescribed nutritional supplement. RPN #122 gave the nutritional supplement containing the medications to a PSW to administer to resident #031. RPN #122 returned to find the glass containing the nutritional supplement and medications empty. PSW indicated to RPN #122 that resident #031 had not received the nutritional supplement and or the medications. PSW indicated to RPN being unaware of who consumed the nutritional supplement containing the medications. The medication incident indicated that there were three other residents at dining room table with resident #031. All four residents are cognitively impaired and were unable to indicate who drank the nutritional supplement containing the medications.

RPN #122 indicated to Inspector #554, recall of the medication incident. RPN #122 indicated that the SDM for resident #031 was notified of the medication incident, but indicated that the other three residents' SDMs were not notified of the incident as RPN did not know which resident consumed the medications.

RCC #104 indicated to Inspector #554, being aware of the medication incident. RCC #104 indicated directing RPN #122 to contact resident #031's SDM, but indicated RPN #122 had not been directed to contact the other three resident's SDM as they were uncertain which resident consumed the medications.

The licensee has failed to ensure that every medication incident involving a resident was reported to the resident's SDM. [s. 135. (1)]

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 228.
Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee had failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Family Council.

Interview with Family Council Chair #152 and Family member #153, both indicated that they did not receive any updates from the licensee in regards to the improvements made through the quality improvement program at the home.

Review of the 2018/19 Quality improvement Plan (QIP) and narrative document attached to the QIP for the home was completed by inspector #570. The initiatives included in the plan were reducing the number of antipsychotics, improve residents' satisfaction with the home and reduce the number of ER visits.

According to the QIP, every resident, SDM or anyone important to the resident, may participate in the development of the QIP or offer input at any time; The plan was displayed and discussed at PAC, CQI, and Residents' Council. The review did not reveal that the QIP was discussed with the Family Council.

During an interview, the Executive Director (ED) indicated that the Family Council was not provided with any information regarding quality improvements made at the home. The ED further indicated that family members are provided with information at care conferences and through the quality improvement program posted information at the home for anyone visiting the home not specific to the Family Council. The ED further indicated, during an interview that the QIP was not discussed with the Family Council, therefore the Family council had no input into the QIP.

The licensee did not communicate to the Family Council any information regarding quality improvements made at the home. [s. 228. 3.]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 22nd day of March, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SAMI JAROUR (570) - (A1)
Inspection No. / No de l'inspection :	2018_598570_0013 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	005363-18, 007888-18 (A1)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 22, 2019(A1)
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 Lindsay Nursing Home 240 Mary Street West, LINDSAY, ON, K9V-5K5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Butch Ashcroft

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

To 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:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with LTCHA, s. 19 (1).

The Licensee shall prepare, submit and implement a written plan for achieving compliance with LTCHA, s. 19 (1).

Specifically the licensee shall:

1. Develop and implement a plan to ensure that all residents, including resident #009 are protected from abuse by anyone.

2. Review and revise the written plan of care for all residents, including resident #009 to ensure that there are interventions in place for the protection of all residents, including resident #009 and that the planned interventions are being implemented and are effective in minimizing potential risk or harm. When interventions are known to be ineffective, registered nursing staff, the BSO team and management are to review the planned care, revise interventions and take appropriate and timely action to protect residents from abuse by anyone. Revisions and reviews of the planned care for each resident is to be documented and kept.

3. All staff and managers are to receive training/retraining on the licensee's written policy that promotes zero tolerance of abuse and neglect of residents, specifically the immediate reporting and investigation of abuse and neglect, and immediate notification of resident's SDM as indicated pursuant to LTCHA, s. 24 (1) and O. Reg. 79/10, s. 97 (1). A written record must be kept of this training.

4. Develop and implement a plan which outlines corrective action to be taken and by whom should staff fail to comply with the licensee's written policy that promotes zero tolerance of abuse and neglect of residents. This plan is to be in writing.

Please submit the written plan for achieving compliance for inspection #2018_598570_0013 to Kelly Burns, LTC Homes Inspector, MOHLTC, by email to CentralEastSAO.MOH@ontario.ca by February 8, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure that residents are protected from abuse by anyone.

Pursuant to O. Reg. 79/10, s. 2 (1) – For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,

'emotional abuse' means (b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

The licensee's policy, 'Abuse and Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff' (dated February 2018) indicates that Caressant Care believes in and is committed to the prevention of abuse. Caressant Care believes in the provision of a safe environment for residents. Abuse, in any form, is a direct violation of this intrinsic right and will not be tolerated.

Related to Intake #025011-17 and Intake #026694-17:

The following Critical Incident Reports were submitted to the Director:

RCC #104 submitted a CIR, Intake #025011-17, to the Director related to a witnessed incident of resident to resident alleged abuse involving resident #036 towards resident #009. The CIR indicated that on an identified date and time, Activity Aid (AA) #132 witnessed resident #036 display a specified responsive behavior towards resident #009. AA #132 indicated resident #009 was trying to get resident #036 to stop. AA #132 indicated that resident #009 indicated that resident #036's behaviour was unwelcome. AA #132 reported the incident to RPN #114.

RPN #114 indicated to Inspector #554 that resident #009 indicated that the actions of resident #036, were upsetting and unwelcome. RPN #114 indicated that the incident was reported to RCC #104.

RCC #128 submitted a CIR, Intake #026694-17, to the Director related to a witnessed incident of resident to resident alleged abuse involving resident #036 towards resident #009. The CIR indicated that on an identified date, resident #009 and resident #036 were in an identified common area when resident #036

approached resident #009 and displayed a specified responsive behaviour. The CIR indicated that the responsive behaviour was not consensual.

RPN #114 indicated to Inspector #554, being aware of the second alleged abuse incident involving resident #009 and resident #036. RPN #114 indicated that resident #009 had indicated that resident #036 displayed a specified responsive behaviour which was upsetting and unwelcomed. RPN #114 indicated that the incident was reported to them by RPN #160 who had witnessed the incident. RPN #114 indicated being uncertain if RPN #160 had reported the abuse incident to either one of the RCCs on the date of the incident. RPN #114 indicated not reporting the incident of abuse to either RCC, as it was RPN #160 who witnessed it.

While inspecting the two CIRs related to alleged abuse involving resident #036 towards resident #009. The clinical health records for both residents were reviewed.

Resident #009:

The clinical health record, for resident #009, documented the following:

- On identified date and time, a PSW notified RCC #104 that resident #036 had displayed a specified responsive behaviour towards resident #009. Documentation was written by RCC #104.
The written care plan for resident #009, in effect at time of incident, directed the following:
- Identified responsive behaviour: Goal of care is indicated as 'decrease episodes of identified responsive behaviour'. Interventions include (but not limited to) 'resident #036 appears to search out resident #009, wanting to be in the same area as resident; document each incident. There was no new intervention specific to the identified responsive behaviour related to interaction with resident #036.

Resident #036:

The clinical record, for resident #036, directed the following:

Written Care Plan (for two identified quarters)
- Mobility: resident uses a mobility aid independently.
- Identified responsive behaviour: Goal of care is indicated as 'reduction of incidents'.

Interventions include, resident will search out resident #009, wanting to be in the same area as resident. Staff to monitor interactions with resident #036 and resident #009; distract resident if possible; document each incident; remove resident from public area when presenting identified responsive behaviour. There was no new intervention specific to the identified responsive behaviour or resident #036's interactions with resident #009.

PSW #151 indicated to Inspector 554, being aware that resident #009 is bothered by the actions of resident #036. PSW indicated that resident #036 is 'always looking for resident #009'. PSW indicated resident #036 will display this responsive behaviour towards resident #009, and indicate desire to seek out resident #009. PSW #151 indicated that staff attempt to distract resident #036 or remove resident away from resident #009 but that the redirection only escalates resident #036's behaviours. PSW #151 indicated that resident #009 voiced frustrated with resident #036 and indicated that resident #036's actions were unwelcomed by resident #009.

RN #100 indicated to Inspector #554, being aware of the alleged abuse incidents by resident #036 towards resident #009. RN #100 indicated that 'resident #036 is obsessed with resident #009'. RN #100 indicated that resident has been known to display a specified responsive behaviour towards resident #009. RN indicated that resident #036 will seek out resident #009. RN #100 indicated that resident #036 is often difficult to direct or redirect when resident is focused on resident #009, indicating that resident #036 will become verbally and physically aggressive with staff direction; RN indicated that often resident #036 is left to 'self-console' (settle on their own). RN #100 indicated being aware that resident #009 is frustrated with the actions of resident #036. RN indicated that the display of this specified responsive behaviour by resident #036 towards resident #009 are unwelcomed by resident #009. RN #100 indicated that resident #009 will often stay in their room with the door closed to avoid resident #036. RN #100 indicated that resident #036's exhibited responsive behaviour has been a challenge to staff and remains an upsetting/frustrating situation for resident #009. RN #100 indicated 'feeling sad for resident #009'.

The ED indicated to Inspector #554, being aware of the alleged abuse incidents involving resident #036 towards resident #009. The ED indicated that the incidents have lessened but do occasionally occur. The ED indicated that staff and managers were aware that resident #009 is upset by the actions of resident #036 and indicated knowing that resident #036's actions were unwelcome to resident #009. The ED

indicated that staff do attempt to keep resident #036 away from resident #009 but indicated staff can't be with resident #036 all the time. The ED indicated 'resident #009 is tolerant of resident #036'.

Resident #009 indicated to Inspector #554, being upset by the actions of resident #036. Resident #009 indicated that resident #036's actions, specifically the display a specified responsive behaviour towards them was 'emotionally exhausting' and unwelcome. Resident #009 indicated to Inspector #554 'I stay in my room most of the time with the door closed to avoid resident #036.' Resident indicated avoidance of activity programs and or sitting in communal lounges to avoid resident #036. Resident indicated voicing frustration to staff on several occasions but indicated that the actions of resident #036 continue. Resident indicated 'feeling trapped in the home.'

The licensee has further failed to comply with:

- LTCHA, 2007, s. 20 (1), by ensuring the written policy that promotes zero tolerance of abuse and neglect of residents was complied with. (as indicated in Written Notification (WN) #17)

- LTCHA, 2007, s. 24 (1) 2, by ensuring the person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. (as indicated in WN #19)

- O. Reg. 79/10, s. 104 (2), by ensuring a report is made to the Director within 10 days of becoming aware of an alleged, suspected or witnessed incident of abuse of a resident by anyone. (as indicated by WN #26)

The licensee has failed to ensure that residents are protected from abuse by anyone.

The severity of this issue was determined to be a level 2. The scope of the issue was level 2. The licensee had a level 4 compliance history as despite MOH action, ongoing non-compliance has continued pursuant to LTCHA, s. 20 (1), a Voluntary Plan of Correction (VPC) issued December 16, 2015, Resident Quality Inspection (RQI) #2015_360111_0028 and a VPC issued July 26, 2017, Critical Incident Report (CIR) inspection #2017_670571_0011. Pursuant to LTCHA, s. 24 (1), a Voluntary

Plan of Correction (VPC) issued December 16, 2015, RQI #2015_360111_0028 and a VPC issued July 26, 2017, Complaint Inspection #2017_670571_0012. Pursuant to O. Reg. 79/10, s. 104, a VPC issued December 16, 2015, RQI #2015_360111_0028. (554)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with LTCHA, s. 15 (2).

The Licensee shall prepare, submit and implement a written plan for achieving compliance with LTCHA, 2007, s. 15 (2).

Specifically the licensee must:

1. Develop and implement a plan to address identified housekeeping concerns identified in this inspection report, specifically staining around toilets and on flooring in resident rooms, washrooms and tub-shower rooms. The plan shall include when the cleaning will take place, including dates, by whom, how the cleanliness of identified areas will be maintained and who will oversee consistency of cleaning procedures. The plan shall be detailed and in writing.

2. Develop and implement a plan to address maintenance concerns identified in this inspection report. The plan shall include when such repairs and/or replacement will be rectified, time frames for repair and or replacement, and who will oversee the repair and or replacement. This plan shall be detailed and in writing.

3. Develop and implement a systematic maintenance procedure that will ensure that the home, furnishings and equipment are maintained in a safe condition, and in a good state of repair. The procedure shall include routine inspections of the home, furnishings and equipment, and what action is to be done, when repairs or replacement will be completed and by whom. Should the home, furnishings and equipment be assessed and or identified as needing repair and or replacement, the licensee will ensure that the repairs and or replacement will be completed without delay. The procedure shall be detailed and in writing.

4. Implement a procedure for the communication of required maintenance concerns for all staff and management. This procedure shall be detailed and in writing. A record of staff who receive the information must be kept.

Please submit the written plan for achieving compliance for inspection #2018_598570_0013 to Kelly Burns, LTC Homes Inspector, MOHLTC, by email to CentralEastSAO.MOH@ontario.ca by February 8, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

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

During the initial tour of the long-term care home (LTCH), the following was observed, by Inspector #554:

In a specified wing, resident home area (RHA):
- Toilet – dark brownish-black staining was observed around the base of the toilet stool, and the flooring. The debris could be easily scraped loose with Inspector's pen. This was observed in the tub-shower rooms on both hallways of the RHA. Dark staining around toilet stools and flooring was observed in nine identified residents' rooms.
- Flooring – tiled flooring in the tub-shower room was observed to have debris (grout) between the tiles along the wall/flooring and at the threshold of the entrance/exit of the tub-shower room. The tub-shower room was located on an identified hallway.
- Exhaust Fan – observed to have thick, dark grey debris on the exhaust fan cover

and visible blades of the fan. This exhaust fan was located in a specified tub-shower room.
- Oscillating Fan - observed to have thick, dark grey debris visible blades of the fan. This fan was located in the north hall tub-shower room.
- Floors – in resident washrooms were observed heavily soiled with dark debris (grout) between flooring tiles in nine identified residents' rooms.

In other identified wing, RHA:
- Flooring – the vinyl sheet flooring in the tub room was observed torn, dark debris was visible on the sub-flooring. Dark brownish-black staining was visible throughout the room, but the flooring was heavily stained along the wall/flooring, at the door and along the threshold entry/exit to the room.
- Toilet – dark brownish-black staining was observed around the base of the toilet stool, and the flooring. The toilet was located in the tub room of the RHA.
- Tub – observed to have a brownish staining along the tub edges, and white film, and debris along the underside of the faceplate of the tub (housing tub-controls). The tub was observed in the tub room of the RHA.

In another identified wing, RHA:
- Toilet – dark brownish-black staining was observed around the base of the toilet stool, and the flooring. The toilet was located in the tub and shower rooms of the RHA.
- Tub – observed to have a brownish staining along the tub edges, and white film, and debris along the underside of the faceplate of the tub (housing tub-controls). The tub was observed in the tub room of the RHA.
- Flooring – the vinyl sheet flooring in the tub room was observed to have dark brownish-black visible throughout the room, but the flooring was heavily stained along the edges of the wall/flooring, at the door and along the threshold entry/exit of the tub room.
- Flooring – vinyl sheet flooring was observed to have whitish film throughout the shower stall in the shower room.

Additionally, windows in multiple identified common resident areas, were observed to have dust and debris covering the window pane; the window panes appeared 'foggy'.

The above identified areas, staining around toilets, on floors in tub-shower rooms, and resident washrooms, and along tub surface was, also, observed on four different

dates.

Housekeeping Staff (HSK) #120, who works on an identified Wing, indicated to Inspector #554 that windows in the home are cleaned twice yearly, by an external service, but cleaned in between by housekeeping staff with thorough cleans. HSK #120 indicated that the stains in the tub rooms on the identified Wing are permanent. HSK #120 indicated that there should not be stains around the toilet stool and flooring in resident rooms or tub-shower rooms. HSK #120 indicated that the tub in the tub room is not cleaned by housekeeping staff but is to be cleaned by nursing staff.

HSK #119, who works on other identified Wing, indicated to Inspector #554 that there should not be stains around the toilet stool and flooring in resident rooms and or tub-shower rooms. HSK #119 indicated that flooring in resident's rooms are old and flooring tiles have separated allowing debris to build up.

Environmental Services Manager (ESM) indicated, to Inspector #554 that:
- Windows in the LTCH are cleaned twice yearly by an external contractor, and that housekeeping staff are expected to clean the windows monthly as part of their 'thorough cleans'. ESM indicated that they believe that contracted window cleaning was last done in June or July 2018, but indicated it was their belief that the job completed was not done well.
- Cleaning around the toilets in tub-shower rooms, as well as resident's washrooms is done daily. ESM indicated there should be no staining around the toilet stools and the flooring in resident rooms and or tub-shower rooms.
- The tiled flooring in resident rooms and washrooms are the original flooring in most rooms, and agreed that debris is building up between separated floor tiles. ESM indicated that resident rooms, which includes adjoining washroom are wet mopped daily and thoroughly cleaned as part of the monthly schedule. ESM indicated the flooring in resident rooms and washrooms should not be stained, and should be kept clean.
- Flooring in the tub rooms on two identified Wings should not be stained, but then indicated that they believe that the stains maybe permanent. ESM indicated that they could place a call to a supplier to see if they have a chemical to remove the stains.
- The tub, itself, is not cleaned by housekeeping staff, but is part of the nursing duties. ESM indicated that the tub should be cleaned following resident use.

The ESM, as well as the ED indicated that the LTCH should be clean.

The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary. (554)

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

i) The licensee's policy, 'Principles Functions of the Maintenance Department' (dated October 2014) directs that maintenance services will ensure all internal and external maintenance concerns are addressed in a timely manner.

The licensee's policy, 'Maintenance Requisitions' (dated December 2009) that maintenance concerns will be addressed in a timely manner. Identified maintenance concerns waiting on parts or awaiting a contractor will be identified as such and an expected completion date will be identified on the maintenance requisition in the maintenance binder at the applicable nursing station.

Related to Intakes #009113-18 and #011949-18:

Intakes for inspection indicated that the 'home was falling apart inside and outside' and voiced concern for the safety of residents residing in the long-term care home.

During the initial tour of the LTCH the following maintenance concerns were observed by Inspector #554:

On an identified Wing - RHA:
- Air Conditioning (AC) window unit – was observed leaking in an identified common area, water was pooling onto the floor;
- Ceiling Tiles – were ceiling tiles in an identified hallway were observed to have brownish staining. The tiled ceiling, in this same hallway, was observed to be sloping;

- Tub-Shower Room – a hole, measuring approximately 30 cm irregular diameter, was observed in the ceiling above the tub, in the north hallway tub-shower room;
- Ceiling Exhaust Fan – observed covered in dark gray debris;
- Tub – acrylic finish on the inside of the tub was chipped in three to four areas and appeared as if the acrylic finish on the tub had been previously repaired. The exposed surface was porous in nature, which poses potential infection control

problems. This tub is located in the north hall of the RHA;
- Tiled Flooring – four to five flooring tiles were observed chipped and or portions of the tiled floor were missing, adjacent by to the threshold of the A-wing door closet to the nursing station.
- Flooring – tiled flooring was observed uneven around a floor drain in the east hallway, adjacent to an identified resident room and common area room; the area presented a potential trip/fall hazard for residents;
- Door Locking Mechanism – the coded door mechanism on the tub-shower room was observed to be dysfunctional. Inspector #554 was unable to enter the tub-shower room, as well as PSW #102 and HSK #119. PSW #102 indicated to Inspector #554, that the door mechanism has 'been a problem' for some time. PSW #102 indicated it is often difficult to 'get into the room' when PSW's are ringing for assistance with a resident;
- Furniture – faux leather surface on the love seat and chairs, located in a common area, was observed peeling or missing in areas along the seating and arms of the furniture;
- Wall – the wall, adjacent to a common area, was observed cracked along the upper wall edging and ceiling, the area measured approximately 60 cm. The paint on this wall was observed chipped and lifting.
- Window Screens – the window screens of all three windows in an identified common area were observed loose and bent.

In other identified Wing - RHA:
- Walls – in the television lounge were observed scuffed and chipped in areas;
- Flooring – the laminate flooring in the tub room was observed torn, an area measuring approximately 60 cm was observed to the left of the door as you entered the room, smaller areas measuring 2.5cm to 3 cm were observed in front of the door, the sub-flooring and debris were visible beneath the torn flooring. Water (from the bathtub) was observed leaking through the torn flooring and onto the sub-flooring. The flooring in the tub room was heavily stained with dark brown-black staining; the flooring was observed separating from the floor and the wall to the right of the tub, this area measured approximately 50 cm;
- Shower Room – a strong 'sewage like' odour was present in the room;
- Nursing Station – laminate was observed chipped in several areas on the outer aspect, facing the hallway and dining room, of the nursing station;
- Tiled Flooring – the flooring in the hallways were observed worn in areas;
- Window Screens – the window screens of two of the four windows in the activity

room/chapel, as well as one of the two windows overlooking the enclosed patio were observed loose and bent.

In another identified Wing - RHA:
- Ceiling Tile – were observed ajar, exposing the ceiling wiring, adjacent to the tub room and an identified resident room;
- Tub – acrylic finish on the inside of the tub was chipped in two areas and appeared as if the acrylic finish on the tub had been previously repaired; the exposed surface was porous in nature, which poses potential infection control problems;
- Flooring – was observed heavily stained, with dark brown-black staining, in the tub room and shower room;
- Window Screens – the window screens of one of the two windows overlooking the enclosed balcony were observed loose and bent.

Outside of the LTCH:
- Sidewalk – the concrete sidewalk, outside of identified door, was observed cracked, chipped, and having loose and or missing areas of concrete along its pathway. The sidewalk was observed cracked and sloped inward toward the building (outside of activity department) and had a hole, was present in the concrete, measuring approximately one foot width and depth.
- Sidewalk – the concrete sidewalk, outside of identified door, was observed uneven in areas and having a raised area. The raised area measured approximately one inch.
- Patio and Ramp Access – the concrete/interlocking brick patio and access ramp, outside of identified Wing door, was observed cracked, missing concrete and uneven in several areas. Residents walking and in wheelchairs were observed maneuvering the uneven concrete patio and ramp.
- Patio – the concrete patio, was observed cracked and missing areas of concrete.

Uneven sidewalks, the access ramp and patios present a potential trip/fall hazard for residents and or others using them.

- Parapet Wall – seven to eight blocks, from the block facing, were observed missing and loose in areas of the parapet wall outside of an identified Wing - RHA. Five blocks were observed on the grass, outside of another identified Wing - RHA. Blocks were observed missing from the parapet wall at the corner of the building. Caution tape was haphazardly lying on the ground.

Falling bricks/blocks present a potential safety hazard for residents and others.

During this inspection, the following was observed by Inspector #554:
- Identified resident room – the tile flooring in the washroom was observed chipped and cracked, involving approximately four floor tiles;
- Identified resident room – the laminate finish on the counter-top vanity and cupboards were observed chipped. The left cupboard door was missing a piece of laminate measuring approximately 10 cm, the plywood under the laminate was exposed; the window screen was loose and bent;
- Identified resident room – there was no lid observed on the toilet tank in the washroom; the counter-top vanity and cupboards in the washroom was chipped, orange tape was holding the outer side of the cupboard (left side) together;
- Identified resident room – the tiled flooring in the washroom was heavily stained, between the toilet and the wall; thick dark debris (grout) was visible between the flooring tiles; there was no lid on the toilet tank in the washroom;
- Identified resident room – the wall-base guard along the entire length of the wall, from the door to the window, was observed loose and or hanging from the wall; the wall, above the wall-base guard, was observed scuffed and chipped in areas; the wall, adjacent to the closet for identified bed, was observed chipped and had visible holes in the dry wall; the tiled flooring adjacent to the threshold separating the room and washroom was chipped;
- Identified resident room – the tiled flooring in the washroom was chipped and cracked in areas around the toilet, involving three tiles, the sub-floor was visible beneath and heaving laden with dark debris; the exhaust fan in the washroom was ¾ off and hanging from the ceiling;
- Identified resident room – the laminate finish on the counter-top vanity and the cupboards in the washroom were observed chipped; the exhaust fan in the washroom was ¾ off and hanging from the ceiling; the window screen was observed bent and loose;
- Identified resident room – the tiled flooring in the washroom had thick dark debris between the tiles; the exhaust fan in the washroom was ¾ off and hanging from the ceiling;
- Identified resident room – the tiled flooring in the washroom was heavily soiled, between the toilet and the wall; thick dark debris was visible between the flooring tiles; the laminate on the cupboard in the washroom was chipped and or missing on the left cupboard door and corner of the cupboard; the finish on the mirror in the

washroom was worn and missing in areas (on the right side); the wooden bathroom door was scuffed and gouged; the wall, to the left, as you enter the washroom was scuffed and gouged; the toilet in the washroom was heard 'running' on multiple dates;
- Identified resident room – the window screen was observed loose and bent, there was duct tape on the sides of the screen's metal frame.

Outside of the LTCH:
- The eaves troughs, and down spouts, along the front of the LTCH, were observed loose (coming away from the building), bent, cracked and or missing in areas. The soffit panels, within the same area, were observed cracked and coming loose from the fascia, the plywood beneath, the soffit panels, was observed exposed to the elements.
- The asphalt shingles on the roof, at the front of the LTCH, were observed cracked and lifting in areas.

HSK #119, HSK #120, PSW #101, WC #103 and RN #100 indicated to Inspector #554, that any items identified as needing repair by maintenance are placed into the 'maintenance binders' located at the nursing stations on all RHA's.

The maintenance binder on all three RHA's were reviewed by Inspector #554. The maintenance binder identified window screens being loose and bent in an identified common area. Other maintenance issues identified by Inspector #554 were not documented as needing repair and or replacement in any of the maintenance binders on RHA's.

The ESM indicated to Inspector #554 that the maintenance binders on all RHA's are reviewed daily and repairs are prioritized. ESM indicated repairs and or replacement are completed in collaboration with MW. ESM indicated that the maintenance department relies on staff to identify maintenance concerns and document the concern(s) in the maintenance binders. ESM indicated that needed repairs within the LTCH are done as soon as possible and indicated that any repairs waiting on parts or contractors are identified in the maintenance binder with date and expected completion. The ESM indicated that the maintenance department is doing it's best to keep up with the repairs in the LTCH.

The ESM indicated the following:

- awareness of the conditions of washrooms on A-wing RHA, specifically washroom floors, cupboards and counter-tops. ESM indicated being recently approved to repair and or replace flooring and counter-tops in ten resident washrooms per year. ESM indicated that two identified resident rooms were not on the list for 2018. ESM indicated that the 'plumbing was causing the toilet to leak in identified resident room' and therefore causing the staining on the washroom floor. ESM indicated that at this time, there was no plan in place to address the plumbing issues in identified resident room/washroom.
- being aware that the acrylic finish inside the tubs on identified two Wings were chipped. ESM indicated that a product had been used to fill the chipped acrylic but must have come loose again.
- no awareness of window screens in the LTCH being bent or loose.
- awareness of the heavily stained flooring in two identified Wings tub-shower rooms and awareness of the torn flooring in an identified Wing's tub room. ESM indicated that the flooring in the tub room has been in the same condition for approximately four years and indicated being aware that water, from the bathtub, was leaking onto the sub-flooring beneath the laminate flooring. ESM indicated being directed, by corporate office's ESM Lead, to fill it with caulking. ESM indicated that the 'caulking was a bandage solution' and indicated that the caulking 'continues to break down and has been ineffective'. ESM indicated at this time, there is no plan to address the torn flooring in the tub room on identified Wing.
- awareness of the concrete issues on sidewalks, patios and ramp access around the exterior of the LTCH. ESM indicated that quotes had been obtained and forwarded to corporate office in 2017 and 2018 identifying that the sidewalks and access ramp pose a 'serious trip hazard' for residents and others. ESM indicated being told by corporate office that the 'repairs would not be done in 2017 and in 2018', ESM stated no reason was given.
- awareness of the damaged eaves trough and downspouts around the exterior of the LTCH. ESM indicated that quotes had been obtained and forwarded to corporate office in 2015 and 2017. ESM indicated being told by corporate office that the 'repairs would not be done in 2015 and in 2017', ESM stated no reason was given.
- awareness of the damaged parapet wall on the exterior of the LTCH. ESM indicated that quotes had been obtained and forwarded to corporate office in 2015. ESM indicated being told by corporate office that the 'repairs would not be done in 2015' despite the repair being marked as 'urgent' and indicating that a section of the wall was coming away from the building. ESM stated no reason was given why the repair to the parapet wall was not approved for repair. ESM indicated in an identified date in

2018, blocks started to fall from the wall. ESM indicated that the 'falling blocks were a safety concerns' and this was communicated to corporate office; and ESM was directed to obtain a second quote for the repair of the parapet wall. ESM indicated that the quote was forwarded to corporate office on an identified date and indicated that approval was granted for the repair of the wall. ESM indicated that the parapet wall should have been repaired in 2015 when the wall was identified as coming away from the building.

The ED indicated to Inspector #554, being aware of maintenance issues on identified Wing - RHA, ED indicated that the washrooms in the identified Wing are old and falling apart. ED indicated that they had approval to fix ten washrooms this year (2018). ED indicated being aware of maintenance concerns on the exterior of the LTCH, specifically uneven concrete on sideways, patios, access ramps, damaged eaves troughs and downspouts and damage to the parapet wall. The ED indicated that quotes for repairs had been forwarded to corporate office over the past four years, as indicated by ESM. The ED indicated that the quotes for needed repairs had not been approved by corporate office and indicated that no reason was provided.

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

ii) On identified date, Inspector #554 was standing at an identified Wing nursing station when the fire alarm sounded. Inspector #554 observed that one of the fire doors on one hallway did not automatically close.

Ward Clerk (WC) #103 and RN #100 indicated that the fire door should close automatically when the fire alarm is activated. Both WC and RN indicated that there had been issues with the fire door not closing for some time and indicated that Environmental Services Manager is aware of the fire door not closing.

The ESM indicated to Inspector #554, that the fire door, located on the north hall on an identified Wing - RHA, had been dysfunctional for approximately three weeks. ESM indicated that an identified contractor had been to the LTCH approximately two weeks ago to service the dysfunctional fire door, but indicated that the representative of the contractor indicated that the issue with the door was not related to the 'meg lock mechanism' but related to the 'automatic door closure arm', which did not fall under their services. ESM indicated being aware that a door company needed to be

called to install a new door closure arm and indicated that the repair of the fire door had not been arranged but should have been.

Following discussion with Inspector #554, required repair of the fire door was arranged by the ESM. On identified date, the fire door was repaired, and operational.

The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, specifically the maintenance of fire separation doors in the LTCH. Dysfunctional fire doors jeopardize the safety of residents and others in the long-term care home.

iii) On identified date, the automatic door closure arm on the fire door, leading to identified area, was observed not attached to the door. The Maintenance Worker (MW) #105 indicated to Inspector #554 being told by ESM that the fire door was not closing properly and needed repair. MW indicated being unaware of who removed the door closure arm. MW indicated that the door closure arm should not have been removed as the door was a fire door and the door closure arm functions to automatically close the door when the fire alarm sounds.

The FSS indicated to Inspector #554 that the fire door in an identified area had not been closing properly for some time and that the door closure arm was removed by the ESM.

The ESM indicated to Inspector #554 awareness that the fire door in the identified area was dysfunctional. ESM indicated removing the door closure arm at some point. ESM indicated that the identified area was 'not high traffic' so the repair was not deemed urgent. ESM indicated that the 'door closure arm was ordered but the repair had been forgotten' until Inspector #554 questioned fire door operations in the LTCH following fire drill on identified date, when another fire door was not closing.

The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, specifically fire separation doors in the LTCH. Dysfunctional fire doors will jeopardize the safety of residents and others in the long-term care home.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents and others. The scope of the issue was level 3 -

widespread, as during this inspection many areas within the LTCH were identified by inspector #554. The licensee has no history of non-compliance pursuant to LTCHA, s. 15 (2). (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 17 (1).

Specifically the licensee shall ensure that:

1. There is a resident-staff communication and response system in every area and is accessible by residents.

Grounds / Motifs :

1. The licensee failed to ensure that there is a resident-staff communication and response system available in every area accessible by residents.

During the initial tour of the long-term care home, Inspector #554 did not observe a resident-staff communication and response system available in the following areas:

- Identified sitting area where residents and visitors were observed sitting in the area;
- Identified area, located outside of identified Wing doors. Residents were observed sitting in the smoking area;
- In an identified Patio area.

WC #103, RPN # 112 and RN #100 indicated to Inspector #554 that the identified sitting area, and identified patios are resident accessible areas. The WC #103, RPN #103 and RN #100 indicated that the sitting area and patios do not have a resident-staff communication and response system available to residents. WC #103 and RN #100 indicated that there has been incidents where residents have fallen outside in an identified area and have had to wait until staff noticed they had fallen or other residents and/or visitors alerted staff of the incident.

The ESM indicated to Inspector #554, being aware that the identified sitting area and the two patios had no accessible resident-staff communication and response system. The ESM indicated being unaware that the outside patios required an accessible resident-staff communication response system. The ESM indicated that all three areas are resident accessible areas.

The licensee has failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents and others. The scope of the issue was level 3 - widespread, as the identified areas, identified by Inspector #554, are accessible to all residents residing in the long-term care home. The licensee has no history of non-compliance pursuant to O. Reg. 79/10, s. 17 (1). (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2019(A1)

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

Ministère 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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 20 (1).

Specifically the licensee shall:

1. Ensure that, if central air conditioning is not available, that home has at least one separate designated cooling area for every 40 residents and that the designated cooling areas are accessible to residents.

2.Train all staff and management on the licensee's policy specific to Hot Weather Guidelines, specifically but not limited to, the monitoring and reporting of air temperature, humidity and humidex readings within the home, when the Hot Weather plan is to be implemented, by whom and interventions to be taken for the safety and well-being of residents and others. A written record must be kept of this training.

Grounds / Motifs :

1. The licensee failed to ensure that the written hot weather related illness prevention and management plan that meets the needs of the residents, is developed in accordance with evidence-based practices and, if there is none, in accordance with prevailing practices, and is implemented when required to address the adverse effects on residents related to heat.

The licensee policy, 'Hot Weather Plan-Residents' (effective date May 2018) indicates that Caressant Care will make every attempt to keep our residents comfortable and well during the hot weather season. The season typically between May 01 and September 30. The Hot Weather Plan-Residents policy indicates that keeping residents comfortable and well will be accomplished from a multi-disciplinary approach, every department has an important role to play. The policy, Hot Weather Plan-Residents directs:

The Administrator will:
- ensure the indoor temperatures and humidex levels are monitored and recorded at the specified times; (refer to policy and procedure entitled Hot Weather Plan-Taking of Humidity and Temperature Readings)
- ensure the humidex level is communicated to staff and residents;
- ensure all staff have been educated to the signs and symptoms of heat related illness;
- implement policies and procedures for the prevention and management of heat related illness;
- monitor and assess the need to declare heat related emergency.

Nursing Department will:
- assess the need for additional fluids to residents 24 hours a day, seven days per week based on assessed needs;
- assess and implement body cooling strategies as required;
- assess and provide additional skin care in response to hygiene requirements of each resident;
- monitor residents for signs and symptoms of heat related illness;
- encourage residents to spend time in the air conditioned lounges;
- during the night, open the doors to the air conditioned lounges, to release the cool air into the corridors.

Housekeeping Department will:
- ensure shades, drapes, blinds and window coverings are kept closed during the warmest parts of the day.

Maintenance Department will:
- ensure lights remain on.

The licensee's policy, 'Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents' (effective May 2018) indicates that Caressant Care will monitor the indoor temperature and humidity levels so that staff can be on heightened alert for signs and symptoms of resident distress due to heat.

Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents policy indicates that a thermal hygrometer is placed in every corridor which is frequented by residents. For a specified period every year, the humidex will be recorded at the start of every shift and more frequently if deemed necessary.

The supervisor and or charge nurse shall:
- refer to the hygrometer for the temperature and the humidity level. Both of these readings are recorded on the 'Hot Weather Plan-Indoor Humidex Recording Form';
- then refer to the humidex chart, align the air temperature with the temperature column (far left) and the humidity level with the humidity row across the top. The humidex value is where the two numbers meet on the chart;
- record the humidex level on the humidex recording form;
- refer the humidex reading to the legend, if the humidex is between 30-39, the Executive Director will communicate this to the staff and the hot weather guidelines will be put into effect.
- the hot weather guidelines will remain in effect until the humidex falls below 30.

Related to Intake #016087-18:

There are 124 residents residing at Caressant Care-Lindsay. The long-term care home (LTCH) has three resident home areas (RHA).

The ED indicated to Inspector #554 that the licensee has policies specific to 'Hot Weather' which included the monitoring of residents for heat related illness and monitoring of indoor temperatures and humidity. The ED indicated that registered nursing staff take air temperatures in the LTCH during their assigned day, evening and night shifts and indicated that air temperatures are recorded for all RHAs. The ED indicated that the LTCH is equipped with designated cooling areas for residents and indicated that resident accessible cooling areas are located in the following areas of the LTCH:

In an identified Wing RHA:

- Four identified areas.

In other identified Wing RHA:
- Three identified areas.

In another identified Wing RHA:
- Two identified areas.

On an identified date and time, Inspector #554 observed the following:

- approximately 5-6 residents sitting in wheelchairs and chairs adjacent to the nursing station, on an identified Wing RHA, resident's faces were observed flushed, three of the residents were asleep in their wheelchairs;
- resident #043's face was observed flushed, damp with sweat and resident's shirt (back portion) was observed 'wet', as resident walked down the hallway;
- one resident was observed sitting in an identified common area, the door to the area was closed and the window air conditioning (AC) unit was on;
- there were no residents observed in the other identified common area, which is located on an identified Wing, door to the room was open and the AC window unit was not observed to be turned on;
- the dining rooms on an identified Wing, which have AC, were locked and not accessible to residents outside of meal times;
- the hallway lights of an identified Wing, were observed turned off;
- Six identified resident rooms and one identified common area windows were observed to be open
- the dining rooms on identified Wings, which have AC, were observed locked and not accessible to residents outside of meal times.

Resident #002 indicated to Inspector #554, that the temperature in the LTCH was 'unbearable', and that the temperature worsens as the late afternoon and evening approach.

On identified date and time, the following temperatures and humidity readings were taken by Inspector #554, using licensee owned hygrometers in the hallways of the RHAs:
- In two areas of an identified Wing – 25 Celsius (C) / humidity 65 and – 28 C / humidity 60.

- In two areas of other identified Wing – 25 C / humidity 70 and – 25 C / humidity 74.
- In one area of other identified Wing – 24 C / humidity 80.

Referencing the licensee's policy, Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents, to determine the humidex within the LTCH. Inspector #554 referenced the humidex chart within the policy, which indicated the humidex in RHA's hallways was 31-35

RPN #122, who was the designated Charge Nurse (CN) on identified date, indicated, to Inspector #554, that the CN routinely takes the air temperatures in the hallways and records it on the 'Air/Water Temperature Daily Log'. RPN #122 indicated air temperatures are taken on all shifts. RPN #122 indicated that registered nursing staff do not take humidity readings. RPN #122 indicated being unaware of what the air temperature in the LTCH was to be. RPN #122 indicated that as the CN on the assigned shift on identified date, there has been no communication to staff as to the Hot Weather Plan being in place. RPN #122 indicated that there has been no direction, by nursing management or the Executive Director, to take additional air temperature readings. RPN #122 indicated being unaware of the licensee's policies, specific to, Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents and or Hot Weather Plan-Residents. RPN #122 indicated being unaware when the Hot Weather Plan is to take effect and or who is to communicate that the plan is in effect. RPN #122 further indicated that the windows in the home are open to allow air into the LTCH, and indicated that the dining room doors are only unlocked during meal times.

Subsequent air temperatures and humidity readings were taken on five identified dates by Inspector #554. Inspector used referenced the humidex chart the Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents policy to determine the humidex in the LTCH on the identified dates, the following was determined:

On five identified dates, the recorded temperatures in multiple areas in the home were between 24 to 28 Celsius with recorded humidity readings ranging between 60 to 72. The humidex level in the long-term care home was identified by Inspector #554 to be 30-39.
At an identified date and time:
- Three areas of identified Wing: 28 C/ humidity 62 / humidex 35, 28 C / humidity 62 /

humidex 35 and 27 C / humidity 62 / humidex 33.
- Two areas of other identified Wing: 25 C / humidity 72 / humidex 32 and 24 C / humidity 71 / humidex 30.

At later time on same date:
- Three areas of identified Wing: 28 C / humidity 63 / humidex 39, 27 C / humidity 67 / humidex 34-35, and
27 C / humidity 65 / humidex 34.

At an identified date and time:
- Three areas of identified Wing: 28 C / humidity 63 / humidex 35, 28 C / humidity 68 / humidex 36-37 and 27 C / humidity 68 / humidex 34-35.

At an identified date and time:
- Two areas of identified Wing: 28 C / humidity 62 / humidex 35 and 27 C / humidity 65 / humidex 34 .

At an identified date and time:
- Three areas of identified Wing: 28 C / humidity 62 / humidex 35, 27 C / humidity 61 / humidex 33 and 26 C / humidity 64 / humidex 31.
- One area of other identified Wing: 24 C / humidity 70 / humidex 30.

At an identified date and time:
- Three areas of identified Wing: 28 C / humidity 60 / humidex 35, 28 C / humidity 60 / humidex 35 and 27 C / humidity 62 / humidex 33.
- Two areas of identified Wing: 25 C / humidity 70 / humidex 32 and 24 C / humidity 70 / humidex 30.

Further observations on five identified dates identified that hallway lights of an identified wing, were turned off; windows in six identified resident rooms and one common area were open; the dining rooms on all wings were locked and not accessible to residents outside of meal times; the AC unit in a common area in identified wing was on, the door was open, and there were residents in the area; one to two residents were in the other common area; and five to seven residents were seated, in wheelchairs, in the hallway adjacent to the nursing station, and residents faces were observed flushed.

RN #100 and RN #130, who are CN's, indicated to Inspector #554 that hallway air temperatures are taken by the CN on each shift and recorded on a form entitled Air/Water Temperature Daily Log. RN #100 and RN #130 indicated that humidity readings are not taken, nor does the Air/Water Temperature Daily Log have a space for humidity readings to be recorded. RN #100 and RN #130 indicated being unaware of how to determine the humidex level in the LTCH. Both RN's indicated being unaware when the Hot Weather Plan is to take effect and or who communicates that the plan is in effect. RN #100 and RN #130 indicated being unaware of the licensee's policies, specific to, Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents and or Hot Weather Plan-Residents, both indicated never seeing either policy.

PSW #131, RPN #122, RN #100, #130, #134 and RCC #104 indicated, to Inspector #554, being unaware if the Hot Weather Plan was in affect during their shift on these dates. PSW, RPN and RN's indicated that the dining rooms are routinely locked between meals and not accessible to residents.

PSW #151 indicated to Inspector #554, being unfamiliar with the term 'Hot Weather Plan' was. PSW #151 indicated 'when it is hot inside, we open windows in resident rooms and lounges'. PSW #151 indicated that if 'residents were hot, they would have dry lips and I would give them water'. PSW #151 indicated that residents are routinely offered fluids during meals, and during the morning, afternoon evening snack cart. PSW #151 indicated being unaware of the Hot Weather Plan policies.

RCC #104, who indicated being the Interim DOC, indicated to Inspector #554, being 'unfamiliar' with the contents of the licensee's policies, Hot Weather Plan-Residents and Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents. RCC #104 indicated being unaware of how to determine the humidex level and indicated being unaware of when the Hot Weather Plan would be activated and or by whom.

During a second interview, the ED indicated being unaware of the contents of the Hot Weather Plan-Residents and Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents policies. The ED indicated that the policies 'must have changed at some point' and indicated that changes with the policies 'had not been communicated' to the LTCH by Caressant Care Corporate Office. The ED indicated being unaware that registered nursing staff were to be taking humidity readings, were

to be using the form entitled 'Hot Weather Plan-Indoor Humidex Recording Form', was unsure how to determine the humidex level in the home and indicated, being unaware when the Hot Weather Plan was to be communicated to staff and residents and by whom. The ED further indicated that the nursing staff were correct, dining rooms are locked outside of mealtimes.

The licensee has failed to ensure that the written hot weather related illness prevention and management plan that meets the needs of the residents was implemented. [s. 20. (1)]

2. The 'Guidelines for the Prevention and Management of Hot Weather Related Illness in Long-Term Care Home' (dated July 2012) indicates that the 'guidelines reflect multiple sources of evidence-based practices' and 'consistent with requirements outlined under O. Reg. 79/10, s. 20 (1).

The Guidelines for the Prevention and Management of Hot Weather Related Illness in Long-Term Care Home indicate that, in order to respond appropriately to hot weather conditions, LTCH's should prepare in advance of the hot weather season and review and update annually a plan that will be in effect during the hot weather season. The Guideline specifically direct the following:

The Administrator will:
- Develop a communication protocol to convey hot weather action plan (including humidex readings) to residents, staff, volunteers, family, visitors and others as required.
- Implement annual staff education and training program on prevention and management of heat related illness and hot weather plan

All Staff will:
- Attend annual staff education and training program on prevention and management of heat related illness
- Review policies and procedures for heat related emergencies.

The licensee policy, 'Hot Weather Plan-Residents' (effective May 2018) indicated the Administrator will, ensure that the humidex level is communicated to staff and residents and will ensure that all staff have been educated to the signs and symptoms of heat related illness.

The licensee's policy, 'Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents' (effective May 2018) directs that the ED will communicate to staff if the humidex is between 30-39 and that the hot weather guidelines will be put into effect. The policy directs that the hot weather guidelines will remain in effect until the humidex falls below 30.

Related to Intake #016087-18:

Caressant Care employs approximately 160 staff and seven managers within the LTCH.
The ED indicated, to Inspector #554 on an identified date that staff and managers are informally aware of the licensee's Hot Weather policies and procedures. The ED indicated informally meant 'word of mouth' at morning huddles. ED indicated staff do not receive formal training specific to the Hot Weather Plan.

On six identified dates, the humidex level in the long-term care home was identified by Inspector #554 to be 30-39. The licensee's hot weather plan was not communicated to staff and residents.

RPN #122, who was the designated CN, indicated to Inspector #554 being unaware of the Hot Weather Plan policy, when the plan is to take effect and who communicates that the plan is in effect.

RN #100 and RN #130, who are both CN's, indicated to Inspector #554, being unaware of the Hot Weather Plan policy, when the plan is to take effect and who communicates that the plan is in effect.

PSW #131 and PSW #151 indicated, to Inspector #554, being unfamiliar with the Hot Weather Plan policy. PSW #151 indicated that staff would open windows if the building was too hot and indicated, if resident's lips were dry staff would give residents water.

RN #159, who is a contracted agency staff, indicated to Inspector #554, being unaware of the licensee policy and or procedures specific to the Prevention and Management of Hot Weather Related Illness.

RCC #104, who indicated being the Interim DOC, indicated to Inspector #554, that his role, as RCC, included Staff Education. RCC #104 indicated that approximately thirty-nine nursing staff were provided education specific to 'Hydration during Hot Weather'. RCC #104 indicated the staff had not been provided education specific to the licensee's Hot Weather Plan. RCC #104 indicated being unaware that staff are to receive annual education specific to the Hot Weather Plan. RCC #104 indicated being unaware of the contents of the licensee's policies related to the Hot Weather Plan.

During a follow up interview, the ED indicated being unaware of the contents of the licensee's policies, Hot Weather Plan-Residents and Hot Weather Plan-Taking of Humidity and Temperature Readings-Residents.

The licensee has failed to ensure that the written hot weather related illness prevention and management plan that meets the needs of the residents, was implemented when required to address the adverse effects on residents related to heat, specifically the licensee failed to ensure that staff are provided education related to the Hot Weather Plan.

The severity of this issue was determined to be a level 2 as there is potential harm to residents. The scope of the issue was level 3 - widespread, as identified by inspector #554 during this inspection. The licensee has no compliance history pursuant to O. Reg. 79/10, s. 20 (1). (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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

(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).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 129 (1).

Specifically the licensee shall:

1. Develop and implement a plan to ensure that all drugs are stored in an area or a medication cart that is secured and locked. This plan is to be in writing and communicated to all registered nursing staff and nursing managers. A written record must be kept of this plan and communication must be kept.

2. All registered nursing staff and nursing management to receive training on the licensee's policy related to medication management systems, specifically the safe storage of drugs. A written record must be kept of this training.

3. Develop and implement a plan which outlines corrective action to be taken and by whom should registered nursing staff fail to comply with the licensee's written policy related to medication management systems, specifically the safe storage of drugs. This plan is to be in writing.

Grounds / Motifs :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secured and locked.

During the initial tour of the long-term care home, Inspector #554 observed the following:
- Two medication cups containing an identified amount of medication were observed sitting on top of a medication cart. The medication cart was located outside of an identified Wing RHA dining room. There was no registered nursing staff in attendance at the time of the observations. RPN #101 returned to the medication cart approximately three minutes later.
- An opened container of identified medication was observed sitting on top of a medication cart in the hallway of another identified wing RHA. The medication cart was observed unlocked and unattended. Residents were observed walking past the medication cart.

RPN #101 indicated to Inspector #554, that the medication cups had an identified medication. RPN #101 indicated pre-pouring the medication 'for ease' and indicated

being aware that medication was not to be left unattended.

RN #100 indicated to Inspector #554, that medications were not to be left unattended at any time. RN #100 indicated that medications are to be stored inside medication carts and medication carts are to be locked when registered nursing staff are not in attendance.

Further Observations:
- Multiple observation on identified date, Inspector #554 observed an opened container of identified medication on top of a medication cart outside the dining room on identified wing RHA. RPN #122, who was the assigned medication nurse, nor any other registered nursing staff were in attendance. Resident #039, as well as other residents were observed wandering past the medication cart.
- On an identified date and time, opened container of identified medication and a container of another identified medication were observed sitting on top of a medication cart, outside the dining room of an identified wing RHA. RPN #123, who was the assigned medication nurse, nor any other registered nursing staff were observed in attendance.
- On identified date, during the morning medication pass, an opened container of identified medication was observed on top of the medication cart, adjacent to the nursing station on identified wing RHA. No registered nursing staff were observed in attendance. The medication cart was observed unlocked. Residents were observed wandering past the medication cart.
- On identified date, during the morning medication pass, an opened container of identified medication was observed on top of the medication cart, outside the dining room on identified wing RHA. The medication cart was observed unlocked. RPN #112, who was the assigned medication nurse, was observed in the dining room with back to the medication cart.
- On identified date, during the morning medication pass, a container of identified medication was observed on top of a medication cart, outside the dining room on idnetified wing RHA. No registered nursing staff were observed present.

RPN #122 indicated to Inspector #554, being aware that medications were not to be left unattended.

RCC #104 indicated to Inspector #554, that registered nursing staff are aware that medications are not to be left unattended and medication carts are to be locked when

staff are not in attendance. RCC indicated being aware that the registered nursing staff are leaving medications unattended and medication carts unlocked and indicated that all registered nursing staff had been provided education recently. RCC #104 indicated that RPN #101, RPN #112, RPN #122 and RPN #123 had signed off education and had acknowledged awareness following the education. RCC #104 indicated awareness that medications being left unattended continues to be an issue of concern in the long-term care home and indicated being 'unsure how to get staff to be compliant with practice and policies'. RCC #104 indicated that the Executive Director, DOC and Corporate Office is aware of concerns surrounding the safety of medications.

The Executive Director indicated to Inspector #554, being unaware that registered nursing staff were leaving medications unattended or medication carts unlocked. The ED indicated that medications were not to be left unattended.

The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secured and locked.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents and others. The scope of the issue was level 2 - pattern, as during this inspection there were several incidents of registered nursing staff leaving drugs not secured as identified by inspector #554 during this inspection even following Inspector #554 bringing this to the licensee or designates awareness. The licensee has no compliance history pursuant to O. Reg. 79/10. s.129 (1). (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 131.

Specifically the licensee shall:

1. Develop and implement a plan to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, specifically but not limited to, resident #003 and all other residents prescribed medication and treatment for management of diabetes.

2. Develop and implement a plan to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. The plan is to be communicated to all registered nursing staff, nursing managers, personal support workers and others (as applicable). The plan and communication is to be in writing and a written record is kept.

4. All registered nursing staff to receive training on the licensee's policy related to medication management systems, specifically the administration of drugs in accordance with directions for use by the prescriber and safe administration of drugs. This training shall include, but not limited to, timely or directed communication with the physician should the nurse not be able to administration a drug to a resident according to directions for use. A written record must be kept of this training.

5. Develop and implement a plan which outlines corrective action to be taken and by whom should registered nursing staff fail to comply with the licensee's written policy related to medication management systems, specifically the administration of drugs in accordance with directions for use by the prescriber and safe administration of drugs . This plan is to be in writing.

Grounds / Motifs :

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

While inspecting upon compliance order under O. Reg. 79/10, s. 114, compliance due date of June 18, 2018, the following was identified.

Resident #003 has an identified diagnosis.

Physician orders indicated resident #003 was prescribed the following:

- Identified medication (an identified dosage) to be administered at two identified times. The physician's order indicated that the medication was depending on the result of an identified test, and indicated that the physician was to be called. This physician's order was effective until an identified date.
- Identified medication to be administered as directed. The physician's order directed that the physician was to be contacted following administration of the medication or if registered nursing staff were unsure that the medication should be administered.

The clinical health record indicated the following for identified month.

- Identified tests results at specified dates and times were documented in the eMAR, at below specified level on multiple dates.
- On identified date and time, CN-RN #134 documented in the eMAR, indicated the physician prescribed an identified medication to be held due to specified test results. There is no documentation to indicate that the test was repeated by RN #134 or another registered nursing staff and There is no supporting documentation indicating the physician was notified.
- On identified date and time, the eMAR documentation indicated that the results of a specified test were at an identified level and indicated that the prescribed identified medication dose was administered by an RPN. There is no supporting documentation indicating that the physician was notified of the tests results.

- On identified date and time, the eMAR documentation indicated that the results of a specified test were at an identified level. There is no indication that an identified medication was administered as prescribed. At an identified time, the documentation indicated that a specified tests results were at specified level. The eMAR indicated that resident was not administered the identified medication. There is no documentation in the clinical health record indicating the physician was notified of the test results and that the medication was not administered.

- On identified date and time, the eMAR documentation indicated that the results of a specified test were at an identified level. The eMAR indicated that the identified medication was held. There is no documentation in the clinical health record

indicating the physician was notified of the test results and that the medication was not administered.

- On identified date and time, the eMAR documentation indicated that the results of a specified test were at an identified level. The eMAR indicated that the identified medication was held. There is no documentation in the clinical health record indicating the physician was notified of the test results and that the medication was not administered.

- On identified date and time, the eMAR documentation indicated that the results of a specified test were at an identified level and an identified medication was administered. There is no supporting documentation to indicate that the physician was contacted following administration of the drug.

RN #100 and RPN #155 indicated to Inspector #554, that drugs are to be administered according to the directions by the physician.

The Physician indicated being unaware that resident #003 had not been administered drugs according to the physician's orders on four identified dates and indicated not being aware that resident's identified test results were below certain level. The Physician indicated that physician's orders for resident #003 were 'clear' indicating registered nursing staff were to contact doctor (MD) if the specified test results were under specified level. The Physician indicated that physician's orders are to be followed unless otherwise indicated by the physician. The physician indicated being unaware that an identified medication was administered on an identified date.

On an identified date, the physician's order were reviewed and a specified dose of identified medication was prescribed to be administered at a specified time.

The clinical health record indicated the following:

- On an identified date, the eMAR for an identified medication was signed and coded as '5' meaning 'hold/see nurses notes'. A progress note, documented by RPN #161 indicated 'resident's specified test result was at a specified level. RPN #161 and CN-RN #130 decided to hold the medication.
- On an identified date, the eMAR for an identified medication was signed and coded

as '2' meaning 'drug refused'. A progress note, dated documented by CN-RN #140 indicated resident #003 was exhibiting responsive behaviours when registered nursing staff attempted to administer the medications. Documentation indicated resident was not administered the medication due to responsive behaviour. There is no documentation to indicate medication administration was attempted again.

- On an identified date, the eMAR for an identified medication was signed and coded as '5'. There was no progress notes to correspond with the identified medication not being administered as prescribed by resident #003's physician.

- On an identified date, the eMAR for an identified medication was signed and coded as '5'. A progress note, documented by an RN indicated a specified test results was at a specified level.

The clinical health record for the above identified four dates, fails to provide support that the physician for resident #003 was contacted when registered nursing staff did not administer an identified medication in accordance with physician's directions, nor is there a physician's order, during an identified month, directing that an identified medication be held or not given to resident #003.

The ED indicated to Inspector #554, that registered nursing staff are to follow physician's direction related to the administration of drugs.

The Physician, for resident #003, indicated, being unaware that registered nursing staff were not administering an identified medication as prescribed. The physician indicated that the medication was not to be held and/or not administered unless directed otherwise by a physician. The Physician for resident #003 indicated frustration with registered nursing staff not following physician's orders.

The Director of Regional Operations indicated to Inspector #554, that physician's orders are to be followed as indicated by the physician.

The licensee has failed to ensure that drugs were administered to resident #003 in accordance with the directions for use as specified by the prescriber.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents and others. The scope of the issue was level 2 - pattern,

as during this inspection there were several incidents of registered nursing staff not following prescribed physician orders as identified by inspector #554. The licensee has a level 3 compliance history as the licensee has been identified as being non-complainant pursuant to O. Reg. 79/10, s. 131 (2). The license was issued a Voluntary Plan of Correction (VPC) under Inspection Report #2015_360111_0028, on December 16, 2015 and a VPC under Inspection Report #2018_591623_0003, issued on January 23, 2018. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of March, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by SAMI JAROUR (570) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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Service Area Office / Bureau régional de services : Central East Service Area Office