Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jul 19, 2017;	2017_574586_0012 (A1)	009908-17	Resident Quality Inspection

Licensee/Titulaire de permis

MAPLEWOOD NURSING HOME LIMITED
500 QUEENSWAY WEST SIMCOE ON N3Y 4R4

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

CEDARWOOD VILLAGE
500 QUEENSWAY WEST SIMCOE ON N3Y 4R4

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

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JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Report amended to correct a date in the licensee report.

Issued on this 19 day of July 2017 (A1)

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

Original report signed by the inspector.

Ontario

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

JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): May 31, June 1, 2, 6, 7, 8, 9, 13, 14, 15, 16, 19, 20, 21 and 22, 2017.

The following Follow-up Inspections were completed concurrently with the RQI:

004733-17 - Prevention of Abuse & Neglect;

004736-17 - Personal Support Services;

004738-17 - Staffing;

004739-17 - Plan of Care;

004740-17 - Responsive Behaviours;

004741-17 - Nursing and Personal Care Services.

The following Critical Incident System (CIS) Inspection was completed concurrently with the RQI:

004776-17 - Prevention of Abuse & Neglect.

The following Complaint Inspections were completed concurrently with the RQI:

005667-17 - Hospitalization & Change in Condition;

010458-17 - Minimizing of Restraining;

010745-17 - Medication Administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Nutrition Manager, RAI-MDS Coordinator, Registered Dietitian, Administration Clerk, Restorative Care staff, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), dietary staff, residents and families.

During the course of the inspection, the inspector also reviewed resident health records, medication incident investigation notes, audits, policy and procedures, and training records, interviewed staff and observed resident care and dining.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **22 WN(s)**
- **13 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 19. (1)	CO #001	2017_573581_0002	581
O.Reg 79/10 s. 31. (3)	CO #004	2017_573581_0002	586
O.Reg 79/10 s. 53. (4)	CO #006	2017_573581_0002	581
LTCHA, 2007 s. 6. (7)	CO #005	2017_573581_0002	586

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted by the home was complied with.

In accordance with Regulation, s. 68 (2), paragraph (a), the licensee was required to ensure there were policies and procedures developed and implemented relating to nutrition care and dietary services and hydration.

According to the Nutrition Manager, as and posted in the home, scheduled breakfast time was 0800 hours.

A) Breakfast meal service was observed on an identified date in an identified dining room. Around 0820 hours, the PSWs began serving the residents their drinks and oatmeal. Dietary aide #112 arrived in the dining room at 0850 hours to begin serving the eggs and toast. Observation and interview with the dietary aide confirmed that due to the delay in service, they did not check the temperature of the food prior to service.

B) Breakfast meal service was observed on an identified date in two identified dining rooms. Breakfast was scheduled to commence in both dining rooms at 0800 hours. The food was in the steam table but there was no dietary worker present. PSW #125 confirmed that the dietary aide comes and sets up the food in the steam table, then leaves to serve in the Atrium in the attached retirement home, and then later returns.

By 0815 hours, residents in one of the identified dining rooms were complaining to the LTC Inspector that breakfast was late:
i. Resident #032 said that breakfast was always late, and that they had been sitting there since 0745 hours (for 30 minutes) and had not even been given a drink.
ii. Resident #033 said that breakfast was later than ever that day; however, that breakfast was usually late, and typically begins closer to 0830 hours rather than 0800 hours every day.
iii. Resident #034 said that breakfast was always late and that it was usually served closed to 0830 hours than 0800 hours. This resident complained of this during the last RQI in January 2017; and when asked if it had improved since then, the resident said that it had not gotten any better.

Dietary aide #112 entered to dining room at 0820 hours, confirming that breakfast was late as it had gone late in the Atrium and they could not leave there until all

retirement residents were fed. The dietary aide said that retirement residents had been given a memo in the past about the importance of coming to breakfast on time; however, some still did not comply, and would come late to breakfast, which would cause the dietary aide to get to the LTC dining rooms late. The dietary aide said they knew "this was not right".

The LTC Inspector went to the large dining room at 0825 hours and observed PSW #111 completing dietary aide duties (plating hot oatmeal and cold cereals to residents from the steam table). PSW's #109, #111 and #127 verified that PSW's regularly plate and serve the cereals until the dietary aide arrived to serve the remaining hot items (eggs, toast, etc.). PSW #111 also indicated that breakfast did not usually start until 0825 hours because the PSW's needed to get everyone out of their baths and into the dining room before they could begin to serve them.

PSW #109 and RN #110 began voicing concern that breakfast was late for the residents on a daily basis due to the fact that the dietary aide needed to serve in the Atrium and then the first dining room, before making their way to the second dining room, and that it was very rushed.

Dietary aide #112 entered the second dining room at 0850 hours. They began serving the residents their eggs and toast and later confirmed that due to the delay in service, they did not check the temperature of the food prior to service.

PSW #111 told dietary aide #112 that resident #035 had left the dining room "again" before finishing their breakfast. In an interview with resident #035, they told the LTC Inspector that they had drinks and cereal but that they may have stayed and eaten the remainder of their meal if the service was not so late. The resident indicated that this happened often.

The residents were not served breakfast on time according to the home's scheduled protocol.

B) The home's policy, "Meal Service to Floors" (DDM-IV-65, last revised April 2007) read, "food temperatures will be taken and recorded in each Dining Room upon arrival". The home's Daily Temperature Sheet logs indicated that hot foods were to be held at a temperature greater than 140 degrees Fahrenheit and cold foods less than 40 degrees Fahrenheit. Interview with cook #120 and dietary aide #123 acknowledged that it was the expectation of the home that the staff check the food temperatures in the steam table just prior to service. [s. 8. (1) (b)]

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45. (1) and 45.1 of the Regulation).

Review of the registered nursing staffing schedule for a three month period identified that a Registered Nurse (RN) that was a member of the regular nursing staff was not on duty on eight shifts.

Interview with the Administrator stated that agency RN staff was present on the identified shifts but confirmed the home was unable to staff those shifts with an RN who was an employee of the home. [s. 8. (3)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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 the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers and full body sponge baths and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A. During the RQI Inspection, resident #024 was interviewed and stated that they did not receive two showers a week and would like to have a second shower. Review of the plan of care identified that they were scheduled to have a shower twice per week on specific days. Review of the POC documentation indicated that the resident did not receive their shower on an identified date and it was not made up during that week. Review of the home's staffing schedule revealed that the home was short one PSW staff that date. Interview with PSW #136 stated that if the home was short one PSW staff, some residents would not receive their bath but it was the home's expectation that the bath would be made up the next day. Interview with the RAI Coordinator confirmed that the resident did not receive two showers a week during that time period.

B. Resident #007's plan of care was reviewed and indicated they received a bath twice per week on specific days. Review of Point of Care documentation identified the resident did not receive their bath on an identified date and there was no documentation that the bath was made up during the week. Review of the home's staff schedule identified that the home worked short one PSW staff that day. Interview with PSW #136 stated that if a resident did not receive their scheduled bath due to the home area being short one PSW staff, the bath was to be made up the next day if possible. Interview with the RAI Co-ordinator confirmed that the resident did not receive two baths during that week when they did not receive their scheduled bath on the identified date.

C. Review of the plan of care for resident #028 identified they were to receive a bath twice per week on specific dates. Review of Point of Care documentation identified the resident did not receive their bath on two specific dates, and there was no documentation that the bath was made up during that week. Review of the home's staffing schedule revealed that the home worked short one PSW on each of those dates. Interview with the RAI Coordinator confirmed the resident did not receive their two baths that week.

The home did not ensure that each resident was bathed at a minimum of twice per week. [s. 33. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out, the planned care for the resident.

During the inspection, resident #020 was observed in bed with bed rails applied as well as devices to mitigate falls risk. Review of the plan of care identified that the

application of the devices on the bed was not documented. Interview with PSW #107 stated that they applied these on an identified date earlier that month as the resident was falling out of bed. Interview with RPN #104 confirmed that the application of the devices on the bed was not documented in the plan of care. [s. 6. (1) (a)]

2. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident.

Resident #031 was at nutritional risk and due to medical diagnoses, required a specific schedule for their meals and snacks. Two sections of the resident's documented plan of care, which front line staff use to direct care, had conflicting information regarding what the resident was to receive at their snacks. Resident #031's documented plan of care did not provide clear direction to staff. [s. 6. (1) (c)]

3. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Resident #031 required a specific schedule for their meals and snacks, which was outlined in the resident's documented plan of care as well as the "Diet Chart/Instructions for Intake Records" form kept in the dining room.

Through interview with staff, it was identified that the resident's regime had changed; however, the RD was not made aware of this, therefore they were unable to update the resident's plan of care. The staff did not collaborate with each other in the development and implementation of resident #031's plan of care. [s. 6. (4) (b)]

4. The licensee failed to ensure that the resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM were provided the opportunity to participate fully in the development and implementation of the plan of care.

A) A review of resident #040's clinical record identified that the physician ordered the resident to start a new medication on an identified date. This medication order was processed by RN #117, who identified that they did not notify the SDM of the

order, as this task was the responsibility of the staff member who completed the second check of the order.

A progress note identified that one of the SDMs was present in the home following the order of the new medication and spoke with RN #117; however, there was no mention of a discussion regarding the new medication order.

Interview with RPN #114 verified that they completed the second check of the order; however, did not contact the family as the check would have been completed in the early morning hours.

A note by RPN #104 identified that the following day, they contacted the SDM to notify of them of the new medication. The initiation of this medication was not agreed to by the SDM, and the RPN put a hold on the administration of the medication until the physician could be reached the following day.

The day after that, the physician was contacted and orders were received to discontinue the medication, which was communicated to the SDM.

A review of the Medication Administration Records identified that the resident was administered the medication on four occassions prior to the physician discontinuing the medication.

Interview with one of the two SDMs, who was in the same room as the second SDM when interviewed, verified that neither of the SDMs were consulted regarding the use of the medication prior to it being ordered or administered, nor were they given an opportunity to discuss why the medication was being proposed, risks or benefits of the use of the medication or a discussion of informed consent.

The SDM was not provided an opportunity to participate fully in the development and implementation of the plan of care. (168).

B) Review of the progress notes identified that resident #020 had a new bed surface. Review of the plan of care did not include documentation that the SDM was notified of the change. Interview with RPN #132 stated the resident required the new surface they were starting to develop skin breakdown; however, confirmed that the SDM was not notified when the surface was changed.

C) Review of the Evaluation For Use of Side Rails assessment indicated that on

an identified date, resident #020 received a new bed that included devices to mitigate falls. Review of the plan of care did not include documentation that the SDM was notified of the new bed. Interview with RPN #132 who documented the note stated the resident received a new bed due to risk of entrapment with their old bed. They confirmed that the SDM was not notified when the resident received a new bed which included a change in the accompanying devices. (581). [s. 6. (5)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident care needs changed.

During the course of this inspection, resident #022's room was observed with two specifics interventions in place in their room. Review of the progress notes identified when these were added. Interview with the DOC stated they did have these interventions in place and confirmed that the plan of care was not reviewed and revised when their care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a written plan of care for each resident that sets out, the planned care for the resident; to ensure the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other; to ensure that the resident, the SDM, if any, and the designate of the resident/SDM are provided the opportunity to participate fully in the development and implementation of the plan of care; and to ensure that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident care needs change, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's policy, Abuse and Neglect, ADM-II-245, dated August 29, 2015, identified under reporting an incident, that all staff, volunteers, service providers and affiliate personnel were required to: "Immediately report to the supervisor (e.g. Charge Nurse) in the home on duty at the time of a witnessed or alleged incident of abuse or neglect", and also identified that management staff "must investigate immediately all reports of abuse or neglect, in accordance with the investigation procedures set out in the document LTCHA Regulation s. 23(1)". They must notify the MOHLTC Director immediately according to protocols established for reporting of abuse and critical incidents.

A review of the progress notes for resident #026 on an identified date in April 2017, included documentation of an incident that occurred between resident #026 and resident #029 which resulted in resident #026 being injured. Interview with RN #117, who was the registered staff who assessed the injury, stated they did not report this incident to Management. They confirmed they had received training on the prevention of abuse and neglect at the home. Interview with the Administrator and the DOC stated they were unaware of the incident until the LTC Inspector brought it to their attention. They confirmed the expectation that this type of allegation be reported and investigated as per the home's policy. [s. 20. (1)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31.

Review of the Evaluation for Use of Side Rails assessment completed for resident #020 identified when they were admitted to the home in March 2017, they required two full bed rails on their bed as the family requested them due to the resident having a history of rolling out of bed. Review of the Physical Restraint Assessment revealed that the registered staff did not fully complete the assessment. Interview with RPN #132 who completed the bed rail assessment stated that they required the bed rails as a restraint to prevent them from falling out of bed and obtained consent from the SDM. RPN #132 confirmed that the physical restraint assessment documentation was not completed and the home did not trial an alternative to restraining the resident to address the risk. [s. 30. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no resident of the home is restrained by the use of a physical device, other than in accordance with section 31, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the of the required interdisciplinary programs, that were required under section 48 of the regulation, that the program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices: Ont. Reg. 79/10 s. 48(1) requires every licensee of a long-term care home to ensure that they have a skin and wound program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Interview with the Administrator verbalized that the home did not complete an evaluation of the skin and wound program in 2016. It was identified that the home had recently organized a committee who was responsible to review each required program and that a program evaluation would be completed in 2017. [s. 30. (1)]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) On an identified date in 2017, an incident occurred between resident #022 and resident #045. Resident #022 had a history of responsive behaviours which included but was not limited to physical aggression. Review of the plan of care for resident #045 identified that the incident was not documented and there was no assessment documented to rule out any injury or responses to the intervention. Interview with RPN #104 stated the resident did not sustain an injury and confirmed the incident was not documented in their plan of care.

B) Review of the progress notes identified an incident occurred between resident #026 and resident #028. This incident required an assessment of both residents to rule out any injuries. Review of the plan of care for both residents did not include documentation of the assessment or the residents responses to the intervention post incident. Interview with RPN #130 who documented the incident occurred confirmed that they assessed both residents, there were no injuries and confirmed they did not document the assessment or the response of the resident in both resident's plan of care.

C) Review of the plan of care for resident #022 identified that Behavioral Supports Ontario (BSO) staff assessed the resident due to an increase in responsive behaviours. BSO staff implemented Dementia Observation System (DOS) charting but it was not fully completed on all shifts so they implemented another five days of observation , which was also not completed fully. Interview with BSO staff stated they implemented the DOS charting as an assessment tool to identify trends and patterns of times when the resident's responsive behaviours increased. Interview with RPN #104 stated that the staff were observing the resident's responsive behaviours over both of the above time periods but did not consistently document on the daily observation record.

D) Resident #024's plan of care identified that they were to receive two baths per

week. Review of the POC documentation for bathing revealed blank entries for three identified dates in 2017.

As part of their bathing audit, the RAI Coordinator confirmed that they spoke with PSW staff who stated that the resident did receive their bath on an identified date, but this was not documented. The LTC Inspector interviewed the resident who also confirmed that they received their bath on the third identified date; however, the RAI Coordinator acknowledged that this was not documented.

Review of the staffing schedule identified that the home was fully staffed on the second identified date. Interview with the RAI Coordinator stated that when the POC was not completed and left blank that the PSW staff most likely forgot to document the bath that was given to the resident. (581).

E) Resident #006's documented plan of care identified that the resident was at risk for falls and required the use of an identified device while in their wheelchair.

Review of the resident's health record indicated that they experienced an incident involving the device that put them at risk, therefore was referred to the restorative care worker #121 by RPN #114. Staff #121 assessed the resident; however, in an interview, confirmed they could not completely recall the outcome, and that the assessment was not documented. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Resident #006's documented plan of care identified that the resident was at risk for falls and required the use of two specific falls interventions.

A progress note by RPN #114 written on an identified date in May 2017, indicated that the resident was found to have slid down their chair and were at risk of injury related to the interventions applied to their wheelchair. The RPN confirmed that restorative care worker #121 was notified and responded that they would assess a portion of the resident's wheelchair to ensure it was appropriately positioned.

During the inspection, PSW #126 indicated that the resident had identified positioning issues in their wheelchair quite frequently in the last week and a half.

In an interview with the restorative care worker they indicated they recalled assessing the resident's cushion on the identified date in May; however, was unsure why they were alerted about the incident rather than the Occupational Therapist (OT), who would have been most appropriate. They indicated that they would send a referral to the OT to assess the resident next time were they were in

the home.

A progress note written by the OT the following week indicated that the resident was inappropriately positioned due the current status of their wheelchair and interventions, and requested multiple changes, including new interventions, to mitigate the resident's risk of sliding in their wheelchair.

Resident #006 was at a safety risk of sliding in their wheelchair as identified in May 2017; however, was not assessed by the OT and interventions put into place to mitigate those risks until greater than one month later, when the LTC Inspector brought this to the attention of restorative care worker #121. [s. 49. (1)]

2. The licensee failed to ensure that the equipment, supplies, devices and assistive aides referred to in subsection (1) were readily available at the home.

Resident #006 was at a risk for falls and experienced multiple falls in the last year; many of which occurred when the resident fell out of bed. The resident's most recent fall occurred when the resident fell out of bed and resulted in injury.

Review of the resident's documented plan of care included the use of three falls prevention interventions, but did not include having the resident's bed put into the lowest position when in bed. In interviews with PSW #109 and RN #110, both staff indicated that the resident did not have this included in their plan of care due to the fact that they had one of the home's "old" beds that did not go all the way down to the floor. PSW #109, RN #110, and RPN #101 all acknowledged that the resident would benefit from a bed that went down to the floor to reduce the resident's risk of injury as they fall so frequently.

Interview with the DOC acknowledged that the resident had an "old" bed that did not go all the way down to the floor as the home was allotted three new beds each quarter and they only have 12 in the home currently, but did not have one available for resident #006, who would benefit from this.

The licensee did not ensure that falls prevention equipment was readily available in the home for those who need it. [s. 49. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the falls prevention and management program provides for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids; and to ensure that the equipment, supplies, devices and assistive aides referred to in subsection (1) are readily available at the home, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) A review of the clinical record identified that resident #009 had altered skin integrity at the time of admission which had since healed. Current progress notes identified that the resident had a new area of altered skin integrity which was treated by RPN #114. A clinically appropriate assessment instrument, that was specifically designed for skin and wound assessment, could not be located during a review of the clinical record for the new area of skin breakdown.

Interview with RPN #114 verified that they would not have completed an initial assessment of the area using a clinically appropriate assessment instrument and that their assessment findings were recorded in the progress notes, which included the size of the area, condition of surrounding skin, any drainage, any reports of pain as well as the treatment applied.

The resident who exhibited altered skin integrity was not assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

B) A review of resident #045's clinical record identified that the resident had a total of three areas of altered skin integrity as identified in the progress notes and Treatment Administration Record (TAR). There were no assessments of the areas in the record completed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment located.

Progress notes reviewed included a brief description of the area and the treatment applied to the first area when it was initially identified; however, no additional assessments regarding the area were present in the notes, the Wound Care binder or TAR binder. Progress notes reviewed for the second area of altered skin integrity included a description of the incident resulting in the area, the condition of the skin and surrounding tissue and the treatment applied when it occurred; however, no additional assessments regarding the area were present in the notes, the Wound Care binder or TAR binder. Progress notes reviewed for the third area included the actions of the resident prior to the area being identified, a description of the area and the treatment applied when it occurred; however, no additional

assessments regarding the area were present in the notes, the Wound Care binder or TAR binder.

Interview with RPN #114, who completed the progress notes for the second and third areas of altered skin integrity confirmed that the clinical record did not include an assessment of the areas using a clinically appropriate assessment instrument, specifically designed for skin and wound assessment and that she did not complete such as assessment when the second and third areas were identified. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home.

Resident #009 had a new area of altered skin integrity identified according to the clinical record. A review of the clinical record did not include a referral to nutritional services for this area of altered skin integrity nor an assessment by the RD. Interview with RPN #114, who conducted the initial assessment confirmed that a referral was not sent to the RD for an assessment to be completed. Interview with the RD confirmed that she did not recall a referral for this resident related to the area of altered skin integrity.

The resident who exhibited altered skin integrity was not assessed by the registered dietitian. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) According to the clinical record resident #009 had previous skin breakdown. A progress note identified that the resident had a new area of altered skin integrity, that a treatment was applied and noted in the Wound Treatment Book. No weekly reassessments of the area could be located during a review of the record. There were no subsequent progress notes regarding the area.

Interview with PSW #112, who reported that they provided care that morning, reported that the resident's skin was intact with no redness or open areas. A review of the Treatment Administration Record for an identified month in 2017,

identified that staff continued to apply a treatment to the area twice a day.

Interview with RPN #114 verified that they did not initiate a Weekly Skin Treatment Assessment Sheet or Resident Wound Assessment Record, both documents where this information would be recorded. The RPN identified that they would assess the area that day and take action as appropriate based on the findings including documentation of the assessment.

B) Resident #012 was identified to have an area of altered skin integrity for the past several months. A review of the clinical record did not include a reassessment of the area, on a weekly basis, by a member of the registered nursing staff, at the home.

Interview with RPN #118 verified the presence of the area and identified interventions as outlined in the plan of care to treat; however, identified that they did not document an assessment of the area, that this task was completed by the RN. Interview with RN #117 identified that any registered staff member could complete the treatment and document the assessment findings; however, verified that assessments were not completed on a weekly basis as required.

C) A review of resident #045's clinical record identified that the resident had a total of three areas of altered skin integrity as identified in the progress notes and Treatment Administration Record (TAR).

Progress notes reviewed included a brief description of the area and the treatment applied to the first area when it was initially identified; however, no additional assessments regarding the area were present in the notes, the Wound Care binder or TAR binder. Progress notes reviewed for the second area of altered skin integrity included a description of the incident resulting in the area, the condition of the skin and surrounding tissue and the treatment applied when it occurred; however, no additional assessments regarding the area were present in the notes, the Wound Care binder or TAR binder. Progress notes reviewed for the third area included the actions of the resident prior to the area being identified, a description of the area and the treatment applied when it occurred; however, no additional assessments regarding the area were present in the notes, the Wound Care binder or TAR binder.

Interview with RPN #114, who completed the progress notes for the second and third areas of altered skin integrity confirmed that the clinical record did not include

weekly assessments of the first or second areas of altered skin integrity. She identified that it was their experience that weekly reassessment of areas were documented on Weekly Skin Treatment Assessments; however, this was utilized for treatment creams only and/or the Resident Wound Assessment record which was utilized for wounds.

Not all residents who exhibited altered skin integrity were reassessed at least weekly by the registered nursing staff. [s. 50. (2) (b) (iv)]

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 resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The record of resident #055 was reviewed and it was noted that they were experiencing pain. The review identified that the resident was treated with medication which was not always effective in managing the pain. There was no record indicating that the resident was assessed using a clinically appropriate assessment instrument designed for this purpose.

The DOC was interviewed and reported that they could not locate documentation indicating that the resident's pain was assessed using a clinically appropriate assessment instrument specifically designed for that purpose. [s. 52. (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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The failed to ensure that the nutrition care and dietary services programs included, (b) the identification of any risks related to nutrition care and dietary services and hydration.

The record of resident #050 was reviewed and it was noted that they were assessed by the RD on an identified date in 2017, as they were experiencing multiple issues with eating. The resident was placed on a one-week trial of a particular textured diet and it was noted that the RD would follow-up after one week. The resident was identified as a particular nutritional risk.

There was no documentation found in the resident's records of the resident being followed-up by a RD. The Physician's Quarterly Medication and Treatment Review included the dietary order of a regular diet. The resident's documented plan of care indicated that they were on a regular diet. The resident's POC documentation was reviewed and indicated that they had poor oral intake. The resident was later admitted to hospital related to their eating difficulties.

The RD was interviewed and reported that based on the assessment they conducted and the plan implemented, the resident was at a high nutritional risk at that time and should have been identified as such in their record, but was identified as moderate and this was an error. It was the RD's last day before their vacation and they had a student with them who did the assessment. They were away from the home for a two week period. Another RD covered for them during that period and they left instruction for that RD to do a follow-up visit with the resident. They assumed the back-up RD followed up and determined that the resident could tolerate the regular diet as there was no information left for them to follow up with when they returned.

The RD searched the resident's record (including their hard copy file) and found no evidence that the back-up RD reassessed the resident as they requested. They also reported that since the resident was incorrectly identified as particular nutritional risk rather than the appropriate nutritional risk, they would not follow-up unless they received a referral.

The RD reviewed the resident's documented food and fluid intake, with the LTC Inspector. They reported that for the majority of their meals, the resident had poor oral intake. This would place the resident at a certain nutritional risk and staff should have completed a referral.

The RD reviewed the resident's record (including the hard copy file) and no referral was found related to the resident's poor food and fluid intake during the period noted above. [s. 68. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the nutrition care and dietary services programs includes, (b) the identification of any risks related to nutrition care and dietary services and hydration, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the regulations at the times or at intervals provided for in the regulations: Ont. Reg. 79/10 s. 221(1)2 identifies that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents: skin and wound care; Ont. Reg. 79/10 s.221(2) identifies that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act on an annual basis.

A review of the mandatory training records provided by the home for 2016 did not include that all staff received training in the area of skin and wound care. Interview with the DOC and Administrator acknowledged that according to the records available for staff training in 2016, approximately 61 percent of direct care staff received training in the area of skin care and pressure ulcers. The DOC verbalized plans to provide the mandatory training to all staff for 2017 and that the training would include the application of treatments creams, as this task is assigned to PSW staff, at the home, when appropriate.

Not all staff received the training as required. [s. 76. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the regulations at the times or at intervals provided for in the regulations, including skin and wound care, on an annual basis, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a personal assistive services device (PASD) under section 33 of the Act was applied by staff in accordance with any manufacturer's instructions.

A) Resident #030's documented plan of care included the use of a particular PASD. During the inspection, the resident was observed in their wheelchair with their PASD very loose. RPN #104 confirmed the PASD was at its loosest setting; however, was not aware of the requirements for appropriate application. The PT adjusted the PASD. Interview with the DOC acknowledged that staff were trained on appropriate PASD application. Resident #030's PASD was not applied by staff in accordance with manufacturer's instructions.

B) Resident #037's documented plan of care included the use of a PASD. During the inspection, the resident was observed in their wheelchair with their PASD very loose. PSW #125 confirmed the PASD was loose and appropriately adjusted it. Resident #037's PASD was not applied by staff in accordance with manufacturer's instructions. [s. 111. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a PASD under section 33 of the Act is applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The record of resident #050 was reviewed including the progress notes, eMAR, Physician's Orders, Pharmacy Requisition sheets, Physician's Medication and/or Treatment Three Month Review, and the resident's Standing Orders.

The resident's Standing Orders indicated that resident #050 was to receive a particular medication. It also included that staff must contact the doctor if therapies were required for more than 24 hours.

The resident was noted to require the medication and it was administered. They also received the medication on three other dates. Progress note documentation indicated that the resident was assessed as needing the medication on several other occasions and when staff attempted to administer the medication the resident refused. The resident was admitted to hospital related to the symptoms they were experiencing which required the use of the medication.

There was one documented instance of the staff unsuccessfully attempting to contact the physician. There was no documentation found indicating that the physician was contacted and informed that the resident required the use of the medication for more than 24 hours.

The DOC was interviewed and reported that there was no documentation indicating the physician was contacted when the resident required the medication for more than 24 hours as per the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

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

WN #15: 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 which involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and 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 the resident and the pharmacy service provider.

A) On request all medication incidents for the past quarter were provided. Medication incident reports were reviewed for three months in 2017. A review of the incident reports identified that the physician was notified after only one of the incidences and the resident assessed and monitored. Other incident reports suggested that the residents may have experienced an undesired effect from the incidents; however, there was no assessment to support these statements. There was no documentation on the reports that the resident, SDM or pharmacy were notified of the incidents.

A review of the clinical record for resident's #042, #044, #045, all who were involved in a medication incident during the identified time period, did not include the incident, actions taken to assess the residents and maintain their health or notification of the appropriate persons.

Interview with the DOC identified that in their opinion, the incident reports were consistently faxed to the pharmacy, despite there not being a record of this on the form. She also communicated plans to modify the incident report to include the requirement of notification of all parties and other required activities. (168).

B) During the inspection, the Administrator was interviewed and reported that RN #138 was involved in a medication incident on an identified date with resident #052.

A review of the document did not identify documentation indicating that the resident's SDM, the Medical Director, the prescriber of the drug and the pharmacy service provider were notified of the incident.

The DOC was interviewed and confirmed the above. [s. 135. (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 every medication incident which involved a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and 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 the resident and the pharmacy service provider, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training was provided to all staff who provided direct care to residents: 4. Pain management, including pain recognition of specific and non-specific signs of pain.

The home's 2016 Pain Management Education records were reviewed. The DOC and the RAI Coordinator were interviewed and reported that in 2016, 13 of 18 registered staff received education in pain management. In addition, they reported that the pain management education was not programmed into the 2016 annual education library of training in Surge Learning for PSWs of the home; therefore, confirmed that no PSWs received training in pain management in 2016.

The home failed to ensure that all staff who provided direct care to residents received training related to pain management, including pain recognition of specific and non-specific signs of pain. [s. 221. (1) 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 for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training is provided to all staff who provided direct care to residents: 4. Pain management, including pain recognition of specific and non-specific signs of pain, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home; 2007, c. 8, s. 15 (1).
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and 2007, c. 8, s. 15 (1).
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure there was an organized program of housekeeping for the home.

During the inspection, one resident, one family member, and one private care worker expressed concern to the LTC Inspectors about the cleanliness of the resident rooms.

Tour of the resident rooms identified that the floors appeared dull and several had significant scuffing. Debris was found under resident beds and behind doors.

The home's policy, "Complete Cleaning of Room" (policy number HKM-IX-121), indicated the following:

1. With damp rag wipe down all furniture, knick knacks, window sills, tops of wardrobes and light fixtures.
2. Dry wet surfaces with a dry rag.
3. Polish all stainless steel fixtures with stainless steel polish.
4. Wipe any glass areas with vinegar and water solution.
5. Spot wipe doors and walls.
6. Polish any wood surfaces with furniture polish.
7. Moving all furniture, sweeping and wet mopping behind everything. Wipe floor borders with a rag dampened in disinfectant solution.
8. Returning all furniture to its previous position.

Interview with the Nutrition, Laundry and Housekeeping Manager, as well as the Administrator, confirmed that the deep cleaning of rooms had not been a regularly scheduled procedure and had only been happening periodically, but would be implemented in the upcoming month.

The licensee did not ensure there was an organized program of housekeeping for the home related to the complete cleaning of resident rooms. [s. 15. (1) (a)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Prevailing practices were identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), the decision to use, continue to use, or to discontinue the use of a bed rail would be made within the context of an individual resident assessment using an interdisciplinary team with input from the resident or the residents substitute decision maker (SDM). The guideline emphasizes the need to document clearly whether interventions were used and if they were appropriate or effective. Other questions to be considered would be the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors, the status of the resident's bed (whether passed or failed zones 1-4). Consideration of these factors would more accurately guide the assessor in making a decision, with either the resident or by the resident's SDM about the necessity and safety of a bed rail. The final conclusion would then be documented on a form (electronically or on paper) as to why one or more bed rails were required, the type of rail, when the rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system

was necessary to minimize any potential injury or entrapment risks to the resident.

During the inspection, resident #020 was observed in bed with bed rails raised. Documentation in the resident's health record identified that they received a new bed surface as well as a different type of bed rail the following month; however, there was no documentation regarding bed rail assessment when the resident's bed system was changed. Interview with RPN #132 confirmed that a bed rail assessment was not completed when the resident received a new mattress or when they received a new bed system with two quarter bed rails. [s. 15. (1) (a)]

2. The licensee failed to ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During the inspection, resident #020 was observed in bed with bed rails raised. Documentation in the resident's health record identified that they received a new bed surface as well as a different type of bed rail on an identified date; however, there was no documentation regarding bed rail entrapment assessment when the resident's bed system was changed. Review of the Facility Entrapment Inspection sheet dated on May 10, 2017, identified that the bed system was not assessed for zones of entrapment when the resident's mattress changed. Interview with PSW #134 who was the staff trained to test the beds for potential zones of entrapment confirmed that when the resident's mattress was changed there were no bed accessories in place and the bed system was not tested for any risk. They stated that they were told by an outside contracted company that all identified bed surfaces fail zones one to four. Interview with Administrator and PSW #107 confirmed that no bed accessories were in place on the bed to mitigate the risk of potential entrapment until two months later when accessories were put on the bed. [s. 15. (1) (b)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 10. Health conditions, including allergies, pain, risk of falls and other special needs.

The record of resident #050 was reviewed and it was noted that the resident experienced pain. The plan of care was reviewed and pain in the identified areas was not included in the resident's plan of care. The DOC as interviewed and confirmed that the resident's pain was not included in their plan of care. [s. 26. (3) 10.]

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

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the home's menu cycle included menus for regular, therapeutic and texture modified diets for both meals and snacks.

The home's lunch menu for May 31, 2017, included a second option of a cold plate that included pasta salad, a slice of cheddar cheese, two slices of salami, and tomato and red pepper slices. Observation of the lunch meal service on the second floor identified that there was no minced or pureed cheddar cheese, tomato slices or red pepper slices for the residents requiring minced or pureed diets. These residents received only minced or pureed pasta salad and salami. Interview with dietary aides #102 and #103 confirmed that there were no minced or pureed cheese, tomatoes or red peppers prepared by the kitchen, and confirmed that residents receiving those diets only received pasta salad and salami. Review of the kitchen's recipes and production sheets could not include these items for texture-modified diets. The home's menu cycle did not include menus for texture modified diets. [s. 71. (1) (b)]

WN #21: The Licensee has failed to comply with LTCHA, 2007, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with the conditions to which the licensee was subject as outlined in section 4.1 Schedule C of the Long-Term Care home Service accountability agreement (LSAA) with the Local Health System Integration Act, 2006, which reads, "…the [Health Service Provider] shall use All Funding allocated for an Envelope for the use or uses set out in the Applicable policy".

The Long-Term Care Homes Nursing and Personal Care (NPC) Envelope Section 1. b) reads, "direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene, services, administration of medication, and nursing care".

On June 9, 2017, PSW #111 was observed completing dietary aide duties (plating hot oatmeal and cold cereals to residents from the steam table) in the large dining room on the first floor during breakfast meal service. PSW's #109, #111 and #127, as well as the Nutrition Manager, verified that plating and serving the cereals was a regularly assigned duty. Plating food in the servery does not meet the definition of direct nursing and personal care services. The Nutrition Manager and Administrator acknowledged this. [s. 101. (4)]

WN #22: 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 all staff participate in the implementation of the infection prevention and control program.

As per the home's policy “Hand Hygiene” (policy number ICM-VII-041, last revised March 2009), all staff having contact with residents or resident environment were expected to practice hand hygiene, including hand washing or alcohol-based hand rub. Interview with the RD on June 7, 2017, confirmed that this applied to dining service as well, including between contact with dirty dishes and clean dishes, as well as between contact with dirty dishes and residents.

During the inspection, lunch was observed in one of the home's dining rooms. PSW #100 was observed clearing dirty dishes from the dining room onto the dish cart. Afterward, the PSW grabbed a straw from the cupboard with their bare hands, bent it, and placed it in a resident’s cup which they began to drink out of, without having sanitized their hands.

Interview with the RD on June 7, 2017, confirmed staff were expected to sanitize their hands between clearing dishes and feeding residents.

The home’s infection prevention and control program related to hand hygiene was not followed. [s. 229. (4)]

Issued on this 19 day of July 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JESSICA PALADINO (586) - (A1)

Inspection No. / No de l'inspection : 2017_574586_0012 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 009908-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jul 19, 2017;(A1)

Licensee / Titulaire de permis : MAPLEWOOD NURSING HOME LIMITED
500 QUEENSWAY WEST, SIMCOE, ON, N3Y-4R4

LTC Home / Foyer de SLD : CEDARWOOD VILLAGE
500 QUEENSWAY WEST, SIMCOE, ON, N3Y-4R4

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

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 MAPLEWOOD NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that any plan, policy, protocol, procedure, strategy or system instituted by the home is complied with. Specifically, the licensee shall develop a plan to ensure that breakfast meal service commences in the LTC home in accordance with the home's scheduled meal time of 0800 hours.

The plan is to be submitted to Jessica Paladino by e-mail at HamiltonSAO.moh@Ontario.ca by July 31, 2017.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (2) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect of the minimal harm/risk or potential for harm to the residents, the scope of a pattern throughout the home, and the Licensee's history of non-compliance (VPC) on the February 23, 2017, Resident Quality Inspection with the r. 8. (1) (b) related to the compliance of the home's policies.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted by the home was complied with.

In accordance with Regulation, s. 68 (2), paragraph (a), the licensee was required to ensure there were policies and procedures developed and implemented relating to nutrition care and dietary services and hydration.

According to the Nutrition Manager, as and posted in the home, scheduled breakfast time was 0800 hours.

A) Breakfast meal service was observed on an identified date in an identified dining room. Around 0820 hours, the PSWs began serving the residents their drinks and oatmeal. Dietary aide #112 arrived in the dining room at 0850 hours to begin serving the eggs and toast. Observation and interview with the dietary aide confirmed that due to the delay in service, they did not check the temperature of the food prior to service.

B) Breakfast meal service was observed on an identified date in two identified dining rooms. Breakfast was scheduled to commence in both dining rooms at 0800 hours. The food was in the steam table but there was no dietary worker present. PSW #125 confirmed that the dietary aide comes and sets up the food in the steam table, then leaves to serve in the Atrium in the attached retirement home, and then later returns.

By 0815 hours, residents in one of the identified dining rooms were complaining to the LTC Inspector that breakfast was late:
i. Resident #032 said that breakfast was always late, and that they had been sitting there since 0745 hours (for 30 minutes) and had not even been given a drink.
ii. Resident #033 said that breakfast was later than ever that day; however, that breakfast was usually late, and typically begins closer to 0830 hours rather than 0800 hours every day.
iii. Resident #034 said that breakfast was always late and that it was usually served closed to 0830 hours than 0800 hours. This resident complained of this during the last RQI in January 2017; and when asked if it had improved since then, the resident said that it had not gotten any better.

Dietary aide #112 entered to dining room at 0820 hours, confirming that breakfast was late as it had gone late in the Atrium and they could not leave there until all retirement residents were fed. The dietary aide said that retirement residents had been given a memo in the past about the importance of coming to breakfast on time;

however, some still did not comply, and would come late to breakfast, which would cause the dietary aide to get to the LTC dining rooms late. The dietary aide said they knew "this was not right".

The LTC Inspector went to the large dining room at 0825 hours and observed PSW #111 completing dietary aide duties (plating hot oatmeal and cold cereals to residents from the steam table). PSW's #109, #111 and #127 verified that PSW's regularly plate and serve the cereals until the dietary aide arrived to serve the remaining hot items (eggs, toast, etc.). PSW #111 also indicated that breakfast did not usually start until 0825 hours because the PSW's needed to get everyone out of their baths and into the dining room before they could begin to serve them.

PSW #109 and RN #110 began voicing concern that breakfast was late for the residents on a daily basis due to the fact that the dietary aide needed to serve in the Atrium and then the first dining room, before making their way to the second dining room, and that it was very rushed.

Dietary aide #112 entered the second dining room at 0850 hours. They began serving the residents their eggs and toast and later confirmed that due to the delay in service, they did not check the temperature of the food prior to service.

PSW #111 told dietary aide #112 that resident #035 had left the dining room "again" before finishing their breakfast. In an interview with resident #035, they told the LTC Inspector that they had drinks and cereal but that they may have stayed and eaten the remainder of their meal if the service was not so late. The resident indicated that this happened often.

The residents were not served breakfast on time according to the home's scheduled protocol. [s. 8. (1) (b)] (586)

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

Jul 31, 2017

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) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_573581_0002, CO #007;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall ensure that a Registered Nurse (RN) who is an employee of the home is scheduled to work in the home and on duty and present at all times unless the home meets the exception outlined in the Regulations, subsection 45 (1) 2.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (2) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect of the minimal harm/risk or potential for harm to the residents, the scope of a pattern throughout the home, and the Licensee's history of a compliance order (CO) on the February 23, 2017, Resident Quality Inspection with the s. 8. (3) related to 24-hour nursing.

The licensee failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45. (1) and 45.1 of the Regulation).

Review of the registered nursing staffing schedule for a three month period identified that a Registered Nurse (RN) that was a member of the regular nursing staff was not on duty on eight shifts.

Interview with the Administrator stated that agency RN staff was present on the identified shifts but confirmed the home was unable to staff those shifts with an RN who was an employee of the home. (581)

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

Jul 31, 2017

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

Linked to Existing Order / Lien vers ordre existant: 2017_573581_0002, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall complete the following:

1. Ensure that all residents are bathed at a minimum of twice a week by a method of their choice;

2. Any resident who misses a scheduled bath or shower due to the home being
short staffed, has the missed bath or shower documented and made up the same week; and,

3. Develop a regular auditing process to ensure residents are receiving minimum bathing requirements.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (2), scope (2) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect of the minimal harm/risk or potential for harm to the residents, the scope of a pattern throughout the home, and the Licensee's history of a compliance order (CO) on the February 23, 2017, Resident Quality Inspection with the r. 33. (1) related to the bathing of residents.

The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers and full body sponge baths and more frequently as determined by the resident's hygiene

requirements, unless contraindicated by a medical condition.

A. During the RQI Inspection, resident #024 was interviewed and stated that they did not receive two showers a week and would like to have a second shower. Review of the plan of care identified that they were scheduled to have a shower twice per week on specific days. Review of the POC documentation indicated that the resident did not receive their shower on an identified date and it as not made up during that week. Review of the home's staffing schedule revealed that the home was short one PSW staff that date. Interview with PSW #136 stated that if the home was short one PSW staff, some residents would not receive their bath but it was the home's expectation that the bath would be made up the next day. Interview with the RAI Coordinator confirmed that the resident did not receive two showers a week during that time period.

B. Resident #007's plan of care was reviewed and indicated they received a bath twice per week on specific days. Review of Point of Care documentation identified the resident did not receive their bath on an identified date and there was no documentation that the bath was made up during the week. Review of the home's staff schedule identified that the home worked short one PSW staff that day. Interview with PSW #136 stated that if a resident did not receive their scheduled bath due to the home area being short one PSW staff, the bath was to be made up the next day if possible. Interview with the RAI Co-ordinator confirmed that the resident did not receive two baths during that week when they did not receive their scheduled bath on the identified date.

C. Review of the plan of care for resident #028 identified they were to receive a bath twice per week on specific dates. Review of Point of Care documentation identified the resident did not receive their bath on two specific dates, and there was no documentation that the bath was made up during that week. Review of the home's staffing schedule revealed that the home worked short one PSW on each of those dates. Interview with the RAI Coordinator confirmed the resident did not receive their two baths that week.

The home did not ensure that each resident was bathed at a minimum of twice per week.

(581)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Jul 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19 day of July 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA PALADINO - (A1)

Service Area Office /
Bureau régional de services : Hamilton