Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 31, 2018	2018_559142_0005	016350-18	Resident Quality Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Carlingview Manor
2330 Carling Avenue OTTAWA ON K2B 7H1

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

JANET MCPARLAND (142), ANANDRAJ NATARAJAN (573), GILLIAN CHAMBERLIN (593), JESSICA LAPENSEE (133), LISA KLUKE (547)

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 12, 13, 16, 17, 19, 20, 23-27, 29,30,31 and August 1, 2018.

The following intakes were completed during the Resident Quality Inspection (RQI): -Log #019636-17 (CIR #2420-000078-17), Log #021030-17 (CIR #2420-000084-17), Log #022151-17 (CIR #2420-000089-17), Log #027413-17 (CIR #2420-000103-17), Log #003821-18 (CIR #2420-000013-18), Log #004587-18 (CIR #2420-000014-18), Log #006775-18 (CIR #2420-000023-18), Log #014219-18 (CIR #2420-000047-18) related

to injuries that resulted in transfer to hospital
-Log #022353-17 (CIR # 2420-000091-17), Log #028141-17 (CIR #2420-000107-17), Log #028222-17 (CIR #2420-000108-17), Log #005529-18 (CIR #2420-000020-18), Log #008783-18 (CIR #2420-000033-18), Log 011681-18 (CIR #2420-000046-18) related to resident to resident alleged abuse
-Log #005349-18 (CIR #2420-000017-18) related to alleged staff to resident improper care
-Log #024747-17, Log #026707-17 complaints related to pest control management
-Log #028266-17, Log #02822-17, Log #008904-18, Log #009452-18 complaints related to provision of care-falls management, continence care, medication administration, dining and snack service.
-Log #010996-18 complaint related to refusal for application for admission

During the course of the inspection, the inspector(s) spoke with residents, family members, the Presidents of Resident and Family Councils, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Housekeeping Staff, RAI-MDS Co-ordinator, Associate Directors of Care (ADOC), Registered Dietitians (RD), Physiotherapist (PT), Environmental Services Manager (ESM), Director of Care (DOC), Assistant Executive Director, and Executive Director.

During the course of the inspection, the inspectors, conducted a tour of the resident care areas, observed delivery of resident care, staff to resident interactions, resident to resident interactions, infection control practices and medication administration. In addition, inspectors reviewed resident health care records, applicable policies, Resident and Family Council meeting minutes and licensee's investigation documents related to above identified inspections.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provided direct care to resident #003.

During the inspection, Inspector #593 observed a logo July 19, 2018, posted on the wall, behind resident #003's bed. The logo was a picture that communicated to staff, the method of transfer they were to use when transferring the resident to and from bed. The description below the logo described a specific type of transfer method.

During an interview with Inspector #593, July 19, 2018, PSW #123 reported that they were transferring resident #003 using a specific transfer intervention with two persons, they added that this required the resident to weight bear. When the PSW was asked where the residents transfer information was located, the PSW showed Inspector #593 the transfer logo, located on the wall behind the residents bed.

During an interview with inspector #593, July 19, 2018, RN #117 reported that resident #003 was non weight bearing and that the transfer logo located on the wall behind the residents bed, was incorrect.

During an interview with Inspector #593, July 19, 2018, PT #124 reported that resident #003 was non weight bearing for transfer and they were still waiting on an assessment from the hospital regarding their weight bearing status. The PT was asked to describe the logo that was located on the wall behind the resident's bed. The PT replied that the logo was for a specific type of transfer, which required the resident to weight bear. They added that this method was useful if the resident was alert and cognitive as they could ask them to weight bear on one leg only however this method of transfer was not suitable for resident #003.

During an interview with Inspector #593, July 19, 2018, resident #003 reported currently they were being transferred to and from bed with a sling and two persons and the resident confirmed that their feet were on the ground during their transfers.

A review of resident #003's health care record, found the following:

• SALT- 2016 e-Assessment, dated March 21, 2018. Under methods of transfer, it was documented that for days, evenings and night shifts, an identified mechanical lift with two staff members was required.
• Care Plan- Current:
  o Toileting- Use mechanical lift to transfer on/off toilet, related to an injury resident sustained on an identified date.
  o Bathing- Use mechanical lift for transfer into the tub, related to an injury resident sustained on an identified date.
  o Transfers- Total mechanical lift, two persons assistance, related to an injury resident sustained on an identified date.

As per resident #003's plan of care, it was documented that a mechanical lift was required for all transfers. As reported by PSW #123, the resident was being transferred with a specific intervention which required the resident to weight bear, due to direction from a transfer logo that was located on the wall behind the resident's bed. Furthermore, RN #117 and PT #124 reported that resident #003 was currently non weight bearing. As such, the licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provided direct care to resident #003. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #013 as specified in the plan.

During an interview with Inspector #593, July 23, 2018, resident #013 reported that they did not receive assistance with toileting, there was no toileting plan and that they wanted to be toileted rather than void in the brief and waiting to be changed.

A review of resident #013's current care plan, found a focus related to toileting and the following intervention documented: toilet every two hours and PRN (as needed).

During an interview with Inspector #593, July 24, 2018, PSW #121 reported that they did not toilet the resident and they have not toileted them for an identified period of time as a result of resident having had a fall and sustained an injury.

During an interview with Inspector #593, July 23, 2018, RPN #108 reported that resident #013 was not on any kind of toileting schedule. The RPN then checked resident #013's care plan and added that there was a toileting plan for resident #013 however, the resident was not asking to be toileted, they were voiding in their brief and asking to be changed.

During an interview with Inspector #593, July 24, 2018, ADOC #122 reported that the resident's care plan indicated that the staff should be asking resident #013 if they need to be toileted as this resident was physically able to be toileted.

As per resident #013's plan of care, it was documented that resident #013 was to be toileted every two hours and as needed. As reported by resident #013, RPN #108 and PSW #121, the resident was not being toileted as per the toileting schedule documented in the plan of care. As such, the licensee has failed to ensure that the care set out in the plan of care related to toileting, was provided to resident #013 as specified in the plan. (log #009452-18) [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

A critical incident report (CIR) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date reporting that resident #003 needed to be transferred and as they could not weight bear, the lift was required, however the two PSWs did not use the lift and they proceeded to transfer the resident by holding them underneath their arms.

During an interview with Inspector #593, July 19, 2018, resident #003 reported that there

were two PSWs transferring them, the resident said that when they were lifting them caused an injury. Resident #003 confirmed that a lift was not used by the PSWs during this transfer.

A review of resident #003's health care record, found the following:

• SALT- 2016 e-Assessment, identified with a specific date. Under methods of transfer, it was documented that for days, evenings and night shifts, a specific mechanical lift with two staff members was required.
• X-ray report, identified with a specific date- soft tissue swelling was demonstrated.
• Progress notes:
o on an identified date- Resident reported they sustained an injury on a specific night during transfer with two person assistance. The resident mentioned that they were feeling a little pain in an identified area and requested for the staff to use the standing lift but they did not listen. They made the resident stand, while they were standing facing toward the bed, they twisted them and transferred into bed which resident sustained an injury.
o on an identified date- The resident complained of pain. The Physician assessed the resident and said that the injury could have caused the pain.
• Care Plan dated August 31, 2017:
o Toileting- Use mechanical lift to transfer on/off toilet.
o Bathing- Use mechanical lift for transfer into the tub.

As per resident #003's plan of care, it was documented that a mechanical lift was required for all transfers. As reported by resident #003, two PSWs failed to use the mechanical lift during a transfer on an identified date, resulting in an injury to an identified area. As such, the licensee has failed to ensure that the care set out in the plan of care related to transfers, was provided to resident #003 as specified in the plan. (log #022151-17) [s. 6. (7)]

4. The licensee has failed to ensure that resident #015's care set out in the plan of care was provided to the resident as specified in the plan.

On an identified date, a complaint was made to the Director of the Ministry of Health and Long-Term Care regarding a concern related to consistency of approach with resident #015 by nursing staff in the home providing care to resident #015 as specified in the plan.

On July 23, 2018 inspector #547 observed that resident #015's denture cup was located in the resident's bathroom before the lunch meal. PSW #126 was observed to have placed the resident's soiled personal clothing in the home's blue laundry bags after providing the resident personal care. PSW #126 then placed the resident's dentures inside the denture cup and located the denture cup on a shelf inside the nursing station.

On July 23, 2018 PSW #126 indicated to inspector #547 to be a casual employee in the home. PSW #126 indicated that the resident liked to hide the dentures under the resident's pillow, so the dentures were removed from under the resident's pillow after the lunch meal, cleaned and placed at the nursing station for safe keeping. PSW #126 indicated to inspector #547 not being aware that the resident's plan of care specified the denture cup is to be located next to the resident's bed to aid in preventing the resident from hiding dentures under the pillow. PSW #126 further indicated to have forgotten that the resident's soiled personal laundry is to be placed in the resident's personal laundry hamper and not in the home's blue laundry hampers.

On July 24, 2018 inspector #547 observed PSW #135 to have placed the resident's personal clothing in the home's blue laundry hampers, and indicated to inspector #547 to be a regular PSW on the resident's unit. PSW #135 further indicated to the inspector to be aware of the resident's plan of care to place soiled clothing in the personal hamper inside the resident's room, however placed the clothing in the home's laundry hamper to prevent odours as the clothing was saturated with urine.

PSW #127 also working with the resident on July 24, 2018 indicated the resident's denture cup should be kept in the bathroom as per the home's process during the lunch meal. PSW #127 indicated to inspector #547 to not be aware that the resident's plan of care indicated to leave the resident's denture cup at the resident's bedside. PSW #127 then placed the empty denture cup on the resident's bedside table, and resident #015 was observed to place the dentures after the lunch meal inside the resident's denture cup at the resident's bedside and not under the resident's pillow as identified in the plan of care. PSW #127 was surprised to see this action by resident #015 and indicated that they had no idea.

On July 26, 2018 inspector #547 interviewed ADOC #111 regarding observations and interviews conducted with PSW staff on July 23 and 24, 2018 regarding care provided to resident #015. ADOC #111 indicated that all PSWs are expected to read resident care plans prior to providing care to these residents, and that no matter if they are regular nursing staff members, or casual nursing staff members, the home's expectation is that

all nursing staff follow the resident’s plan of care as set out their plans.

As such, nursing staff are not following the resident's plan of care related to location of the resident's denture cup to prevent the resident from losing dentures in the laundry and for proper storage as well as the resident's personal laundry is not located in the resident's personal laundry hamper as identified in the plan of care.(Log # 008904-18) [s. 6. (7)]

5. The licensee has failed to ensure that resident #015’s continence was reassessed and the plan of care was reviewed and revised when the care set out in the plan has not been effective.

On an identified date, a complaint to the Director of the Ministry of Health and Long-Term care was received regarding a concern of inconsistency from nursing staff in managing the resident's continence plan of care.

On an identified date and time resident #015 was observed in bed and PSW #126 indicated the resident had a continence brief changed that morning as the resident was saturated in urine from incontinence and personal hygiene was provided before breakfast meal as required. Resident #015 returned to bed after the breakfast meal according to PSW #126 and refused to be toileted after breakfast. Resident #015 was observed by inspector #547 to be brought to the lunch meal accompanied by RN #113 and refused to be toileted before lunch. After the lunch meal, resident #015 returned to the resident's room accompanied by PSW #129 and the resident refused to be toileted and transferred self back to bed. PSW #129 indicated the resident always refuses to be toileted and is mainly incontinent. PSW#126 indicated at 1330 hours to have changed the resident's brief that was saturated with urine and stool and required the resident's clothing to be changed. PSW #126 indicated the resident always saturates clothing during the day from incontinence.

On July 24, 2018 PSW #127 indicated the resident refused care that morning and was currently wearing jogging pants. The resident was brought to lunch wearing a different colour jogging pants due to an incontinence episode. PSW #135 indicated to inspector #547 to have changed the residents brief before lunch as the resident's clothing was saturated in urine before going to the lunch meal. Resident #015 returned to room after the lunch meal, refused to be toileted and transferred self back to bed. PSW #135 indicated at 1340 hours while changing the resident's sheets as the resident was gone for a shower, that the resident's mattress and sheets were heavily saturated with urine

and odours were present. PSW #135 indicated having washed the resident's mattress as required with full linen change, however was unable to remove the lingering odour as the resident has been having issues related to continence in bed. PSW #135 indicated the resident's continence would need to be reassessed.

Resident #015's plan of care indicated the resident requires support of one nursing staff member to be toileted upon request for continence. The resident's plan of care further indicated the resident is incontinent of urine and stool most of the time. The resident's plan of care does not identify the resident's responsive behaviours of refusing personal care and hygiene, directions for staff approach options, or requirements to change the resident's brief to avoid complications related to skin care management, falls prevention and hygiene requirements by remaining clean, dry and odour free. (Log # 008904-18) [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that plans of care set out clear direction to staff and others who provide direct care to residents, that care set out in plans of care are provided as specified in the plans and that residents are reassessed and plans of care are reviewed and revised at least every six months and at any other time when care set out in the plans have not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with weight changes, as described under this section, are assessed using an interdisciplinary approach and that actions are taken and outcomes are evaluated.

On July 16, 2018, Inspector #573 reviewed resident #002's health care record which indicated that on an identified date, the resident was sent to hospital and diagnosed with a specific diagnosis. The most recent Nutrition assessment was conducted by the Registered Dietitian (RD) on April 27, 2018 for resident's significant change in health status. Resident #002 was identified as high risk for nutrition and hydration.

The monthly weight record for resident #002 was reviewed from April to July 2018 and was as follows:
April 2018 – 87 kgs
May 2018 – 80.2 kgs
June 2018 – 78.2 kgs
July 2018 – 73.9 kgs

Resident #002 was identified by the Inspector as having a weight loss of 7.8% over one month in May 2018, 10.3% over two months in June 2018 and 15.1% over three months in July 2018.

On July 16, 2018, Inspector #573 reviewed resident #005's health care record which identified that resident was high risk for Nutrition and Hydration. Resident #005's nutritional care plan goals included adequate food/ fluid intake for optimal Nutrition/ Hydration, promote weight gain, and maintain skin integrity. On February 02, 2018, the RD ordered Ensure plus 119ml four times daily.

The monthly weight record for resident #005 was reviewed from March to July 2018 and was as follows:
March 2018 – 52.6 kgs
April 2018 – 52.4 kgs
May 2018 – 52 kgs
June 2018 – 48.4 kgs
July 2018 – 46.5 kgs

Resident #005 was identified by the Inspector as having a weight loss of 6.9% over one month in June 2018 and 10.6% over two months in July 2018.

On July 16, 2018, Inspector #573 reviewed resident #002 and #005's health care record in the presence of the home's RD #104. Upon, review RD #104 indicated to the inspector that resident #002 and #005's significant weight loss, was not assessed and the outcomes were not evaluated.

As such the weight monitoring system does not ensure that for all residents, weight loss defined by O.Reg 79/10, is assessed and that actions are taken and outcomes evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 residents with weight changes are assessed using an interdisciplinary approach and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (2) The licensee shall ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care. O. Reg. 79/10, s. 34 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #015 received assistance to insert dentures prior to meals as required by the resident's plan of care.

On an identified date, the complainant indicated in a complaint made to the Director of the Ministry of Health and Long-Term Care that resident #015 is not being provided with dentures when required for meals.

On July 23, 2018 Inspector #547 observed RN #117 accompany resident #015 to the dining room for the lunch meal. Resident #015 was observed to eat soup and a milk type beverage. Resident #015 began to eat a grill cheese sandwich, and with food in mouth, asked PSW #125 to provide the resident's dentures. PSW #125 returned to the dining room with the resident's dentures and assisted the resident to insert dentures.

Inspector #547 reviewed the resident's health care records that indicated in the resident's plan of care, that nursing staff are to check the resident has dentures at meal times as the resident is known to remove dentures between meals.

On July 23, 2018 RN #117 indicated to inspector #547 that resident #015 was not checked to ensure that the resident's dentures were in the resident's mouth prior to going to the lunch meal as required (Log # 008904-18). [s. 34. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The Licensee has failed to ensure that when withholding approval for admission, the licensee shall give the persons described in subsection (10) a written notice setting out, a) the ground or grounds on which the Licensee is withholding approval; b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; c) an explanation of how the supporting facts justify the decision to withhold approval; and d) contact information for the Director.

LTCHA 2007 stipulates in s.44(7) whereby the appropriate placement coordinator gave the Licensee copies of the assessments and information that were required to have been taken into account, under subsection 43(6), and the Licensee is to review these assessments and information and shall approve the applicant's admission to the home unless, as the Licensee specified in their response letter that:

a) the home lacks the physical facilities necessary to meet the applicant's care requirements;

b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements.

The written notice provided by the Licensee was in a format of a letter with a specific date. In this letter, the Licensee did not identify the ground or grounds(a or b or both) on which the Licensee is withholding approval. In this letter, the Licensee did not provide detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care. In this letter, the Licensee did not provide an explanation of the supporting facts associated with grounds a or b or both in order to justify the decision to withhold approval. In this letter, the Licensee did not set out the contact information for the Director as required by this section. (Log #010996-18). [s. 44. (9)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004, exhibiting altered skin integrity, was assessed by a registered dietitian (RD) who was a member of the home.

During the RQI, it was identified that resident #004 had a pressure ulcer.

A review of resident #004's current care plan, documented a pressure ulcer.

A review of resident #004's health care record found a completed initial wound assessment dated a specific date in June 2018. It was documented that there was a pressure ulcer.

A review of resident #004's health care record, found that the last assessment completed by the RD was on a specific date in May 2018 and this completed as a quarterly assessment. The most recent weekly wound assessment completed on a specific date in July 2018 found that the wound was still present.

During an interview with Inspector #593, July 17, 2018, RPN #108 reported that the resident has had a recurrent pressure ulcer and that the current wound returned in June, 2018. The RPN further added that for all new wounds, a referral was made to the RD.

A review of resident #004's health care record found a referral to the RD, on a specific date in June 2018. The reason for the referral was documented as "skin integrity-pressure".

During an interview with Inspector #593, July 20, 2018, the RD reported that they did receive a referral for resident #004 however this resident had yet to be assessed. The RD added that they try to get to the referrals within 21 days however referrals related to wounds are usually prioritized. [s. 50. (2) (b) (iii)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee has failed to develop and implement a quality improvement system that monitors the quality of the pest control program.

As per O. Reg. 79/10, s. 88 (2), the licensee is required to have a pest control program in place.

On July 12, 2018, the Environmental Services Manager (ESM, #149) indicated the name of the home's current licensed pest controller. Related to cockroaches and residents' bedrooms, the ESM indicated that they saw and heard of minimal activity, with few ongoing challenges. When asked by the Inspector if they could think of any examples of bedrooms in which there was ongoing cockroach activity, the ESM referenced a specific bedroom and indicated that there was ongoing surveillance for cockroach activity and an accelerated daily cleaning program in place. The ESM indicated that overall, things seemed to be under control.

On July 12, 2018, in twelve identified resident bedrooms, including resident #009's bedroom, the Inspector observed glue board insect monitors (monitors) in and around the bathrooms sinks and/or the heating/cooling units under the bedroom windows. On the monitors, the Inspector observed between 10 and 50 dead cockroaches, of various sizes. In six of the twelve identified bedrooms including resident #009's bedroom, the Inspector also observed one or more live cockroaches on a monitor or in the general area of a monitor. The 16 monitors that were observed were not dated and were "catchmaster" brand. Many of the monitors also had white or brown bait on them. In resident #009's bedroom, the Inspector also observed a small live cockroach on the bathroom wall, above and to the right of the sink.

On July 12, 2018, housekeeper #147 indicated that it was their understanding that the monitors were being routinely observed by the pest control technicians. The housekeeper indicated that when they mop in resident bedrooms, cockroaches may come out of hiding, and they will step on them if they can.

On July 13, 2018, resident #009 indicated that they see cockroaches go up the wall around their bed, and that they use a flyswatter to swat at them when possible. The resident indicated that they have seen cockroaches on their bedside table and that

cockroaches hide under the certificates on their wall, around their bed. The resident indicated that staff were aware of the problem, and that it was ongoing. The resident indicated that there were monitors around their bed, and that they were full from what they could see. The resident indicated that it seemed that no one checked the monitors. The resident indicated that the cockroaches seemed to be out of the home's control.

On July 13, 2018, the Inspector returned to resident #009's bedroom and observed that under the resident's bed, there was a monitor with approximately 37 cockroaches on it, of various sizes, and two were alive. The Inspector also observed a live cockroach under resident #009's bed that was not in the monitor. It was observed that the outside and inside of resident #009's bedside table drawers were dirty with sticky residue and debris and there were two dead cockroaches in the bottom drawer, the floor around the bed was sticky, the wheelchair charger next to the bed was dirty with accumulated sticky matter, the underside of the bed was dirty with accumulated sticky matter.

On July 13, 2018, while in resident #009's bedroom, Personal Support Worker (PSW) #123 indicated that cockroach sightings were an everyday thing for resident #009's bedroom and for the other four bed rooms in the area.

On July 13, 2018, while in resident #009's bedroom, PSW #116 indicated that they saw cockroaches daily in resident #009's bedroom, mostly around resident #009's bed area, and in other identified rooms.

On July 13, 2018, housekeeper #148 indicated that it was known that there was a cockroach problem in resident #009's bedroom, and in other identified rooms. The housekeeper indicated that there were no additional cleaning measures in place. The housekeeper confirmed that they had been in resident #009's bedroom that morning, prior to the time that the Inspector had been in the bedroom. The housekeeper indicated that they did not check the monitors in the residents' bedrooms. The housekeeper indicated that they thought that the pest control technicians were checking the monitors, and that they were going into all of the bedrooms.

On July 13, 2018, the home's ESM and the Inspector revisited the majority of the twelve identified bedrooms, to observe the monitors and surrounding areas. Further observations were made, for example, in an identified bedroom, three live cockroaches were observed upon entry to the washroom, around the toilet, and another live cockroach was on the monitor under the sink. Behind the toilet, there was a plunger on top of a white plastic bag, and when it was moved, a number of live cockroaches dispersed. The

ESM located housekeeper #147 and directed them to remove the plunger and to clean the area. In resident #009's bed space, a live cockroach was again observed under resident #009's bed. Following their observations of the environment, the ESM indicated that resident #009's bed space would require additional cleaning interventions. In an identified bedroom, in the washroom, there was a bedpan in a bucket in front of the monitors and in the bucket there was five dead cockroaches. There were three live cockroaches on the floor, in the corner, under the sink. The ESM was informed that on July 12, 2018, the Inspector had observed a live cockroach go into the small open space above the baseboard. The ESM noted the space and indicated that it would have to be sealed. The ESM located housekeeper #148 and directed them to attend to resident #009's bed space and to the bathroom in the other identified bedroom.

Following the observation process, the ESM indicated that they had found no evidence that anyone in the home had been tasked with observing the monitors in residents' bedrooms. The ESM indicated that they had not known that the level of cockroach activity was so high in some areas. The ESM indicated that they would be contacting the pest control technician.

On July 17, 2018, the home's pest control technician (technician) indicated to the Inspector that the undated "catchmaster" monitors would have been placed in residents bedrooms in December 2017 or March 2018, during a home wide "cockroach cleanout" project (project). The technician indicated that in March 2018, any existing monitors should have been discarded, however, as they were not dated there was no way to know how long the monitors had been in place. The technician indicated that under ideal conditions, the glue surface on the monitors was guaranteed for 3 months, as was the bait. Related to residents' bedrooms, the technician confirmed that the project involved placing cockroach bait and monitors in areas such as under the bathroom sinks, and to the sides of the heating/cooling units under windows. The technician indicated that the monitors had been placed in order to allow for a determination of the level of pest activity in an area, however, no process had been put into place to re-inspect all of the monitors after they were placed. The technician indicated that before they were contacted by the ESM on July 13, 2018, they were not aware of any bedrooms with ongoing cockroach activity. The technician indicated that they had been doing routine bedroom inspections, approximately seven a month, and had not been finding evidence of ongoing cockroach activity on the monitors they had seen. The technician indicated that they would never leave a monitor with cockroaches on it.
The technician indicated that they would now be going bedroom to bedroom, to collect all of the old monitors. The technician indicated that they would make note of any activity on

the old monitors. The technician indicated that they would place new monitors where the old monitors showed signs of cockroach activity, and the new monitors would be dated. The technician indicated that they would go back to observe the new monitors, and this would allow them to develop a sense of the current level of cockroach activity and what further actions may be required.

The licensee has failed to develop and implement a quality improvement system that monitors the quality of the pest control program. (Logs #024747-17 and #026707-17) [s. 84.]

Issued on this 15th day of October, 2018

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

Original report signed by the inspector.