Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

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


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 27, 2016 | 2016_191107_0004 | H-003342-15 | Resident Quality Inspection |

### Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - MISSISSAUGA
2250 HURONTARIO STREET MISSISSAUGA ON L5B 1M8

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

MICHELLE WARRENER (107)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): October 13, 19, 21, 22, 23, 26, 27, 28, 29, 30, November 3, 4, 5, 6, 20, 23, 24, 25, 26, 2015.**

**The following inspections were completed concurrently with this Resident Quality Inspection**

**(RQI):**
**Complaint inspections:**
**006231-14**
**000024-15**
**023555-15**
**023562-15**
**013222-15 (also a critical incident)**

**Critical Incident inspections:**
**003003-14**
**003480-14**
**009554-14**
**002493-15**
**002559-15**
**003534-15**
**003921-15**
**008724-15**
**010456-15**
**013222-15 - (also a complaint)**
**018566-15**
**022449-15**

**Follow up inspection 008045-15 related to regulation 19(4)was completed July 21, 2015 by**
**inspector #120.**

**This inspection was completed by the following inspectors:**
**Michelle Warrener (107)**
**Kathy Millar (527)**
**Daria Trzos (561)**
**Samantha Di Piero (619)**

**During the course of the inspection, the inspector(s) spoke with Residents, family members of residents, President of the Resident and Family Councils, Executive Director, Directors of Care, Associate Directors of Care, registered and front line nursing staff, Director of Dietary Services, Registered Dietitians, front line dietary staff, Director of Resident Programs, Resident Relations/Volunteer Coordinator, Environmental Service Manager, Behavioural Support Ontario (BSO) Lead, Office**

**Manager**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Critical Incident Response**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 that where bed rails were used, bed systems were evaluated in accordance with evidence-based practices and in accordance with prevailing practices, to minimize risk to residents.

A bed entrapment audit was completed by the home's maintenance department between September 14 and October 28, 2015. According to the audit report provided on October 30, 2015, 170 out of 237 beds had been tested for entrapment zone hazards. The Executive Director confirmed that prior to this audit, beds in the home had not been tested or re-tested for entrapment hazards using a standardized assessment tool in accordance with prevailing practices titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, March 2008". At the time of this inspection, on October 28, 2015, 67 beds still required testing. [s. 15. (1) (a)]

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

A bed entrapment audit was completed by the home's maintenance department between September 14 and October 28, 2015. According to the audit report provided on October 30, 2015, 170 out of 237 beds were tested for entrapment zone hazards. Entrapment zones included those areas between the rail rungs, the mattress and the rail, under the rail, or at the end of the rail, which were numbered one through four.

The audit report identified 142 of 170 beds tested failed at least one zone of entrapment. One hundred and twenty seven beds were identified to have issues with mattresses and

34 were identified by the home to have bed/bed rail issues.

The Executive Director identified that 25 new mattresses were installed in November 2014, and 20 mattresses in September 2015. Not all beds were re-tested in accordance with prevailing practices after the new mattresses were installed to ensure the entrapment risks had been mitigated. Health Canada guidelines titled, "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008" requires that bed systems be re-tested when a different mattress is applied to ensure that the bed and mattress combination meets the recommendations of the guidelines. The licensee did not ensure all beds that had mattresses replaced were re-tested. The licensee did not take immediate action for those residents who remained in a bed that failed one or more entrapment zones and where the resident was assessed to required the use of a rail while in bed.

Bed safety guidelines endorsed by Health Canada titled, "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, 2003", created by the Federal Drug and Food Administration, were not implemented or incorporated into the home's existing bed safety program. The guidelines are current prevailing practices with respect to bed safety and include various measures and interventions to reduce entrapment risks for residents using bed rails while occupying a failed bed system.

Resident #026 was observed in bed on October 23, 2015, with one assist rail in the middle of the bed. The health care records indicated that the resident was assessed for bed rails using a Restraint/PASD assessment form dated July, 2015. This assessment indicated that the bed rails were assessed for the zones of entrapment. The ESM was interviewed on October 28, 2015, and indicated that the home had only started testing the beds in September, 2015, and had not completed the entire process. The ESM confirmed that the home had changed the mattress for resident #026 and did not re-test the bed. On October 29, 2015, the ESM had the bed re-tested and confirmed that the bed failed zone 2. The report indicated that resident #026's bed did not pass zone 2. The licensee did not take steps to mitigate the risk of entrapment that was present under the rail while the resident was in bed.

Resident #040 was observed in bed with two assist rails raised in the middle of the bed during this inspection. Staff confirmed that two assist rails were raised when the resident was in bed. The resident's bed had been assessed for zones of entrapment in October, 2015, with failure in zone 3 (between the mattress and the rail). Staff confirmed

immediate steps, as outlined in the above noted clinical guideline, were not taken at the time to mitigate the risks in the failed zones of entrapment. [s. 15. (1) (b)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r.15(1)(a) 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, to be implemented voluntarily.***

---

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

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

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

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

**s. 6. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**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 resident #073 that set out clear directions to staff and others who provided direct care to the resident.

A skin assessment for resident #073 was conducted by the registered staff on the day of admission to the home. A second skin assessment was conducted about 1.5 months after admission, which identified the resident had altered skin integrity. Two days later the registered staff conducted another skin assessment, which identified the resident had impaired skin integrity including a staged open area. The written plan of care for the resident provided no interventions and/or strategies to address the resident's skin care needs. The charge nurse and PSWs confirmed the resident was at risk for skin breakdown and identified the resident's written plan of care was unclear. The Charge Nurse also confirmed that they were expected to establish a written plan of care, which provided clear direction to staff to address the resident's skin care needs. The home did not ensure that the written plan of care for resident #073 provided clear direction to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

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

Resident #073 exhibited responsive behaviours and was resistive to care when admitted to the home. Upon admission the family provided the home with the resident's past history of behavioural triggers and the strategies that worked effectively to prevent or minimize the behaviours when at home. The clinical record was reviewed and there was documentation from the Substitute Decision Maker (SDM) and family related to their preferences for the care of the resident. The plan of care was reviewed and did not include the resident's needs and preferences. The Community Care Access Centre (CCAC) assessment for admission to the home identified the responsive behaviours and interventions implemented; however, these were not included in the plan of care. The charge nurse was interviewed and confirmed that they reviewed the CCAC information at the time of admission, but because the information was so old it didn't get included. There was no other responsive behaviour assessments or reassessments found in the resident's clinical record. The plan of care for resident #073 was not based on an assessment of the resident and the resident's needs and preferences. [s. 6. (2)]

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

Resident #073 had dentures. The resident was also exhibiting symptoms of resisting care. When the resident was admitted to the home, the family identified strategies that worked best for the resident related to oral hygiene. The documentation provided to the home by the family also identified this preference for dental care; however it was not included in the plan of care. The PSW documentation identified that the resident had refused dental care in the evenings fifteen times over a six week period. The plan of care identified there were no interventions to address the resident refusing dental/oral care in the evenings. The clinical record review and dietary assessments identified the resident's diet texture had been changed several times. When interviewed, the family identified the resident was having trouble with their dentures, resulting in reduced intake at meals, a sore mouth and difficulty putting their dentures in. The plan of care was not based on the resident's needs and preferences. [s. 6. (2)]

4. The licensee failed to ensure that staff and others involved in the different aspects of care of residents collaborated with each other in the assessment of the residents so that their assessments were integrated and consistent with and complemented each other in

relation to personal assistance services devices (PASD).

A) Resident #055 had a physician order that required one quarter bed rail to be raised as a personal assistance services device (PASD). PASD assessments identified the resident required two quarter bed rails. The PASD consent form identified two quarter bed rails were required. The resident's plan of care identified one quarter bed rail was required. The resident had two quarter rails raised on their bed. Information between the physician order, consent, plan of care, and at bedside were not consistent.

B) Resident #040 had a physician order for one quarter bed rail to be applied. Two PASD assessments stated the resident required two quarter bed rails. The resident's plan of care identified the resident required one quarter bed rail. A consent form, signed by the resident's substitute decision maker (SDM) required two quarter bed rails. The resident had two quarter rails raised while they were in bed. Information on the assessments, consents, physician orders, and plan of care were not consistent. [s. 6. (4)(a)]

5. The licensee failed to ensure that staff and others involved in the different aspects of care of resident #061 collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other in relation to continence.

A) Resident #061 had a plan of care that identified the resident had bladder incontinence. The most current Resident Assessment Instrument - Minimum Data Set (RAI-MDS) identified the resident was occasionally incontinent of bladder. Interview with the PSW who routinely provided care to the resident stated the resident was continent of urine with only one episode of incontinence several months prior. Point of Care (POC) documentation over a 45 day period identified thirteen episodes of bladder incontinence with most of the episodes of incontinence being documented by the same PSW who routinely provided care to the resident. The PSW stated the documentation of incontinence must have been in error as they did not believe the resident to be incontinent at all. The resident stated they were not incontinent when asked by the Long Term Care (LTC) Inspector and the resident did not wear an incontinence product. Information was also not consistent on the most current "Continence/Bowel Assessment V5". The assessment stated the resident was continent of urine and also identified the resident had urinary "accidents" once daily.

Information related to the resident's continence was not consistent between the RAI-MDS assessment, the POC continence documentation, PSW interview, and the plan of care

(no incontinence product), and also within the last continence assessment.

B) Resident #073 was assessed for continence on admission. The RAI-MDS assessment completed a week later identified the resident was frequently incontinent of bladder and occasionally incontinent of bowel. The admission "Continence/Bowel Assessment V5" identified the resident was continent of bladder, but had accidents greater than once per day, and the resident was incontinent of bowel. The staff implemented a nursing rehabilitation program for toileting the resident to decrease episodes of bladder incontinence. The resident was re-assessed using the "Continence/Bowel Assessment V5" for continence and was identified as being frequently incontinent of bladder, but had accidents only once per day, and was incontinent of bowels. The written plan of care from the week after admission identified the resident was continuing on the restorative toileting plan as was implemented on admission, and also identified the resident was a check and change for incontinence every two hours. The PSWs were interviewed and identified the resident was incontinent of bladder and bowels from admission to when the resident was transferred to the hospital two months later. The registered staff confirmed the resident was on a toileting plan when admitted to the home, and also wore briefs for incontinence. The family confirmed they had provided information to the home related to bladder and bowel interventions to maintain continence, which they found effective at home when the resident was admitted to the home.

Information related to the resident's continence was not consistent between the RAI-MDS assessment, the continence and bowel assessments, the family's interventions they had identified to staff, the PSW and the registered staff interviews, and the plan of care. The registered staff and PSWs confirmed the interventions for the resident's bladder and bowel management were confusing. [s. 6. (4) (a)]

6. The licensee failed to ensure that 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 consistent with and complemented each other.

Resident #045 had a plan of care that directed staff to provide a shower twice weekly. PSW staff interviewed stated the resident was unsafe to have a shower and staff had been providing a bed bath for the resident. Staff did not collaborate with each other in the development and implementation of the plan of care related to bathing resulting in inconsistencies between the plan of care and what was being provided to the resident. The resident was unable to voice their preferences to the Inspector.

Resident #040 had a plan of care that directed staff to provide a bath twice weekly. PSW staff interviewed stated the resident was provided a shower or a bed bath not a tub bath. PSW staff stated they felt a tub bath would not be appropriate for the resident. Staff did not collaborate in the development and implementation of the resident's plan of care to ensure a consistent approach to bathing.

Resident #019 had a plan of care that directed staff to provide oral hygiene twice daily with no specific instructions related to the provision of care. Two PSW staff providing care to the resident stated that they did not brush the resident's teeth due to pain; only mouthwash or a washcloth was used when providing oral hygiene. Registered staff interviewed was unaware that the care being provided to the resident was different than what was identified on the plan of care. Staff did not collaborate in the development and implementation of the resident's plan of care related to oral hygiene. The resident was observed with white debris on their teeth and poor dentition.

Resident #053 had a plan of care that directed registered staff to monitor the resident's toenails and refer to the foot care nurse if indicated. Staff confirmed that consent for foot care services had not been obtained, resulting in the resident not having their toenails cut over a four month period. The resident was observed with very long toenails during this inspection. Registered staff were not initially aware that the resident was not receiving foot care services. Staff did not collaborate in the development and implementation of the resident's plan of care related to toenail care to ensure that the care was provided to the resident as required.

Resident #040 had a plan of care that directed staff to provide a specific nutrition intervention at the breakfast meal; however, the plan of care also identified that the resident did not consume the item at the breakfast meal. Information was not consistent between the different areas on the resident's plan of care in relation to nutritional strategies. Staff confirmed the resident was not receiving the nutrition intervention. Staff did not collaborate in the development of the plan of care to ensure that the interventions were consistent and met the resident's needs.

Resident #025 had a plan of care that identified a risk of dehydration and to provide and serve a minimum serving of fluids daily, completed by the Registered Dietitian. The resident also had a plan of care that directed staff to restrict the resident's fluids, completed by nursing staff. The Registered Dietitian confirmed the different aspects of care were not integrated and consistent with each other. [s. 6. (4) (b)]

7. The licensee failed to ensure that the resident, the resident’s substitute decision maker, if any, and any other persons designated by the resident or substitute decision maker were given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

Resident #073 was admitted to the home and an initial plan of care was implemented based on the admission assessment. A week later the interdisciplinary team conducted assessments, which resulted in the plan of care being updated. The clinical record was reviewed by the LTC Inspector and identified documentation from the family related to the residents medications, routines at home and preferences, as well as strategies to manage the resident's care. The documentation from the family was reviewed with the charge nurse and they were not aware of the information. In addition, the LTC inspector reviewed the plan of care with the charge nurse and they confirmed there were no strategies from the family's information integrated into the plan of care related to bladder and bowel control. The family were interviewed and confirmed they provided strategies to manage the resident's incontinence to the home at the time of admission and provided documentation to the home on three occasions over a two month period. The family identified that they did not feel the home listened to them and the resident was placed in a brief from admission to discharge. The family identified the resident's continence had deteriorated from continent to frequently incontinent, and they were wearing briefs all the time by the time of the first care conference they were invited to. The resident’s substitute decision-maker, and other persons designated by the resident or substitute decision maker were not given an opportunity to participate fully in the development and implementation of the resident’s plan of care. [s. 6. (5)]

8. The licensee failed to ensure that the care set out in the plan of care was provided to residents as specified in their plans at the breakfast meal October 27, 2015.

The breakfast meal was delayed and nursing staff prepared and provided thickened consistency fluids for some residents. Thickening directions were available on the fluids cart; however, directions were not followed by staff preparing the thickened beverages.

Resident #025 had a plan of care that required honey consistency thickened fluids with meals. The thickened beverage provided to the resident was thicker than pudding consistency (very gummy, jelly like) and was inconsistent with a honey consistency thickened fluid as per the resident's plan of care.

Resident #054 had a plan of care that required honey consistency thickened fluids with meals. The thickened beverage provided to the resident was thicker than pudding consistency (gummy and jelly like) and was inconsistent with a honey consistency thickened fluids as per the resident's plan of care.

The Director of Dietary Services confirmed that the thickened fluids prepared for residents #025 and #054 were not the required consistency as per the residents' plans of care. [s. 6. (7)]

9. The licensee failed to ensure that the care set out in the plan of care was provided to resident #022 as specified in their plan in relation to skin and wound management.

Resident #022 was observed in bed on three occasions with a medical device in place. The interview with the PSW and RN, and review of the plan of care, confirmed that the resident required the device be applied when the resident was in their wheel chair only and not when the resident was in bed. The licensee failed to ensure that the care was provided to the resident as specified in the plan. [s. 6. (7)]

10. The licensee failed to ensure that the care set out in the plan of care was provided to resident #049 as specified in their plan in relation to the call bell.

On October 19, 2015, the LTC Inspector heard a call for help coming from an identified room. Resident #049 required assistance but their call bell was hanging on the wall behind the bed and could not be reached. Registered staff was notified and the call bell placed within reach. The nurse in charge confirmed that the call bell should have been pinned to resident’s clothing so that it was within reach of resident. The resident's written plan of care was reviewed and indicated the same. The home failed to ensure that the care was provided to the resident as specified in the plan. [s. 6. (7)]

11. The licensee failed to ensure that the care set out in the plan of care was provided to residents as specified in their plan in relation to nutritional supplementation.

Resident #036 had a physician order for a nutritional supplement. Documentation in the progress notes identified that the nutritional supplement was not available and therefore not provided on four days over a 42 day period. Documentation on the Medication Administrator Record (MAR) confirmed that the supplement was not provided to the resident on those dates and intake of the nutritional supplement was also not recorded on another three days. The resident was at high nutritional risk.

Resident #019 had a physician order for a nutritional supplement. Documentation in the progress notes identified the supplement was not available as per kitchen staff on an identified date. Documentation in the MAR confirmed the resident was not provided the supplement. The resident was at high nutritional risk.

The Director of Care confirmed that the process in place for registered nursing staff to obtain nutritional supplements outside of regular hours was cumbersome and not everyone was able to obtain the required supplies. Not all residents were therefore provided the nutritional supplement according to their plan of care.[s. 6. (7)]

12. The licensee failed to ensure that the care set out in the plan of care was provided to resident #061 as specified in the plan in relation to a physician order.

Resident #061 had a physician order that required staff to monitor the resident's blood pressure every shift over a three day period. Documentation on the Medication Administration Record (MAR) reflected that the resident's blood pressure was not monitored on every shift over the three days as per the physician order. Staff could not confirm that the blood pressure was taken during those dates and times. Documentation in the progress notes for the same dates did not reflect blood pressure was taken or recorded during those same dates and times.

The plan of care was not followed by staff in relation to monitoring the resident's blood pressure. [s. 6. (7)]

13. The licensee did not ensure that the following was documented: The provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care in relation to shaving.

Numerous residents throughout the inspection were routinely observed unshaven. Personal Support Worker staff stated that some residents refused being shaved when their plan of care indicated daily shaving. Staff confirmed they did not document when shaving was refused due to the way the the Point of Care (POC) documentation system was set up. Shaving as a task could not be independently separated from routine hygiene and grooming. Staff stated they were documenting that personal hygiene was provided because all other grooming was completed. Residents who routinely refused shaving did not have this documented on the POC system, or in the progress notes for staff to develop behavioural strategies to address the ongoing refusals or to update the

residents' preferences.

Resident #078 was observed unshaven with multiple day stubble October 27, 2015, at 1310 hours. Registered staff stated the resident required assistance with shaving. The PSW providing care that day stated the resident refused to be shaved; however, documentation did not reflect the resident refused to be shaved.

Resident #019 was observed on multiple days with stubble. Staff stated the resident was refusing; however, documentation did not reflect refusals.

Resident #040 was observed unshaven on multiple days. Staff stated the resident was refusing; however, documentation did not reflect refusals. [s. 6. (9)]

14. The licensee failed to ensure that when resident #073 was reassessed for skin, that the plan of care was reviewed and revised as the resident's care needs had changed.

A skin assessment for resident #073 was conducted by the registered staff on the day of admission to the home. A second skin assessment was conducted after admission which identified the resident had altered skin integrity. Then two days later the registered staff conducted another skin assessment, which identified the resident had altered skin integrity with an open area on the skin. The clinical record was reviewed and there were no interventions or strategies identified in the plan of care to address the change in the resident's care needs, specifically related to skin care. The registered staff were interviewed and identified the resident's care needs had changed; however the plan of care was not reviewed and revised as a result of the change in the resident's status. [s.6. (10) (b)]

15. The licensee failed to ensure that resident #039 was reassessed and the plan of care reviewed and revised when the resident's care needs changed in relation to preferences for shaving.

On October 13, 2015, resident #039 was observed by inspectors to be unshaven; this was observed again on October 19, 2015, and October 28, 2015. In an interview with unregistered staff it was determined that the resident was to be shaved at "the regular time" which was defined by the unregistered staff as the resident's shower days scheduled twice weekly. An interview with PSW staff confirmed that the resident had not been shaved by the home's staff from October 13, 2015 to November 1, 2015. The staff indicated that the resident was resistive to care regarding shaving and had expressed a

preference to have a family member complete this task. An interview with registered staff confirmed that the plan of care directed staff to undertake the shaving task as it related to the resident's personal hygiene and grooming tasks but was not updated to reflect the resident's preferences as it pertained to shaving. An interview with the DOC confirmed that the plan of care related to the resident's shaving preferences was not updated at the time when the residents care needs changed. [s. 6. (10) (b)]

16. The licensee failed to ensure that resident #036 was reassessed and the plan of care reviewed and revised when the resident's care needs changed and care set out in the plan was no longer necessary in relation to shaving.

On October 13, 2015, resident #036 was observed to be unshaven. PSW staff confirmed that they used professional judgment and had not shaved the resident recently due to safety concerns. The resident's plan of care stated that they were to be shaven at the regular time, which was determined to be on bath days twice weekly or when the resident was willing. However, registered staff confirmed that in the previous week the resident had not been shaved in accordance with the resident's plan of care at bath time or any other available time. An interview with the DOC confirmed that the plan of care related to the residents personal hygiene and grooming preferences was not updated at the time when the resident's care needs changed. [s. 6. (10) (b)]

17. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the care set out in the plan for resident #073 was not effective.

Resident #073 had a plan of care that identified an estimated daily fluid requirement. The resident was reviewed by the Registered Dietitian (RD) and the RD noted the resident was consuming less than the identified fluid requirement. The resident's plan of care was not revised to include strategies to promote hydration to within the resident's identified target / goal. The RD confirmed that the resident's written plan of care was not revised when strategies related to hydration were ineffective to meet the resident's hydration target. [s. 6. (10) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with LTCHA, sections 6(1)(c), s. 6(2), s. 6(4)(a)(b), s. 6(5), s. 6(7), s. 6(9), s. 6(10)(b)(c), to be implemented voluntarily.***

---

**WN #3: 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 the home's Skin Care Program was complied with.

The home's policy called "Skin Care Program", policy number V3-1400, revised February 2012, indicated:
"Complete a weekly skin assessment during the resident's first bath/shower of the week, and will document on the Head to Toe Skin Assessment Form. The direct care provider will observe high-risk areas such as bony prominences, skin folds, sacrum, and heels for redness, and skin breakdown and report altered skin integrity to charge nurse. Report any redness, skin breakdown, skin tears, rushes, bruising, etc. to charge nurse each shift."

Resident #072 had altered skin integrity which was discover by a family member. The interview with the DOC indicated that the area was not reported by a PSW on the bath day. The documentation provided by the home called, "Baths/skin checks" that the PSW staff used to document skin assessments on bath days was reviewed. The

documentation indicated that four days prior the PSW staff noted that resident had redness. On the day the family identified the area the PSW staff noted that resident's skin was clear. The health records and interview with the DOC indicated that the PSW staff did not report redness found to registered staff and the PSW staff did not document the area nor did they report the area to registered staff four days later. The DOC indicated that the area was large in size and would have been noticed by staff on the second date during the resident's bath day. The staff did not follow the home's policy and did not report the altered skin integrity to registered staff on bath days. [s. 8. (1) (b)]

2. The licensee failed to ensure that the "Skin Care Program" policy and procedures were complied with.

The home's "Skin Care Program" policy, number V3-1400, and revised February 2012, directed registered staff to develop and implement an individualized skin care program. The policy also directed registered staff to complete a referral to the Skin and Wound Care Coordinator for Stage II wounds. In addition, the policy directed the registered staff to complete a pain assessment when a resident had a significant change in status.

The clinical record for resident #073 was reviewed by the LTC Inspector and there was no referral to the Skin and Wound Care Coordinator for the resident's staged ulcer, there was no pain assessment conducted although the resident had a significant change in status, and there was no individualized written plan of care to address the resident's skin care needs. The registered staff confirmed that they were expected to complete a referral to the Skin and Wound Care Lead and this did not occur. The registered staff confirmed there was no pain assessment, and this should have been conducted when the resident developed impaired skin integrity. In addition, the registered staff and the DOC confirmed that there should have been an individualized skin care plan implemented to include strategies and interventions for resident #073, and this was not done. The registered staff failed to comply with the home's Skin Care Program policy and procedures. [s. 8. (1) (b)]

3. The licensee failed to ensure that the Hydration Management Program policy and the Dietary Intake policy were complied with.

The home's policy, "Hydration Management Program", number V9-251, revised November 2013, directed the registered nurse (RN) to review the resident's written plan of care to ensure they were meeting their individualized daily fluid goals, and if not the RN was to initiate a hydration program. The policy also directed the RN to initiate a hydration program if the resident had not consumed at least 12 servings (1500mls) of

fluids per day.

Resident #073 was identified at moderate nutritional risk and their estimated daily fluid intake requirement was identified. The resident did not meet the estimated target over a 52 day period. In addition, the resident did not consume 12 servings of fluid provided at meals and snack by the homes' menu for three consecutive days. The clinical record identified there was no hydration program initiated by the RN, and there was no referral to the RD. The RD confirmed that a hydration program was expected to be initiated by nursing based on the resident not consuming at least 12 servings of fluid per day for three consecutive days, and they were expected to complete an RD referral when the resident was not consuming their goal fluid intake on an ongoing basis. The registered staff did not comply with the home's policy to address the resident's fluid intake needs. [s. 8. (1) (b)]

4. The licensee failed to ensure that the home's system for managing wandering and exit seeking residents was complied with.

Registered nursing staff and PSWs communicated that the home had a system for managing wandering and exit seeking residents. Staff did not follow the home's system for managing those behaviours resulting in an incident. [s. 8. (1) (b)]

5. The licensee failed to ensure that the "Continence Management Program - Bladder and Bowel", number V3-239, and revised September 2013, was complied with.

The home's policy, "Continence Management Program - Bladder and Bowel", number V3 -239, and revised September 2013, directed registered staff to provide education to the PSWs, resident and/or SDM regarding the purpose of the voiding record and how it was to be implemented as well as the Continence Management program. The policy directed the PSWs to complete a voiding and bowel record for all new admissions. The registered staff were also expected to use the data from the voiding record and the incontinence decision tree, to determine the type of incontinence the resident was experiencing. It was at this point that the registered staff were expected discuss the written plan of care with the resident and/or power of attorney.

The clinical record and staff interviews confirmed there was no voiding or bowel record completed for resident #073 when they were admitted to the home. The family confirmed that they were not provided with the education on the Continence Management program. Resident #073 had a change in their bladder continence and it was not discussed with

the SDM, as confirmed by the family interview, and there was no documentation of a conversation in the progress notes. The resident was assessed as being continent of bladder upon admission, and then re-assessed after admission, which identified the resident's continence had deteriorated and they were frequently incontinent for bladder. The registered staff confirmed that because they had incomplete continence assessment information, they were unable to determine the type of urinary incontinence, and the interventions that they were expected to develop and implement for resident #073. The staff did not comply with the home's Continence Management Program. [s. 8. (1) (b)]

6. The licensee failed to ensure that "Personal Care - Oral Hygiene" policy, number V3-1110, revised April 2013, was complied with.

The home's policy called "Personal Care - Oral Hygiene", directed the staff to remove the resident's dentures at bedtime, clean, and soak according to resident's preference. In addition, the policy directed staff to assess the resident's needs and implement the necessary interventions. The staff were also directed to document their care in the home's electronic documentation system. Resident #073 required oral and dental care twice daily and frequently by staff. The family provided suggestions to the staff regarding what worked effectively at home to ensure the resident received oral and dental care. The PSWs confirmed that they were expected to provide resident #073 with oral/dental care in the morning and at bed time. The PSWs confirmed they were not aware of the suggestions by family of the effective strategies used at home for the resident's oral/dental care. The clinical record confirmed there was no documentation of the resident's oral and dental care on five days over an 11 day period. The staff did not comply with their oral hygiene policies and procedures. [s. 8. (1) (b)]

7. The licensee failed to ensure that the home's hygiene and grooming policy was complied with.

The home's policy related to grooming, "Hygiene, Personal Care & Grooming VIIG-10.50", revised January 2015, directed staff to shave residents, including females if applicable, during grooming time or with the bath/shower procedure.

Numerous residents who required assistance were routinely observed unshaven during the day.

Resident #055 was observed unshaven on two occasions the same day and the PSW stated they did not have time in the morning to shave the resident. On another day in the

afternoon the resident was observed unshaven and the resident asked the Inspector to be shaved. On another occasion prior to the lunch meal the resident was observed unshaven and had just had a shower. The PSW confirmed the resident was not shaved during their shower (as per the home’s policy) and stated the resident would be shaved after the PSW break. The resident's plan of care identified the resident required extensive assistance with personal hygiene and shaving.

Resident #040 was observed unshaven in the afternoon on an identified date. The resident required extensive assistance by staff for shaving. The PSW providing care to the resident stated the resident refused; however, when the resident was asked by the Inspector about shaving, the resident stated they had not been offered a shave and asked to be shaved. On another occasion mid morning, the resident asked the Inspector to be shaved and the PSW confirmed they did not have time to do it in the morning. On another date the resident was not shaven until the afternoon shift. On another date staff stated the resident refused in the morning. Afternoon staff stated the resident was frequently not shaved during the day shift. The resident had a plan of care that directed staff to negotiate a time for activities of daily living; however, staff were unable to confirm that they had done this or that the resident had a preferred time other than the morning for offering shaving. Concerns were voiced by family members about personal grooming and the resident not being routinely shaven.

Resident #019 was observed unshaven on three days. The resident stated their electric razor wasn't working and they had to speak with nursing staff as their facial hair was too long. Registered staff demonstrated the shaver was working and stated the resident was refusing to be shaved. One staff stated the resident was able to shave themselves; however, the resident's plan of care required extensive assistance by staff to complete personal hygiene. Documentation did not reflect the resident had refused shaving by staff and the resident stated their facial hair was too long.

Not all residents were offered shaving at grooming time or with the bath/shower as per the home’s policy. [s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r.8(1)(b) 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, (b) is complied with, to be implemented voluntarily.***

---

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that all doors leading to non-residential areas of the home were kept closed and locked when they were not being supervised by staff.

On October 13, 2015, during the initial tour of the home, several doors leading to soiled and clean utility rooms were found to be unlocked and unsupervised. These rooms contained several hazardous cleaning solutions that residents could access and were located on the second, third, and fourth floors of the home for a total of six rooms. Inside the soiled utility rooms Inspectors observed chemicals that could cause harm to residents which included Chemsyn Euphora cleaning solution, Chemsyn Virudex-7, and Chemsyn disinfectant cleaner. An interview with registered staff confirmed that staff were expected to ensure that the doors to the soiled utility rooms were locked at all times. The DOC confirmed the home's expectation was that doors leading to non-residential areas were kept locked at all times. [s. 9. (1) 2.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r.9(1)2 - All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.***

---

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that resident-staff communication and response system could be easily seen, accessed and used by residents, staff, and visitors at all times.

i) On October 20, 2015, LTC Inspector found the following call bells that were not functioning for the following residents:

- Resident #018's call bell by the bed was checked and did not activate when the button was pressed
- Resident #041's call bell in the bathroom was not functioning, the cord was not attached to the metal switch on the wall

ii) On October 23, 2015, LTC Inspector checked the call bell in the bathroom in an identified room and once pulled did not activate.

The home had a process in place for auditing call bells and repairs. The PSWs were interviewed and indicated that when they found a non-functioning call bell they were required to report to registered staff. Registered staff indicated that once they were informed of the non-functioning call bell, they informed the ESM via telephone. If unable to reach them the electronic request was sent to ESM for maintenance. The ESM was interviewed and indicated the same. The ESM was not informed that the call bells were not functioning. The request for maintenance was sent once the LTC informed registered staff of the non-functioning call bells. [s. 17. (1) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r.17(1)(a) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.***

---

**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

The home's policy,"Abuse and Neglect - Resident", number V3-010, last revised April 2013, identified the definition of different types of abuse and directed staff to immediately report any suspected or known incident of abuse to the Director.

Resident #057 had eight separate incidents of inappropriate behaviours that met the licensee's definition of abuse over a three month period; these incidents were not reported to the Director.

During an inquiry by LTC Inspector #560, the DOC confirmed that these incidents should have been reported to the Director. LTC Inspector #527 confirmed with the DOC during this on-site inspection that these incidents of abuse should have been reported to the Director as directed by their policy. The licensee did not ensure that their "Abuse and Neglect - Resident" policy was complied with. [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 with 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, 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. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented in relation to skin, meals and continence care.

A) Documentation in the point of care (POC) system for resident #073 was incomplete. The resident required turning and repositioning every two hours, and the documentation over a one month period in POC did not reflect the resident was turned and repositioned every two hours. The documentation reflected the resident was being turned and repositioned every three to four hours.

The meal and snack intake documentation was incomplete for five days over an 11 day period in the POC electronic documentation system.

Resident #073 was on a bladder toileting plan and on four days over a 10 day period there was no documentation on the day shift, and on two days there was no documentation on the evening shift.

The direct care providers were interviewed and confirmed that they were expected to document the interventions as specified on the plan of care, and the resident's responses to the interventions, and this was not consistently done in their documentation. The DOC was interviewed and confirmed that staff were expected to document care provided to the resident as outlined in their plan of care.

B) The clinical record was reviewed for resident #073 and identified the assessments, interventions and the resident's responses to the interventions were incomplete. The

PSWs confirmed they were expected to document their continence checks and changes every two hours in the point of care system, and were expected to document a three day voiding record and seven day bowel record when the resident was admitted. The registered staff confirmed the PSWs were expected to complete the documentation on the voiding and bowel records as part of the resident's admission continence assessment. The registered staff also confirmed that a TENA incontinence product assessment and supply form was expected to be completed by the registered staff.

The checks and changes every two hours for bowel and bladder continence were not documented on four days over a 10 day period on the day shift, and two days on the evening shift. The three day voiding record and seven day bowel records were not documented when the resident was admitted. The TENA incontinence product assessment and supply form was blank and not completed by the registered staff or the vendor.

The home failed to ensure that the assessments, interventions and the responses to interventions for resident #073 were 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 with r.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, to be implemented voluntarily.***

---

**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices**

**Specifically failed to comply with the following:**

**s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).**

**s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:**
**1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).**
**2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).**
**3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).**
**4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).**
**5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).**
**6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).**

**s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:**
**2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the restraining by a physical device was included in the resident's plan of care.

Resident #045 was observed on October 26, 2015, sitting in the lounge with a physical device in place that had a restraining effect. The registered staff on the unit indicated that

the device was applied at all times while the resident was in their wheelchair. The written plan of care was reviewed and did not indicate that the device was used as a restraint but as a PASD. The Restraint Lead/ADOC indicated that the device was used as a restraint because it was not being used to only assist the resident with the activities of daily living. The ADOC confirmed that the plan of care did not include the device as a restraint. [s. 31. (1)]

2. The licensee did not ensure that when resident #055 was restrained by a physical device as described in paragraph 3 of subsection 30 (1), the restraining of the resident was included in the resident's plan of care.

Resident #055 did not have a restraining device included in their plan of care; however, staff were using the restraining device. Personal Support Workers interviewed stated they used the device to prevent the resident from falling.

On October 27, 2015, the resident was observed with the restraining device in place the resident stated they were uncomfortable. The resident was again observed with the restraining device in place on two other occasions. Registered and front line nursing staff interviewed confirmed the device was not to be used.

The resident was assessed by a Physiotherapist who determined the resident did not require the device. An assessment of the resident had not been completed since that time in relation to using the device for fall prevention, a physician order and consent was not obtained for using the device, and the use of the device was not included in the resident's plan of care. [s. 31. (1)]

3. The licensee failed to ensure that the restraining of a resident by a physical device was included in a resident's plan of care only if all of the following were satisfied:
2. Alternatives to restraining the resident had been considered, and tried where appropriate, or had not been effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class, or other person provided for in the regulations, had ordered or approved the restraining.
5. The restraining of the resident had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #044 was observed on October 22, 2015, at 1500 hours sitting in the hallway in a wheelchair with a device that had a restraining effect applied. The health records were

reviewed and there was no assessment done to indicate that the device was a restraint. There was no physician order for the restraint and the use of the restraint was not consented to by the SDM. The home had completed a Restraint/PASD Assessment which indicated that the device was used as a PASD. The order was obtained for the PASD and the SDM consent was given for the PASD. The registered staff confirmed that the device was not being removed and that the device was applied at all times while resident was in the wheelchair. The interview with the Restraint Lead/ ADOC confirmed that the device for this resident was considered a restraint and all the requirements under the legislation were not completed. [s. 31. (2)]

4. The licensee failed to ensure that the restraint plan of care included alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk.

Resident #045 was observed on October 21, and 26, 2015 at 1500 hours sitting in a wheelchair with a device that had a restraining effect applied. The resident's written plan of care and interview with the registered staff indicated that the device was used as a PASD. The registered staff also indicated that the device was applied at all times while the resident was in their wheelchair. The health records indicated that the resident was last assessed for the use of the device, and consent obtained from the POA, the year prior. The assessment form did not indicate whether the device was a restraint or a PASD. The interview with the Restraint Lead/ ADOC confirmed that the device for this resident was considered a restraint and did not complete the requirements under the legislation. [s. 31. (2) 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 with sections 31(1), s. 31(2), and s. 31(2)2, to be implemented voluntarily.***

---

**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that the use of a PASD under subsection (3) to assist a resident included approved usage by a physician, and consent for use by the resident's substitute decision maker.

Resident #036 was observed resting in bed with two three quarter bed rails in the raised position. PSW staff stated that the rails were in the raised position for the resident's safety; no padding on the rails was present. Registered Nursing staff confirmed that the use of the two ¾ rails for the resident were considered PASDs. The resident's written plan of care included the use of only one bed rail as a PASD. A physician's order, assessment by registered staff, or consent from the SDM for the use of the second 3/4 rail was not obtained. The home's policy, “Restraint Implementation Protocols”, number VII-E-10.00, stated that to implement the use of a PASD registered staff were to obtain a physician’s order and obtain consent for the use of the PASD from the resident or SDM. Interviews with Registered staff confirmed that the no orders, consent, or assessment were completed or obtained for the use of the second bed rail as a PASD while the resident was in bed. An interview with the home's DOC confirmed that these actions did not meet the home's expectations and did not meet the legislative requirement. [s. 33.(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 with section 33(4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:***
***1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.***
***2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.***
***3. The use of the PASD has been approved by,***
***i. a physician,***
***ii. a registered nurse,***
***iii. a registered practical nurse,***
***iv. a member of the College of Occupational Therapists of Ontario,***
***v. a member of the College of Physiotherapists of Ontario, or***
***vi. any other person provided for in the regulations.***
***4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.***
***5. The plan of care provides for everything required under subsection (5), to be implemented voluntarily.***

---

**WN #10: 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 each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Not all residents were bathed by a method of their choice on an identified date during this inspection. Staff confirmed an identified floor was short staffed on an identified date (usually had nine PSWs and at times had five to six PSWs that day), and some residents were provided a bed bath due to staffing shortages.

The plan of care for resident #081 directed staff to provide extensive assistance by one staff with a shower twice weekly and as necessary. Staff stated the resident received a bed bath instead of a shower due to staffing shortages on the identified date. Documentation did not reflect the resident was offered a bath or a shower on that date.

The plan of care for resident #082 reflected the resident preferred a shower. The resident received a bed bath on the identified date. Staff confirmed bed baths were provided due to staffing shortages.

The plan of care for resident #083 identified the resident preferred showers. The resident received a bed bath on the identified date. Staff confirmed bed baths were provided due to staffing shortages.

The plan of care for resident #084 identified the resident preferred a shower. The resident received a bed bath on the identified date. Staff confirmed bed baths were provided due to staffing shortages.

The plan of care for resident #085 directed staff to provide total assistance with a bath twice weekly and as necessary. The plan of care stated that the resident refused showers. Documentation did not reflect that the resident was offered a bath on the identified date; however, staff stated the resident was provided a bed bath.

2. Not all residents received their preferred method of bathing as indicated on the residents' plans of care.

Registered and front line nursing staff interviewed confirmed that none of the residents

on the identified floor received a tub bath; only a shower or bed bath. Staff also confirmed that documentation indicating "bath" on resident flow sheets reflected a bed bath was provided and not a tub bath as no tub baths were provided to the current residents. At least six residents on the identified floor had a bath identified as their bathing preference on their plan of care and nine residents on the floor did not have their preference for bathing identified on their plan of care. The identified floor included residents with dementia and some residents who were unable to voice their preferences.

The plan of care for resident #086 directed staff to provide total assistance with a bath twice weekly. During interview, the resident's family identified the resident usually preferred a tub bath. Documentation in the resident's flow sheets reflected the resident was provided a shower for the month of October 2015. The resident was unable to voice their preference to the LTC Inspector and staff did not follow the direction identified on the resident's plan of care.

The plan of care for resident #080 directed staff to provide extensive to total assistance with a bath twice weekly and as necessary. During interview, the resident's family stated the resident usually preferred a tub bath. The resident was unable to voice their bathing preference to the Inspector during interview. Flow sheets reflected the resident was given a shower or a bed bath during the month of October, 2015. Staff did not follow the direction identified on the resident's plan of care related to bathing preference. The resident was unable to voice their bathing preference to the LTC Inspector.

The plan of care for resident #030 directed staff to provide total assistance with a bath twice a week and to provide a bed bath if the resident refused the bath. Documentation reflected the resident received a shower on seven dates in October and a bed bath on one occasion in October, 2015. The resident was not able to voice their preference to the LTC Inspector.

The plan of care for resident #045 directed staff to provide two plus person assist with a shower twice weekly and as necessary. Staff confirmed the resident routinely received a bed bath instead of a shower. The resident was unable to voice their bathing preference to the inspector. Direction related to bathing on the resident's plan of care was not consistent with what was routinely being provided for the resident.

The plan of care for resident #040 directed staff to provide 1 or 2 staff physical assistance with a bath twice weekly. Staff stated the resident was not receiving a tub bath; only showers or bed baths. The plan of care for the resident was not consistent with

what was being provided to the resident. [s. 33. (1)]

***Additional Required Actions:***

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

---

**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that resident #073 received oral care to maintain the integrity of the oral tissue that included, (a) mouth care in the morning and evening, including the cleaning of dentures.

Resident #073 had dentures. The resident was also exhibiting symptoms of resisting care. When the resident was admitted to the home, the family identified strategies for the provision of oral hygiene. The charge nurse was interviewed and confirmed that the PSWs removed the resident's dentures in the evening and rinsed and soaked them in water as documented in the plan of care; however, the PSW documentation identified that the resident had refused dental care in the evenings fifteen times over a six week period. The plan of care identified there were no interventions implemented to address the resident refusing or resisting dental/oral care in the evenings.

The clinical record and dietary assessments identified the resident's diet had been changed several times over a two month period. The family identified during an interview that the resident was having trouble with their dentures, had a decline in dietary intake, and the resident's mouth became sore. The resident did not receive consistent oral and dental care to maintain the integrity of the oral tissue, and/or cleaning of dentures. [s. 34. (1) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r.34(1)(a) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,***
***(a) mouth care in the morning and evening, including the cleaning of dentures, to be implemented voluntarily.***

---

**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care**

**Specifically failed to comply with the following:**

**s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that each resident of the home received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Resident #053 was observed with long toenails on October 26, and 28, 2015. During interview, registered staff stated that the home did not cut resident toenails and that family would have to do this if foot care services were not purchased by residents or their substitute decision maker (SDM).

The home's policy, "Hygiene, Personal Care & Grooming VII-G-10.50", revised January 2015, stated that registered staff would provide foot care to residents with diabetes and those residents whose care was outside the scope of practice for a PSW."

Registered staff confirmed the resident did not have consent for an external foot care service and confirmed registered staff were not cutting the resident's toenails. Staff confirmed the resident's toenails had not been cut by staff while at the home over a four month period. The resident was at risk for foot related problems. Documentation in the flow sheets reflected the resident had their toenails cut on an identified date in October, 2015; however, the PSW who documented confirmed the toenail edges were filed for safety and not cut. [s. 35. (1)]

2. The licensee failed to ensure that resident #019 received fingernail care, including the cutting of fingernails as required. Resident #019 was observed with very long fingernails on October 22, 2015. Documentation did not reflect that the resident had their nails cut since October 3, 2015. Documentation in October, 2015, reflected that fingernails were not cut and not marked as refused after October 3, 2015. The resident did not say that they preferred their nails to be long when asked by the inspector. [s. 35. (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 with r.35(1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.***

---

**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

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

A) Resident #074 was transferred out of bed and from the floor to bed by one PSW without assistance. The resident had a plan of care that required a two person transfer by staff at that time. Staff did not use safe transferring techniques when assisting resident #074.

B) Resident #019 had a plan of care that required two staff extensive assistance to reposition and turn in bed. The resident stated they were turned in bed by one PSW using techniques which the resident stated were uncomfortable. The PSW involved confirmed that the resident was turned in bed using one staff and that positioning techniques used were not consistent with the resident's plan of care.

C) Resident #056 had an un-witnessed fall from their wheelchair. The resident's plan of care was reviewed and identified the resident was at high risk for falls. The falls prevention and transfer interventions identified that staff were to ensure a positioning device was properly applied when the resident was up in the wheelchair and the resident required total assistance of two staff for transfers. On an identified date the resident was being transferred. One staff member started the transfer and then left the resident unattended with no positioning device in place. The resident subsequently fell to the floor and sustained an injury. The staff were interviewed and confirmed they did not provide the care the resident required. The registered staff were interviewed and confirmed the care was not provided to the resident to prevent them from falling, and to ensure they were transferred safely. [s. 36.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r.36 Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.***

---

**WN #14: 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,**
**(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that resident #073, who was dependent on staff for repositioning, was repositioned every two hours or more frequently as required.

Resident #073 was assessed by the physiotherapist as being at risk for altered skin integrity. The resident was also assessed by the registered staff and the assessments identified that the resident required repositioning by staff every two hours. The clinical record identified the resident developed impaired skin integrity that progressed to an open area on the resident's skin. The staff were interviewed and identified that they did not always have time to reposition residents every two hours. The point of care documentation by the direct care providers identified that the repositioning of the resident every two hours was occurring inconsistently over a 53 day period. The registered staff and the PSWs confirmed that they were expected to turn and reposition the resident every two hours. [s. 50. (2) (d)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r.50(2)(d) Every licensee of a long-term care home shall ensure that, any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated, to be implemented voluntarily.***

---

**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

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

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that resident #061, who was documented as having a decline in their urinary continence over a three month period on the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) coding, received an assessment that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. Registered staff and the RAI-MDS Coordinator stated that a "Continence/Bowel Assessment" was to be completed quarterly with the RAI-MDS assessment or when there were changes to the resident's level of continence. Staff confirmed an assessment of the resident's continence using the required assessment instrument was not completed when the resident had a documented decline in their continence noted at the RAI-MDS quarterly review. [s. 51.(2) (a)]

2. The licensee failed to ensure that (b) each resident who was incontinent had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

Resident #073 was assessed on admission as being continent of bladder and incontinent

of bowel. A week later the resident was re-assessed as being frequently incontinent of bladder and remained continent of bowels. The family were interviewed and confirmed they had provided information to the home related to bladder and bowel control interventions that they found effective for the resident when they were admitted, and throughout the subsequent weeks leading up to the six week care conference. The interventions identified by the family were not integrated into the individualized plan of care to promote and manage the resident's bowel and bladder continence. The charge nurse was interviewed and confirmed the interventions for the resident's bladder and bowel management were not individualized based on the information provided by the family. [s. 51. (2) (b)]

3. The licensee failed to ensure that resident #073 had sufficient continence care products to remain clean, dry and comfortable.

Resident #073 was assessed by the charge nurse for continence care products. They identified the resident required three specific incontinence products over a 24 hour period. The charge nurse was interviewed and confirmed that they usually did the continence care product assessments during the admission phase, and they may also bring in the vendor (TENA) to assess the resident. The clinical record was reviewed and the TENA Incontinence Management System product assessment and supply form was blank. The inspector reviewed the plan of care with the charge nurse and they confirmed there were no continence care products identified for the resident at the time of admission. The clinical record was reviewed and confirmed the resident was wearing the identified briefs from the time of admission to when they were transferred to the hospital two months later. The documentation by the PSWs was reviewed and identified inconsistent documentation for checking and changing the resident every two hours. There were six shifts in one month when there was no documentation that the resident was checked and changed at all. The PSW documentation reflected that the resident was checked and changed once per shift. The resident had developed altered skin integrity and within two days had developed a staged open area on their skin. The home did not provide the continence care products the resident required to ensure there were sufficient changes to remain clean, dry, comfortable, and promote and maintain skin integrity. [s. 51. (2) (g)]

***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 with r.51(2)(g) Every licensee of a long-term care home shall ensure that, residents who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.***

---

**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

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

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that for all responsive behaviour programs and services, the matters referred to in subsection (1) were integrated into the care that was provided to all residents.

Resident #050 exhibited responsive behaviours on an identified date during this inspection. Staff responding to the resident were not using behavioural strategies to de-escalate the resident resulting in increased responsive behaviours from the resident. Strategies for managing responsive behaviours were not integrated into the care that was provided to resident #050. Registered staff confirmed that staff did not use appropriate strategies to de-escalate the resident's responsive behaviours. [s. 53. (2) (a)]

2. The licensee failed to ensure that the behavioural triggers for resident #039 were identified.

On review of the resident’s records it was determined that the resident received antipsychotic medication. The resident's plan of care identified the overall mood and behaviour issues and interventions as they related to the resident but did not identify any causal triggers for the resident's responsive behaviours. Registered staff confirmed that they had not identified any behavioural triggers for the resident and that no triggers had been updated on the plan of care to communicate the information to other front line care givers. Registered staff stated that they, at times, were very busy and did not have time to identify the resident’s behavioural triggers and that the resident would benefit from behavioural assessment and support from the BSO. Registered staff confirmed that the resident had not been referred to the Behavioural Support Ontario (BSO). An interview with the home's DOC confirmed that not identifying the resident's behavioural triggers as part of the resident's plan of care did not meet the home's expectations. [s. 53. (4) (a)]

3. The licensee failed to ensure that (a) the behavioural triggers for the resident were identified, where possible; (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented.

Resident #073 was admitted and exhibited responsive behaviours. Upon admission the family provided the home with the resident's past history of behavioural triggers and strategies that worked effectively to prevent or minimize the behaviours. The clinical record was reviewed and there was no Dementia Observation System (DOS) monitoring located, which would have identified the frequency, severity and patterns of behaviours. The written plan of care was reviewed and did not include the triggers and causes of the behaviours, and therefore, strategies were not developed and implemented to respond to the individualized behaviours of this resident. In addition, the strategies the family provided on admission were not integrated into the plan of care. There was no other

responsive behaviour assessments or reassessments found in the clinical record. The point of care documentation was reviewed for a two month period and for over 80 percent of the time during this period the mood and behaviours documented identified that these were not exhibited, which was not consistent with documentation in the progress notes. The LTC Inspector was unable to identify documentation related to the resident's responses to the interventions that were implemented to prevent and/or minimize the resident's behaviours. The charge nurse was interviewed and confirmed that there was no documentation related to the assessments to identify triggers, and the causes for the responsive behaviours.

The home's policy called "Responsive Behaviours Management", number V3-092, revised March 12, 2012, directed staff to identify the prevention, reduction and management strategies for responsive resident behaviours, which included assessment and identification of behavioural triggers, implementing strategies to respond to the needs of the individual resident using an inter-professional approach, re-assessing, planning, implementing management strategies, evaluating and documenting for the individual resident responses. The procedures included utilizing screening protocols such as reviewing and evaluating the CCAC application for placement, and obtaining a past history of recognized behavioural triggers and strategies from the SDM and family upon admission. The procedures also included monitoring the resident for any changes in their behaviours, followed by appropriate assessments and informing the SDM of the responsive behaviours and plans of care.

The behavioural triggers for resident were not identified, strategies were not developed and implemented to respond to these behaviours, and actions were not taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented. [s. 53. (4) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r.53(2)(a) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,***
***(a) integrated into the care that is provided to all residents, and***
***r. 53(4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,***
***(a) the behavioural triggers for the resident are identified, where possible;***
***(b) strategies are developed and implemented to respond to these behaviours, where possible; and***
***(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.***

---

**WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**
**7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that sufficient time was provided for all residents to eat at their own pace at an observed lunch meal. The home had two dining seatings; one at noon and the other to start at 1315 hours.

Not all residents at the first meal seating were finished eating and drinking when their tables were being cleared (table cloths removed, table wiped down), giving the appearance of being rushed. Staff assisting residents with eating appeared to be rushing residents (not taking much time between mouthfuls, packing up quickly).

Resident #050 had their table cleared while they were consuming their beverages and dessert and the resident was still chewing as staff were taking them out of the dining room.

Resident #051 required an extensive amount of time for eating. The resident's plate was cleared when staff needed to re-set the table. The PSW assisting the resident confirmed the resident would likely have eaten more if they had additional time. The resident did not respond when asked by the Inspector if they had finished their meal.

Resident #052 still had beverages that were unfinished when the resident was taken out of the dining room. The resident was not encouraged to stay and finish their beverages prior to leaving the dining room.

The home's policy, "Pleasurable Dining VII-I-10.40", revised January 2015, directed staff to allow residents sufficient time to eat their meals without feeling hurried and directed the registered staff to promote a relaxed and quiet dining atmosphere. The Director of Dietary Services stated that residents who took longer to eat would be placed at the second meal sitting to ensure adequate time to finish their meals. The observed meal was very loud, disruptive and chaotic. [s. 73. (1) 7.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r.73(1)7 Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: Sufficient time for every resident to eat at his or her own pace, to be implemented voluntarily.***

---

**WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

**Specifically failed to comply with the following:**

**s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:**
**6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that resident #045's condition had been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Resident #045 was observed by the Inspector sitting in the lounge in a wheelchair with a positioning device applied. The registered staff on the unit indicated that the device was applied at all times while the resident was in their wheelchair. The health care records were reviewed and re-assessment and effectiveness of the restraining at least every eight hours could not be found. The Restraint Lead/ADOC indicated that the device was used as a restraint because it was not being used to only assist the resident with the activities of daily living. The ADOC confirmed that the requirements for a restraint under the legislation were not complied with. [s. 110. (2) 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 with r.110(2)6 Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.***

---

**WN #19: 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. (1) Every licensee of a long-term care home shall ensure that a PASD used under section 33 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained. O. Reg. 79/10, s. 111. (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the PASD used to assist resident #018 with a routine activity of living was removed as soon as it was no longer required to provide such assistance, unless the resident requested that it be retained.

Resident #018 was observed by the Inspector while they were in their room. The resident was sitting in a wheel chair that had a restraining device in place. The RN on the unit was interviewed and indicated that the device was used as a PASD and should not have been applied. The resident required the use of the device only during transport to prevent them from falling out of the wheelchair. The plan of care was reviewed and indicated that the device was only applied during transport and must be taken off after transporting the resident. The licensee failed to ensure that the PASD was removed as soon as it was not required. [s. 111. (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 with r.111(1) Every licensee of a long-term care home shall ensure that a PASD used under section 33 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained, to be implemented voluntarily.***

---

**WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

On October 13, 2015, at 1207 hours, a medication cart was left unlocked and unattended outside the dining room on an identified floor. Residents who wandered and those that consumed non-food items resided on that floor. The RN confirmed the cart was required to be locked when unattended. [s. 129. (1) (a) (ii)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r.129(1)(a)(ii) Every licensee of a long-term care home shall ensure that drugs are stored in an area or a medication cart,***
***(ii) that is secure and locked, to be implemented voluntarily.***

---

**WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply**
**Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:**
**1. All areas where drugs are stored shall be kept locked at all times, when not in use.**
**2. Access to these areas shall be restricted to,**
**i. persons who may dispense, prescribe or administer drugs in the home, and**
**ii. the Administrator.**
**3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including the following: All areas where drugs were stored should be kept locked at all times, when not in use.

A) On October 13, 2015, at 1010 hours, during the initial tour of the home on the third floor of the home, Inspectors located an unlocked insulin storage fridge in a cut through hallway that was accessible to all residents and visitors. Inside the fridge inspectors noted multiple vials of insulin, liquid eye drops, and insulin pens. The RPN on the unit confirmed that the fridge was unlocked and stayed beside the fridge until maintenance arrived to fix the locking mechanism. An interview with the DOC confirmed the homes expectation was that all medication storage areas were to be kept locked at all times.

B) On October 26, 2015, at 1100 hours, the third floor medication cupboard was found unlocked and unattended by staff. The cupboard contained:
- 8 bottles of potassium chloride
- 2 bottles of Milk of Magnesia
- 2 bottles of Almagel
- 4 bottles of Diphenhydramine
- 1 bottle of Tylenol Extra Strength
- 7 bottles of Vitamin B12 injections
- 2 bottles of Isopto Tears
- 3 bottles of Koffex DM

The RPN confirmed the cupboard was unlocked and should have been locked. The cupboard was then locked by the RPN. [s. 130. 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 with r.130.1 Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:***
***1. All areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.***

**WN #22: 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 a resident in accordance with the directions for use specified by the prescriber.

On October 22, 2015, during observation of medication administration to resident #053, a registered nursing staff was observed administering a test to the resident. The physician's orders indicated that the resident must have a test prior to the administration of medication, which was to be given before meals. The test was completed one hour and forty five minutes prior to the meal and administration of the resident's scheduled medication dose. An interview with the DOC confirmed that the registered staff did not meet the home's expectation for the administration of the resident's medication and that the registered staff did not administer the medication as directed 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 with r.131(2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

---

**WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes**
**Every licensee of a long-term care home shall ensure that,**
**(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;**
**(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and**
**(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that (a) when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

When resident #073 was admitted to the home the physician ordered a psychotropic medication for the resident. The family were interviewed and identified that the resident was on the same medication and dosage at home, and that it was effective. About one month later, the medication was changed to a different medication and subsequently the physician increased the dose of the different medication. The clinical record was reviewed and there was no documentation of the resident's response and the effectiveness of the drugs until the new medication was increased and the physician assessed the resident. The SDM informed the LTC Inspector that they believed the medication was having a significant negative impact on the resident's activities of daily living. The charge nurse was interviewed and was unable to locate any documentation related to monitoring the resident's response and the effectiveness of the drugs. The annual conference occurred and family were concerned regarding the resident being lethargic, not very responsive over the past couple of weeks, and being tired all the time. The physician reduced the psychotropic medication. There was no monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drug prescribed for resident #073. [s. 134. (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r.134 (a) Every licensee of a long-term care home shall ensure that,***
***(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.***

---

**WN #24: 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 the staff participated in the implementation of the infection prevention and control policy. On October 13, 2015, during the initial tour of the home two spa tub rooms on the second and third floors were found to have unlabeled personal hygiene products. These personal hygiene products included unlabeled hair combs, nail trimmers, and deodorant. Staff confirmed that these items should be labeled in accordance with the homes infection prevention and control policy. An interview with the home's DOC confirmed that not labeling these items did not ensure staff participated in the home's infection prevention and control policy. [s. 229. (4)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r.229(4) The licensee shall ensure that all staff participate in the implementation of the program, to be implemented voluntarily.***

---

**WN #25: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that resident #007 had the right to privacy in treatment and in caring for their personal needs.

On October 28, 2015, staff were providing continence care to resident #007. The door to the room was left open and the curtain around the resident's bed was not fully closed in a shared room. The staff member left the room with the resident unclothed and visible to anyone entering the room. Registered staff confirmed that the door and curtains were to be closed when providing personal care to the resident. [s. 3.(1) 8.]

2. The licensee failed to maintain confidentiality with respect to personal health information within the meaning of PHIPA.

On October 13, 2015, during the initial tour of the home the door to a clean linen storage room was found unlocked. Inside of that room a closet was found to be unlocked. Inside of that closet inspectors found discontinued and thinned resident charts concealed in envelopes that contained the personal health information of the homes residents and Registered staff confirmed that this storage closet was to be locked at all times. The DOC confirmed that the storage area needed to be locked at all times to protect the personal health information of the homes residents. [s. 3. (1) 11. iv.]

---

**WN #26: 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:**
**5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the responsive behaviour plan of care for resident #040 was based on an interdisciplinary assessment of the resident that included: any mood and behaviour patterns, including wandering; any identified responsive behaviours; any potential behavioural triggers and variations in resident functioning at different times of the day.

Point of Care Documentation over a one month period identified 16 episodes of socially inappropriate / disruptive behaviours, with 15/16 occurring between 1800 and 2100 hours. The plan of care did not reflect variations in the resident's functioning at different times of the day. The plan of care for a seven month period directed staff to monitor behaviour episodes and attempt to determine underlying cause and to consider time of day, persons involved, and situations; however, the plan of care was not revised to include this information when a pattern was identified. [s. 26. (3) 5.]

---

**WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that each resident of the home was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

Resident #087 was observed walking the hallway with a large amount of dried on food from the lunch meal on their top and pants just prior to the evening meal. Staff confirmed the resident should have been changed.

Resident #052 was observed walking the hallway in the afternoon with dried on food on their clothing from the lunch meal. Staff went to change the resident at that time.

Resident #071 was observed walking the hallway just prior to the noon meal. The resident had a large dried stain on the front of their shirt (appeared to be a beverage stain) and their shirt had a large area that was wet from oral secretions. The resident had not had their clothing changed when it was soiled.

Resident #045 was observed sleeping in their wheelchair in the hallway in the afternoon. The resident had a large dried on liquid stain on the sleeve of their shirt and dried food on their pants. When the LTC Inspector asked the PSW about it they picked off some of the food from the resident's pants; however, the resident's clothing was not changed.

Residents #088 and #082 were observed with dried on food on their clothing at 1005 hours. The same dried on food was still there at 1420 hours. [s. 40.]

---

**WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

Concerns and complaints were voiced to the home about the care of resident #059. The home's investigative notes were reviewed, the home's policy and procedures were reviewed, the home's complaint logs were reviewed, and the Quality and Leadership team minutes were reviewed. There was no documented record of the complaints received to ensure they were reviewed and analyzed for trends, and the results of the review and analysis were used in determining what improvements were required or were made in response to the complaints.

The Executive Director (ED) was interviewed and confirmed the home did not have a documented record, which identified that the complaints received were reviewed and analyzed for trends on a quarterly basis, and/or a documented record to identify what improvements were required in the home of improvements made in response to the complaints. The ADOC was interviewed and was not aware of a documented record of complaints reviewed and analyzed quarterly to identify trends and areas that may need improvement. [s. 101. (3)]

---

**WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that a report to the Director was made within 10 days of becoming aware of suspected abuse, or earlier as required by the Director.

The home suspected that resident #058 was being abused. The Director was not notified of the suspected abuse until two and one half years later.

The Executive Director and the Business Office Manager were interviewed and confirmed that the home did not notify the Director immediately or within ten days when they suspected abuse. The ED and Business Office Manager confirmed they were not in compliance with the legislation and their abuse policy and procedures. [s. 104. (2)]

---

**WN #30: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal**

**Specifically failed to comply with the following:**

**s. 136. (2) The drug destruction and disposal policy must also provide for the following:**
**2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that as part of the medication management system, any controlled substances that were to be destroyed and disposed of were stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident until the destruction and disposal occurred.

On October 22, 2015, during observation of medication administration, three packages containing ten vials each of injectable narcotic medication for a deceased resident were found in the double locked narcotics storage area on an identified floor of the home which also contained active narcotic medication for residents currently residing in the home. Staff confirmed that the resident whom the controlled substances belonged to had died and also confirmed that the home's expectation was to remove the discontinued medication from the regular controlled substances stock and to destroy the medication as soon as possible following the death of the resident. Registered staff confirmed that the destruction of the medication required one registered staff and the home's DOC. The home's policy titled "Drug Disposal" index #04-08-10 stated that discontinued narcotics and controlled substances were to be removed from the medication cart and the individual Narcotic and Controlled Substance Administration Record signed and dated prior to being placed into the double locked centralized storage area within the facility. An interview with the DOC confirmed that the medication was not removed from the double locked narcotic box that contained active narcotic medications for other residents and that the discontinued narcotic medications were not destroyed following the death of the resident and that this did not meet the home's expectation. [s. 136. (2) 2.]

---

**Issued on this 29th day of February, 2016**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | MICHELLE WARRENER (107) |
| **Inspection No. / No de l'inspection :** | 2016_191107_0004 |
| **Log No. / Registre no:** | H-003342-15 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Feb 27, 2016 |
| **Licensee / Titulaire de permis :** | Vigour Limited Partnership on behalf of Vigour General Partner Inc.<br>302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8 |
| **LTC Home / Foyer de SLD :** | LEISUREWORLD CAREGIVING CENTRE - MISSISSAUGA<br>2250 HURONTARIO STREET, MISSISSAUGA, ON, L5B-1M8 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | GARY BUTT |

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(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).

**Order / Ordre :**

The licensee shall:

1. Re-assess all bed systems to determine if they passed zones of entrapment 1 -4. Refer to Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards".

2. Implement a system to keep track of all beds in the home, what size of bed rails are used, all the zones that were tested, whether they failed or passed, date of the audit that was completed and by whom.

3. Where bed systems have failed zones of entrapment 1-4, the home shall mitigate immediately any entrapment risks to residents.

4. Develop a comprehensive bed safety assessment tool using as a guide the US Federal Food and Drug Administration document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".

5. An interdisciplinary assessment of all residents using the bed safety assessment tool shall be completed and the results and recommendations of the assessment shall be documented.

6. The home shall continue to re-assess the bed system and complete the comprehensive bed safety assessment when there is a change in resident's condition, when a new resident is admitted to the home and when any parts of the bed systems are changed.

7. Update all resident plans of care to include whether bed rails are used, how many, which side of the bed and the reason. Include the use of any interventions, such as bed accessories if the bed has not passed all entrapment zones.

8. Educate all staff that provide direct care to residents on bed safety, bed rail use and entrapment zones.

**Grounds / Motifs :**

1. The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A bed entrapment audit was completed by the home's maintenance department between September 14 and October 28, 2015. According to the audit report provided on October 30, 2015, 170 out of 237 beds were tested for entrapment zone hazards. Entrapment zones included those areas between the rail rungs, the mattress and the rail, under the rail, or at the end of the rail, which were numbered one through four.

The audit report identified 142 of 170 beds tested failed at least one zone of entrapment. One hundred and twenty seven beds were identified to have issues with mattresses and 34 were identified by the home to have bed/bed rail issues.

The Executive Director identified that 25 new mattresses were installed in November 2014, and 20 mattresses in September 2015. Not all beds were re-tested in accordance with prevailing practices after the new mattresses were installed to ensure the entrapment risks had been mitigated. Health Canada guidelines titled, "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008" requires that bed systems be re-tested when a different mattress is applied to ensure that the bed and mattress combination meets the recommendations of the guidelines. The licensee did not ensure all beds that had mattresses replaced were re-tested. The licensee did not take immediate action for those residents who remained in a bed that failed one or more entrapment zones and where the resident was assessed to require the use of a rail while in bed.

Bed safety guidelines endorsed by Health Canada titled, "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, 2003", created by the Federal Drug and Food Administration, were not implemented or incorporated into the home's existing bed safety program. The guidelines are current prevailing practices with respect to bed safety and include various measures and interventions to reduce entrapment risks for residents using bed rails while occupying a failed bed system.

Resident #026 was observed in bed on October 23, 2015, with one assist rail in the middle of the bed. The health care records indicated that the resident was assessed for bed rails using a Restraint/PASD assessment form dated July, 2015. This assessment indicated that the bed rails were assessed for the zones of entrapment. The ESM was interviewed on October 28, 2015, and indicated

that the home had only started testing the beds in September, 2015, and had not completed the entire process. The ESM confirmed that the home had changed the mattress for resident #026 and did not re-test the bed. On October 29, 2015, the ESM had the bed re-tested and confirmed that the bed failed zone 2. The report indicated that resident #026's bed did not pass zone 2. The licensee did not take steps to mitigate the risk of entrapment that was present under the rail while the resident was in bed. (561)

Resident #040 was observed in bed with two assist rails raised in the middle of the bed during this inspection. Staff confirmed that two assist rails were raised when the resident was in bed. The resident's bed had been assessed for zones of entrapment in October, 2015, with failure in zone 3 (between the mattress and the rail). Staff confirmed immediate steps, as outlined in the above noted clinical guideline, were not taken at the time to mitigate the risks in the failed zones of entrapment.
(107)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** May 31, 2016

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 27th day of February, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** MICHELLE WARRENER

**Service Area Office /**
**Bureau régional de services :** Hamilton Service Area Office