Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 27, 2016	2016_226192_0006	002309-16	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

COLUMBIA FOREST
650 MOUNTAIN MAPLE AVENUE WATERLOO ON N2V 2P7

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

DEBORA SAVILLE (192), CAROLYN MCLEOD (614), MARIAN MACDONALD (137), NUZHAT UDDIN (532), SHARON PERRY (155)

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): February 8, 9, 10, 11, 12, 16, 17, 18 and 19, 2016.

This Resident Quality Inspection was completed with the following:
Critical Incident Inspections; 006070-15, CI 2856-000005-15 related to staff to resident abuse and 017946-15, CI 2856-000007-15 related to falls.
Follow-up Inspection, 008321-15 and Complaint Inspection 023036-15. Non-compliance identified during these inspections are included within the Resident Quality Inspection.

Additional Concurrent Inspections:
Complaint Inspection 035500-15 - findings related to O.Reg 79/10 s. 50(2)(b)(iv) were included in this report.
Complaint Inspection 021875-15 - findings related to O.Reg 79/10 s. 50(2)(b)(iv) and Long-term Care Homes Act 2007, s.o. 2007, Chapter 8, s. 6(7) were included in this report.

During the course of the inspection, the inspector(s) spoke with residents and family members, the Executive Director, Director of Care, Associate Directors of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aides, Director Regional Operations, Resident Assessment Instrument (RAI) Coordinator, Restorative Care Aide, Program Manager, Environmental Services Manager, Physiotherapist, Maintenance Person, Housekeeping Aide, and the Nutrition Manager.

Inspectors toured the home, observed meal service, medication administration, medication storage areas, recreation activities, reviewed relevant clinical records, reviewed relevant policies and procedures, the provision of resident care, resident-staff interactions, posting of required information and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #003	2015_271532_0005	192
LTCHA, 2007 S.O. 2007, c.8 s. 31. (1)	CO #002	2015_271532_0005	192

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The plan of care for a specified resident identified on the Treatment Administration Record (TAR) that the resident was to have specified devices in place.

On a specified date the resident was observed between 1139 hours and 1415 hours continuously; at 1530 hours and at 1630 hours in the presence of Director of Care #101, with no specified device in place.

Interview with Registered Practical Nurse (RPN) #118 identified that the resident was to have specified devices in place and confirmed that the specified devices were to have been applied for the resident in the morning by Personal Support Workers providing care and should be replaced at bedtime when care was provided.

RPN #118 indicated that physiotherapy had initiated an alternative device in 2015, but the resident developed altered skin integrity and the device was put on hold. At that time staff were instructed to use the specified device.

Interview with Personal Support Worker #125 confirmed that the resident was to have the specified device in place and and that the device was not present.

Interview with Personal Support Worker #126, confirmed that they had been unable to put the device in place.

Review of the medical record failed to identify that the resident had refused care. Interview with RPN #118 confirmed that care refused would be documented in the progress notes in Point Click Care.

The resident was observed on a subsequent date without the specified device in place.

The licensee failed to ensure that the care set out in the plan of care for the specified resident was provided to the resident as specified in the plan.[s. 6. (7)]

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

The plan of care for a specified resident, indicated under Nutritional Risk High, a recommended fluid requirement per day and that a referral to the Registered Dietitian was to be completed if the resident's intake was less than 50% of the meal or if fluid

intake was less than required for three consecutive days.

Review of the intake record for the resident between specified dates in 2016 identified that the residents intake was less than the identified required amount on 28 of 32 days.

Review of the medical record identified that no dietary referral had been completed in relation to the fluid intake of the resident between the specified dates in 2016. It was noted that a Nutrition Reassessment was last completed in 2015 and a referral related to weight loss of 26.6% body weight over three months was completed in 2016.

The resident was observed to be left in bed without being offered food or fluid on a specified date in 2016, and interview with Registered Practical Nurse #118 identified that on the specified date in 2016, the resident was provided their morning nourishment with breakfast.

Interview with Director of Care #101 confirmed that dietary referrals would be found under the assessment tab on point click care. DOC #101 confirmed that dietary referrals had not been completed when the resident had not taken their required amount of fluid for three consecutive days and indicated that the Registered Dietitian (RD) was aware of the risks for the resident.

The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan when the specified resident was not referred to the RD when fluid intake was less than the identified required amount on 28 or 32 days in 2016. [s. 6. (7)]

3. This non-compliance was identified during complaint inspection 2016_226192_0008 log #021875-15.

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

The plan of care for resident #034 identified that the resident was at high nutritional risk and was to be weighed weekly on bath day. Weekly weights were added to the plan of care on a specified date in 2015.

Review of the assessment completed by the Registered Dietitian (RD), identified that the resident was less then their Goal Weight Range (GWR) at the time of admission. The

Care Conference note, indicated that the resident had lost weight since admission. A progress note by the RD indicated that the resident had lost six percent body weight since admission and that while not significant, it was undesirable and a plan was in place to promote weight gain.

Review of the medical record with Registered Nurse #120 confirmed that weekly weights were to have been completed and recorded in Point Click Care, but were not completed for resident #034 for specified weeks in 2015.

The licensee failed to ensure that care set out in the plan of care was provided to resident #034 when weekly weights were not completed. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure the temperature in the home was maintained at a minimum of 22 degrees Celsius (C).

During observations and interview of residents and staff, throughout the Resident Quality Inspection, it was revealed residents and staff complained of being cold, specifically on Schneider House. Residents were observed in their rooms/dining rooms/lounges wearing sweaters, fleece jackets, shawls and fleece blankets.

On February 9, 10, 11 and 16, 2016, Inspector #137 monitored air temperatures on Schneider House and air temperatures were not at the required minimum temperature of 22 degrees Celsius.

Temperatures were recorded to be between 19C and 21C in common areas and resident rooms. Residents and staff interviewed identified that they felt cold.

The Executive Director (ED) #100 was made aware that the temperatures were not at the required minimum of 22 degrees Celsius, on February 11, 2016, at 1203 hours. When touring the home area with Inspector #137, four residents expressed to the Executive Director that they were cold. During the tour of Schneider House, the ED indicated they could feel the temperature difference from other areas of the home.

On February 11, 2016, at 1415 hours, the Environmental Services Manager (ESM) #117 shared that the automated electronic monitoring system was showing the temperatures as being satisfactory but that cooler temperatures were physically felt when the ESM conducted a tour of the home area and confirmed that there was a problem with the system. The ESM shared that the Air Make-Up System was blowing cold air to the area and the ESM recorded air temperatures between 19.7 and 20.5 C.

The ESM shared that the designer of the building's automation system visited the home on February 11, 2016, and indicated the system was not working properly. A previously submitted proposal to repair the system had not yet received a response from the corporate office. The ESM confirmed the temperatures did not meet the legislative requirements and the expectation was the home should be maintained at a minimum temperature of 22C, as per the legislative requirements. [s. 21.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

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 has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #006 was observed on a specified date in 2016, to have an area of altered skin integrity with a dressing applied.

Review of the medical record identified that resident #006 sustained areas of altered skin integrity on specified dates.

Interview with Assistant Director of Care (ADOC) #104 identified that when altered skin integrity occurs registered staff were to complete a progress note in Point Click Care that included the location of the altered skin integrity, measurements of the area of altered skin integrity, notification of the Power of Attorney and treatment provided. The area of altered skin integrity was to be added to the Treatment Administration Record (TAR) and weekly assessments of the area of altered skin integrity would be included in a progress note.

Review of the medical record for resident #006 with ADOC #104 for altered skin integrity sustained on a specified date in 2015, identified that weekly wound assessments were not completed on three specified dates in 2015. Review of the TAR identified that the area of altered skin integrity continue to be documented as having been checked daily, three months after it was acquired and a dressing remained in place although no open area was noted. The progress notes failed to identify that the area of altered skin integrity had healed and no weekly wound assessments were completed.

Review of the TAR for January 2016, identified that the resident sustained altered skin integrity that was to be checked daily to ensure the dressing was intact. Review of the progress notes failed to identify weekly assessments of this area of altered skin integrity on four specified dates in 2016. It was noted that daily checks were stopped, however the progress notes failed to identify that the area of altered skin integrity had healed.

Interview with ADOC #104 confirmed that weekly wound assessments were not completed in relation to altered skin integrity sustained by resident #006. [s. 50. (2) (b) (iv)]

2. This non-compliance was identified during complaint inspection 035500-15 inspection number 2016_226192_0007.

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

Record review identified that resident #033 had sustained identified areas of altered skin integrity.

Interview with Associate Director of Care #104 confirmed that it would be the expectation of the home that any altered skin integrity including bruising and skin tears would be assessed at the time of injury and a note made in the progress note. The area of altered skin integrity would be identified in the Treatment Administration Record and weekly assessments would be completed in the progress notes.

Review of the progress notes with ADOC #104 and Registered Nurse #145 confirmed that weekly wound assessments were not completed in relation to the identified areas of altered skin integrity.

The licensee failed to ensure that weekly wound assessments were completed for areas of altered skin integrity for resident #033. [s. 50. (2) (b) (iv)]

3. This non-compliance was identified during complaint inspection 021875-15 inspection number 2016_226192_0008.

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

Review of the medical record for resident #034 identified that the resident sustained specified areas of altered skin integrity.

Interview with the Associate Director of Care responsible for the Skin and Wound Program confirmed that when an area of altered skin integrity was identified it was to be recorded in the progress notes and added to the Treatment Administration Record to remind registered staff to reassess the area weekly. Weekly assessments would be recorded in the progress notes for skin tears and altered skin integrity that was less than a stage II.

Review of the medical record with Registered Nurse #120 confirmed that weekly assessments of these areas of altered skin integrity were not documented within the progress notes.

The licensee failed to ensure that resident #034 who exhibited altered skin integrity was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

4. The licensee has failed to ensure that the resident who was dependent on staff for repositioning had been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

The plan of care for a specified resident, who was dependent on staff for all aspects of care identified that the resident was at risk of impaired skin integrity related to incontinence and immobility. Interventions included the application of pressure relieving devices when in bed. The resident was not able to assist with bed mobility, was totally dependent on staff to change positions as necessary and they were not able to verbalize requests.

Observation identified that a resident was positioned on their right side, facing the door during continuous observation during a two hour and thirty-five minute period. When approached by the inspector observing, the resident would open their eyes, but did not respond. The resident was not approached by any staff member during the observation period.

Interview with Director of Care #101 confirmed that the resident should be repositioned at a minimum, every two hours.

The licensee failed to ensure that the specified resident, who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep. [s. 50. (2) (d)]

Additional Required Actions:

CO # - 003 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 ensuring 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 #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was offered a minimum of three meals daily.

The plan of care for a specified resident identified that the resident was at high nutritional risk, ate in the dining room, in an upright position and required total assistance to eat meals and beverages.

Interview with Director of Care #101 confirmed that the expectation would be for the resident to receive three meals daily and additional snacks as ordered by the Registered Dietitian.

During continuous observation for two hours and thirty-five minutes over the noon meal time, the resident was observed in bed, positioned on their right side, facing the door of the room. No staff member entered the room to check on the resident's status, offer to get the resident up for their meal or to bring a tray to the room for the resident. A staff member from the evening shift was observed to look in on the resident and shortly thereafter two staff members entered the room to reposition the resident on their left side.

Review of the medical record for the resident identified that point of care documentation indicated "Resident Not Available" for the lunch meal. Documentation on Point of Care for two subsequent days in 2016, also indicated "Resident Not Available" for the noon meal.

Interview with Personal Support Worker #126 identified that "Resident Not Available" meant that the resident was not in the Dining Room for lunch. The PSW indicated that the resident had not been having lunch and that if sleeping the resident was not wakened for lunch.

Interview with Personal Support Worker #126 and #127 indicated that if the resident was sleeping they do not provide the resident with lunch.

Review of the weights for the resident identified that they had sustained weight loss over a three month period.

Dietary referrals were completed in relation to the weight loss and interventions were in place. Progress notes completed by the Registered Dietitian indicated that the resident had lost 26.6 percent body weight in three months and that weight loss was likely due to declined intake at meals. Intake was on average Poor (25-50%) to Fair (50-75%) but the resident often missed one meal per day.

The licensee failed to ensure that a specified resident was offered, at a minimum, three meals daily. [s. 71. (3) (a)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

**s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).**

**s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).**

Findings/Faits saillants :

1. The licensee has failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On a specified date in 2016, a specified resident was observed with Director of Care #101 in a common area. The resident was observed to have a potential symptom of infection. Review of the progress notes and shift report on a subsequent date in 2016, for the resident, failed to identify documentation of the potential symptom of infection. DOC #101 confirmed that the presence of the specified symptom, would be considered a symptom of a potential infection and had not been recorded in the progress notes. Interview with Registered Practical Nurse (RPN) #118 confirmed that they had not been made aware of the presence of a potential infection for the resident.

Interview with Associate Director of Care #103, identified that any resident with sign and symptoms of infection should have documentation of the specific signs and symptoms within the progress notes. Review of the twenty-four hour shift report is completed each morning Monday to Friday, excluding holidays and when ADOC #103 is not absent from the home, by ADOC #103 and the surveillance record is completed. ADOC #103 confirmed that they would not be aware of any resident with infection if the registered staff on the home area failed to document the signs and symptoms of infection within the progress notes. ADOC #103 also confirmed that the surveillance record is not maintained in their absence. Review of the Surveillance Record for February with ADOC #103 failed to identify the presence of signs and symptoms of a potential infection for the specified resident.

During observation on a specified House it was observed that resident #003 voiced complaints of feeling unwell, with specified symptoms. The resident was assisted to their room, medication provided for symptom relief. The next day, at the noon meal resident #003 continued to complain of symptoms of infection, refusing their meal and taking only fluids. This information was shared with DOC #101 following which the resident did appear on the surveillance record, although the progress notes failed to identify the signs and symptoms of potential infection exhibited by resident #003.

A resident was observed by inspector #192 for nutritional intake and was noted to exhibit signs and symptoms of a potential infection. This information was reported to DOC #101. The progress notes failed to identify the presence of signs and symptoms of infection for the resident and the resident was not included on the surveillance record.

During observation on a specified House, resident #036 was observed sitting in a common area. The resident complained of signs and symptoms of an infection. Interview with Registered Practical Nurse #118 confirmed that the resident had signs and symptoms of infection, similar to another resident in the home area (#037) and that both residents were on the physician list to be seen in relation to these signs and symptoms of infection. RPN #118 confirmed that signs and symptoms of infection for residents on the home area were not recorded on a surveillance record maintained in the home area.

Interview with Registered Practical Nurse #147 identified that resident #035 had symptoms of an infection that had been identified by the staff member the previous evening. Interview confirmed that the identified symptoms of infection had not been recorded in the progress notes and review of the surveillance record confirmed that the signs and symptoms of infection for resident #035 had not been included on the surveillance record when first identified.

Interview with ADOC #103 confirmed that surveillance records are not kept on the home areas. Interview with Registered Nurse #145 identified that they act as the charge nurse for the home in the absence of management staff. In the event that a resident was exhibiting signs and symptoms of infection in the absence of ADOC #103, charge nurses on the home area would manage signs and symptoms of infection. If more than one resident presented with signs and symptoms of infection, or if a resident presented with symptoms that the registered staff member could not manage, then the registered staff would call the charge nurse for guidance. RN #145 confirmed that it would be the responsibility of registered staff on the home area to complete documentation in relation to any change in a residents condition.

The licensee failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and if there are none, in accordance with prevailing practices. [s. 229. (5) (a)]

2. The licensee has failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required.

Interview with Associate Director of Care #103, Registered Nurse(RN) #145, identified that when a resident was observed to have signs and symptoms of infection, precautions would immediately be initiated. Interview with Registered Practical Nurse #147 and RN #120 failed to identify the initiation of precautions when a resident presented with signs and symptoms of infection.

Resident #039 was identified in progress notes to have presented with signs and symptoms of infection on a specified date in 2016. Later the same day an external foot care provider who moved from resident to resident in the home, provided care to resident #039. The following day, resident #039 was documented to have additional signs and symptoms of infection and staff used an emergency wheelchair to assist the resident to the dining room for lunch. The record indicated that the resident refused to get up in spite of staff efforts.

Review of the medical record for resident #043 indicated that on a specified date 2016, the resident presented a symptom of infection. A progress note at 0630 on the same date identified that the resident had additional signs and symptoms of infection. A progress note completed at 1044 hours on the same date indicated that resident #043 was up for breakfast and then resting in their wheelchair in a common area.

Observation of resident #003 on two specified dates in 2016 identified that the resident complained of signs and symptoms of infection. There was no documented assessment of the resident. The resident continued to take meals in the dining room, participated in recreational activities on other home areas, interacted with other residents of the home area and spent time in common areas on the home area. No precautions were initiated.

Review of the respiratory line listing initiated by the home indicated that resident's #039 and #043 who reside on the same home area, presented with similar signs and symptoms of infection within a twenty-four hour period in February 2016.

The Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes, Ministry of Health and Long-Term Care, September 2014, indicted that whenever there are two cases of acute respiratory tract illness within 48 hours on one unit, an outbreak should be suspected and tests should be done to determine the causative organism.

Interview with ADOC #103 confirmed that the home had not identified a potential respiratory outbreak based on this information, no action was taken.

It is noted that this home area was confirmed to have a respiratory outbreak on a specified date in 2016 when four additional residents were identified with signs and symptoms of infection.

The licensee failed to ensure that on every shift staff record symptoms of infection in residents and take immediate action as required. [s. 229. (5) (b)]

Additional Required Actions:

CO # - 005 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 ensuring that on every shift, the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

WN #6: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity.

On a specified date in 2015, resident #011 reported to the day shift Registered Nurse that an incident had occurred on the previous weekend. An investigation was initiated by the Director of Care. The resident was able to describe the actions of the Personal Support Worker. During interview conducted as part of the investigation into the incident, by the Director of Care, the resident reported that the PSW had taken their dignity away.

Review of the staff members personnel file identified that the Personal Support Worker identified in the incident had received discipline related to failing to uphold resident rights in January 2015.

Interview with resident #011, ten months after the incident, identified that the resident was able to recall the incident clearly.

The licensee failed to ensure that resident #011 was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that every resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, are respected, to be implemented voluntarily.

WN #7: 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 where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

The home's policy titled Head Injury Routine, LTC-E-70 dated as revised November 2015, indicated that the frequency of observations to be followed as per the Neurological Flow Sheet, or as determined by the Physician or regional requirement.

Review of the Neurological Flow Sheet for resident #008, identified that monitoring every eight hours for 56 hours was not completed on 2 of 6 occasions.

Review of the Neurological Flow Sheet for resident #008, identified that monitoring every hour was not completed for three of six required assessments and monitoring every four hours was not completed for one of two required assessments.

Interview with Director of Care #101 confirmed that it was the expectation that all assessments be completed as identified on the Neurological Flow Sheet.

The licensee failed to ensure that the Head Injury Routine policy was complied with when not all required neurological assessments for resident #008 were completed post falls. [s. 8. (1) (b)]

2. The licensee failed to ensure that where the Act or this Regulation required 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 was required to ensure that

the plan, policy, protocol, procedure, strategy or system, was complied with.

The home's policy titled Personal Care, LTCH-H-10, dated as revised November 2015, indicated that daily personal care would be provided in a manner that promoted comfort, independence, safety and health while considering the preferences, dignity and privacy of the resident. In addition, to morning and bedtime care, personal care would be provided to the resident throughout the day as required.

A resident was observed to be assisted from bed on a specified date in 2016, at 1539 hours. The resident was positioned in a wheelchair. Observation of the resident in the lounge, with the Director of Care #101 and Personal Support Worker #125 confirmed that the resident had dry discharge on the nose and upper lip, had discharge in the eye and the resident was not well groomed.

Director of Care #101 confirmed that it would be the expectation that a resident receive care and be groomed before going into a common area of the home.

The licensee failed to ensure that the Personal Care Policy was complied with when personal care was not completed for the specified resident. [s. 8. (1) (b)]

3. The licensee has failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

The licensee's policy titled Skin and Wound Program, LTC-E-90, dated as revised August 2015, indicated that the nurse and Wound Care Champion would be informed of all altered skin integrity and that documentation of altered skin integrity would be completed by the nurse in the interdisciplinary progress notes and the resident's care plan.

The policy also indicated that the unregulated care provider (UCP) would report any altered skin integrity to the nurse and document as per the home's process in Point of Care (POC)and that the Resident/Substitute Decision Maker (SDM)/Family communication would be documented in the interdisciplinary progress notes and may include; involvement in the development and awareness of plan of care approaches related to skin and wound care goals and interventions reflecting choices and preferences; when altered skin integrity was discovered, treatment initiated and

interdisciplinary team involvement; previous treatment and prevention interventions attempted and if a treatment was refused, whether counseling on alternatives or other interventions offered.

Resident #006 was identified to have an area of altered skin integrity in 2015. Record review and interview with Assistant Director of Care #104 who was the Wound Care Champion for the home, confirmed that they were not notified of the area of altered skin integrity.

Review of the plan of care for resident #006 identified that areas of altered skin integrity, were recorded on the Treatment Administration Record but were not included in the plan of care. Review of the plan of care with ADOC #104 confirmed that there was no focus on the plan of care related to skin integrity and that it would be expected that when resident #006 sustained altered skin integrity this information would be included in the plan of care.

Resident #006 was identified on the Treatment Administration Record to have an area of altered skin integrity in January 2016.

Review of the progress notes failed to identify that the resident had sustained altered skin integrity on this date and that the SDM was notified of the area of altered skin integrity, when it was discovered, treatment initiated and interdisciplinary team involvement.

Interview with Registered Practical Nurse #118 indicated that the altered skin integrity may have been a re-occurrence of a previous area and therefore a dressing was applied and the area of altered skin integrity was added to the Treatment Administration Record, however no progress note was made in relation to the re-occurrence, family being notified or treatment initiated.

Resident #006 was observed to have altered skin integrity in 2016 and was subsequently observed with ADOC #104, to have additional altered skin integrity.

Review of the medical record and tasks in POC failed to identified documentation of the altered skin integrity.

Interview with Personal Support Worker #127 confirmed that changes in skin condition should be recorded on POC and communicated to the nurse.

The licensee failed to ensure that the policy titled Skin and Wound Program was complied with in relation to altered skin integrity sustained by resident #006. [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 ensuring that where the Act or this Regulation required 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, is complied with, to be implemented voluntarily.

WN #8: 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 has failed to ensure that all doors leading to non-residential areas that were equipped with locks were kept locked when they were not being supervised by staff.

A) The initial tour of the home was completed on February 8, 2016. On the third floor of the home, Eby House, it was identified that the electrical door 3B 116 was not locked. Behind this door were a collection of thin wires and solid metal panels. The Director of Care (DOC) #101 was notified by the inspector.

An interview with the DOC confirmed that it was the expectation of the home that the

door was to be locked and it was not. The DOC confirmed that the door handle was loose and not functioning properly at the time.

When notified of the repair required to the door, replacement of the door handle was completed immediately. Further checks done on the door found it to be locked securely after being repaired.

On Watson House, room 2C-290, an electrical room opened when the door was pulled. The room contained three breaker panels and one white locked panel. The Restorative Care Manager #108 observed the open door and confirmed that the door should be locked at all times.

B) During the initial tour, it was identified that the doors to the clean linen room, 3B 230 and the soiled linen room, 3B 236 were not locked.

Upon observation inside the clean utility room, a small plastic care basket identified with resident names, contained prescription treatments including Ketoderm, Nizoral Shampoo and Clomitraderm. Personal Support Worker #107 confirmed that the PSW staff get the creams in the morning from the registered staff. The creams are then put in the residents personal basket and put in the cupboard until care is provided. Director of Care (DOC)#101 confirmed that this was the practice of the home.

DOC #101 confirmed that the doors were not locked and that it was the expectation of the home that both of these doors were to be locked.

C) Upon completion of the tour it was noted that the following doors were not securely locked:

Johnston House- 3C 230 clean linen room, 3C 236 soiled linen room. Personal Support Workers #123 and #124 verified that it was the expectation of the home that these doors be kept locked .

Breithaupt House- 2B 230 clean linen room, 2C 236 soiled linen room.

On the Schneider House soiled linen room, 1B 236 opened when pulled despite the non-handled door being secured with floor and ceiling bolts. Personal Support Workers #121 and #122 confirmed that the door was left open and unattended and that it is the

expectation of the home that these doors are to be securely locked when not in use by staff.

On Dickson House the soiled utility room, 1C-236, door handle was locked but when pulled the doors opened. This was confirmed by Personal Support Worker #112 who also confirmed that it was the expectation of the home that the doors be locked when not attended.

Interview with the DOC #101 confirmed that it was the expectation of the home that all clean and soiled linen rooms were to be locked.

The licensee failed to ensure that all doors leading to non-residential areas that were equipped with locks were functioning and kept locked when they were not being supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observations, during the initial tour of the home and throughout the Resident Quality Inspection (RQI), revealed identified deficiencies, such as damaged wooden bedroom and bathroom doors, paint chipped metal bathroom door frames and damaged bedroom walls, in 20 out of 40 resident rooms (50 per cent). Wooden doors to home area entrances, spas, shower rooms and medication rooms, as well as the finish on wooden base boards, were also damaged.

During a tour of the home on February 18, 2016, the Environmental Services Manager #117 confirmed the identified deficiencies, as well as the expectation that the home and furnishings were to be maintained in a good state of repair. [s. 15. (2) (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 ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

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

The home had a staffing plan for when there were staff absent from their shift. The plan included duties that were to be completed by each staff. One of the duties that was listed was bathing.

The home tracks their unfilled shifts on a form called a floor staff plan. A review of the floor staff plans for January 2016, revealed that there were a total of 27 shifts not filled for the month.

The bath shift on a specified date in 2016, on a specified House for the time frame of 0700 hours to 1130 hours was not filled. A review of the bath list for that day indicated a total of six residents that were to be bathed. A review of each of those six residents files revealed that none of the residents received their bath. Further review showed no documented evidence of any further baths until the next scheduled bath day.

Interview with Registered Practical Nurse (PSW) #139 confirmed that there was no formal process for ensuring that missed baths were completed at the earliest opportunity. An interview with PSW #140 confirmed that the PSW staff were not aware of any process in the home used to ensure that baths were caught up as soon as possible when missed.

The home failed to ensure that the staff mix was consistent with the assessed needs of the residents in the home. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the staffing plan provided for a staffing mix that was consistent with residents' assessed care, to be implemented voluntarily.

WN #11: 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).**

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent received an assessment that included 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 required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A) Resident #002 was admitted to the home on a specified date.

The only documented evidence of a continence assessment was completed on a specified date in 2015, and the resident was deemed continent. The Minimum Data Set assessment, completed on a subsequent date in 2015, indicated the resident was frequently incontinent of bladder.

There was no documented evidence that a further continence assessment was completed, regarding the change in the resident's condition.

B) Resident #005 was admitted to the home on a specified date.

The only documented continence assessment, indicated the resident ambulated independently, was aware of the urge to void, was able to locate toilet, could ask for assistance, could remove clothing to void and required prompted voiding.

The Minimum Data Set (MDS) Assessment completed on a specified date in 2015, indicated the resident required extensive assistance of two staff for toilet use and was frequently incontinent of bladder.

There was no documented evidence that a further continence assessment was completed regarding the change in the resident's condition.

C) Resident #007 was admitted to the home on a specified date.

The admission continence assessment deemed the resident as incontinent, despite a medical device being in place.

The MDS assessment, of a specified date in 2015, indicated the resident was occasionally incontinent of bowel and frequently incontinent of bladder.

The medical device was removed and re-inserted multiple times and was permanently removed in 2015.

There was no documented evidence that a continence assessment was completed regarding the changes in the resident's condition.

During an interview, with ADOC #102, it was confirmed that Continence Assessments were not completed for residents #002, #005, and #007 and it was the expectation that Continence Care Assessments be completed on admission, quarterly and with a change in a resident's condition. [s. 51. (2) (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 ensuring that 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, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
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).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident'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 #031 was observed in a medical device with a restraint in place. The resident was unable to release the restraint when asked.

Review of the medical record confirmed that the device used by resident #031 was a restraint.

Interview with Associate Director of Care #103 confirmed record review that included the Treatment Administration Record and Documentation Survey Report for February 2016, and failed to identify documentation that resident #031 had been reassessed and the effectiveness of the restraint evaluated by registered staff at least every eight hours and at any other time based on the resident's condition. [s. 110. (2) 6.]

2. Resident #032 was observed in a medical device with a restraint in place.

Review of the medical record confirmed that a device used by resident #032 was a restraint.

Interview with Associate Director of Care #103 confirmed record review that included the Treatment Administration Record and Documentation Survey Report for February 2016, and failed to identify documentation that resident #032 had been reassessed and the effectiveness of the restraint evaluated by registered staff at least every eight hours and at any other time based on the resident's condition. [s. 110. (2) 6.]

3. The licensee has failed to ensure that the documentation related to restraining of resident #032 included all assessment, reassessment and monitoring, and the resident's response.

Resident #032 was observed with a device in place that was identified in the medical record to be a restraint.

Review of documentation related to the use of a restraint for resident #032 and interview with Associate Director of Care (ADOC) #103 identified that documentation related to the application of a restraint including hourly monitoring and repositioning every two hours was to be completed by Personal Support Workers (PSW) under tasks in Point of Care.

Review of the documentation for resident #032 was unable to identify when the resident was monitored or their response to the restraint. Interview with ADOC #103 confirmed that PSW's sign for hourly checks but this may be done four or more hours into their shift. For example, documentation was completed for resident #032 at 1053 hours for the 0600, 0700, 0800 and 0900 checks for all questions on POC related to the use of the restraint. ADOC #103 confirmed it was unclear in the documentation when the resident

was monitored or when they were repositioned and that the documentation provided did not identify the resident's response. [s. 110. (7) 6.]

4. Resident #031 was observed with a device in place that was identified in the medical record to be a restraint.

Review of documentation related to the use of a restraint for resident #031 and interview with Associate Director of Care (ADOC) #103 identified that documentation related to the application of a restraint including hourly monitoring and repositioning every two hours was to be completed by Personal Support Workers (PSW) under tasks in Point of Care.

Review of the documentation for resident #031 was unable to identify when the resident was monitored or their response to the restraint. Interview with ADOC #103 confirmed that PSW's sign for hourly checks but this may be done four or more hours into their shift. For example, documentation was completed for resident #031 at 1053 hours for the 0600, 0700, 0800 and 0900 checks for all questions on POC related to the use of the restraint.

ADOC #103 confirmed it was unclear in the documentation when the resident was monitored or when they were repositioned and that the documentation provided did not identify the resident's response. [s. 110. (7) 6.]

5. The licensee has failed to ensure that the documentation related to restraining of resident #032 included every release of the device and repositioning.

Resident #032 was observed with a device in place that was identified in the medical record to be a restraint.

Review of documentation related to the use of a restraint for resident #032 and interview with Associate Director of Care (ADOC) #103 identified that documentation related to the application of a restraint including hourly monitoring and repositioning every two hours was to be completed by Personal Support Workers (PSW) under tasks in Point of Care.

Review of the documentation for resident #032 was unable to identify when the resident was released from the restraint and repositioned. Interview with ADOC #103 confirmed that PSW's sign for hourly checks but this may be done four or more hours into their shift. For example, documentation was completed for resident #032 at 1053 hours for the 0600, 0700, 0800 and 0900 checks for all questions on POC related to the use of the

restraint.

ADOC #103 confirmed it was unclear in the documentation when resident #032 had the restraint released and when they were repositioned. [s. 110. (7) 7.]

6. The licensee has failed to ensure that the documentation related to restraining of resident #031 included every release of the device and repositioning.

Resident #032 was observed with a device in place that was identified in the medical record to be a restraint.

Review of documentation related to the use of a restraint for resident #031 and interview with Associate Director of Care (ADOC) #103 identified that documentation related to the application of a restraint including hourly monitoring and repositioning every two hours was to be completed by Personal Support Workers (PSW) under tasks in Point of Care.

Review of the documentation for resident #031 was unable to identify when the resident was released from the restraint and repositioned. Interview with ADOC #103 confirmed that PSW's sign for hourly checks but this may be done four or more hours into their shift. For example, documentation was completed for resident #031at 1053 hours for the 0600, 0700, 0800 and 0900 checks for all questions on POC related to the use of the restraint.

ADOC #103 confirmed it was unclear in the documentation when resident #032 had the restraint released and when they were repositioned. [s. 110. (7) 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 ensuring that where a resident is being restrained by a physical device under section 31 of the Act, 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; and shall ensure that the following are documented: All assessment, reassessment and monitoring, including the resident's response; every release of the device and all repositioning, to be implemented voluntarily.

WN #13: 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. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who was permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident.

On a specified date in 2016, at 1500 hours observation for 2 out of 5 residents revealed that residents who were authorized to self administer medication were keeping a drug on their person or in their room without authorization by a physician, registered nurse in the extended class or other prescriber who attended the resident.

A resident had an order to self apply a topical medication, and that the resident could keep the medication in their room. Observation in the resident's room with Registered Practical Nurse #139 identified two additional topical medications at the bedside. Neither had been prescribed for self administration or to be kept in room.

A resident had an order for a topical medication, may self-apply. Record review revealed that the resident had no order by a physician or a registered nurse in the extended class to keep the above medication at the bedside.

RPN #139 confirmed that the resident had no order and they were not permitted to administer or keeps the the two additional topical medications in the room. [s. 131. (7) (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 ensuring that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident, to be implemented voluntarily.

WN #14: 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 has failed to ensure that the resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

The plan of care for resident #007 stated that staff provided assistance with oral care as the resident was not able to do it. It indicated that the best time of day for mouth care was during morning and evening care.

In an interview resident #007 shared that they did receive oral care, once a day, in the morning only and not in the evening.

Personal Support Worker #141 reported that resident #007 refused oral care in the evening, oral care was only done when the resident allowed them to do it.

Record review and the Point of Care (POC) documentation revealed that there were no refusals documented for oral care. The documentation stated that oral hygiene was performed; however, 20 out of 30 days the documentation was completed at the beginning of the evening shift before evening care.

Resident and staff interview conflicted with the record review. The resident interview indicated that oral care was not done and staff interview indicated that oral care was refused.

The Personal Support Worker Manager #109 confirmed that the resident was not receiving oral care, including mouth care in the evening as the documentation was an inaccurate reflection of care and it was also not being documented at the time when the care was being provided and for all of the 30 days there was only one refusal documented for the resident. Therefore, oral care, including mouth care in the evening was not done for resident #007. [s. 34. (1) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #003 was observed to have long dirty finger nails.

Review of the medical record identified that the resident received assistance with bathing one day prior to the interview with the resident. Documentation under the tasks indicated under finder nails and toe nails cleaned at 2009 hours, "not applicable" and under nails trimmed, "not applicable". Documentation for the previous bath day, indicated under finger nails and toe nails cleaned, that the resident refused, and under nails trimmed, the resident was not available. Resident #003 was last recorded to have had their nails cleaned on January 29, 2016, there was no recorded trimming of the fingernails.

The licensee failed to ensure that resident #003 received fingernail care. [s. 35. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances were labelled properly and kept inaccessible to residents at all times.

A) On February 17, 2016, at 0957 hours a housekeeping cart was observed to have been left unattended outside the Education Room on the third floor. Residents were observed to come to the area where the cart was left unattended to use the vending machine and wandering residents were frequently observed entering the area.

The cart contained housekeeping chemicals including Stride Neutral Cleaner, outdated hand antiseptic gel, a container of blue liquid that had "windx" written on it in black marker, stainless steel cleaner that required the use of personal protective equipment and Crew Mean Green that was a corrosive product.

Interview with the Housekeeper #132 and Environmental Services Manager #117 confirmed that the housekeeping cart was to be kept locked at all times when not attended.

B) On February 18, 2016, at 1313 hours a linen closet was observed to have been left open and unattended on Breithaupt House. Within the closet was a cart that was not locked and which contained a container of Virox wipes and an aerosol bottle of air freshener.

Interview with Personal Support Worker #127 confirmed that the cupboard was to be kept locked at all times and that it had been left open and unattended.

The licensee failed to ensure that all hazardous substances were labeled properly and kept inaccessible to residents at all times. [s. 91.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the drugs were stored in an area or medication cart that is used exclusively for drugs and drug-related supplies, that is secure and locked, that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and that complies with manufacturer's instructions for the storage of the drugs.

On February 19, 2016, observation of the Government stock room was completed with the Associate Director of Care (ADOC) #103 at 1200 hours and it was noted that 10 bottles of Almagel 200 (Antacid) had an expiry date of January 2016.

On February 19, 2016, the ADOC in an interview reported that she checks all of the medications for expiry dates and confirmed that Almagel 200 had expired and that it did not comply with manufacturer's instructions for the storage of the drugs (e.g. expiration dates). [s. 129. (1) (a)]

WN #18: 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 has failed to ensure that where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

The vaccine fridge was observed to be kept in the Resident Assessment Instrument (RAI) room (chart room) on Schneider House. The vaccine fridge was not locked. It contained Pneumovax, Tubersol, and Adacel (Tetanus toxoid, Diptheria, and Pertussus) vaccines. Registered Nurse #120 confirmed that Personal Support Workers, Housekeepers, Maintenance staff and Managers all had keys to the room.

The licensee failed to ensure that where drugs were stored was restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 2.]

Issued on this 23rd day of June, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBORA SAVILLE (192), CAROLYN MCLEOD (614), MARIAN MACDONALD (137), NUZHAT UDDIN (532), SHARON PERRY (155)
Inspection No. / No de l'inspection :	2016_226192_0006
Log No. / Registre no:	002309-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 27, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	COLUMBIA FOREST 650 MOUNTAIN MAPLE AVENUE, WATERLOO, ON, N2V-2P7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ruthanne Lobb

To REVERA LONG TERM CARE 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)

Linked to Existing Order / Lien vers ordre existant: 2015_271532_0005, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care for a specified resident in relation to the following is provided as specified in the plan;
i) monitoring the resident's intake and referral to the Registered Dietitian according to the assessed need, and
ii) other interventions are implemented as identified in the plan of care.

The licensee shall also ensure that where a resident is assessed to required weekly weights in relation to undesirable weight loss; those weights are completed and recorded.

Grounds / Motifs :

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

The plan of care for resident #034 identified that the resident was at high nutritional risk and was to be weighed weekly on bath day. Weekly weights were added to the plan of care on a specified date in 2015.

Review of the assessment completed by the Registered Dietitian (RD), identified that the resident was less then their Goal Weight Range (GWR) at the time of admission. The Care Conference note, indicated that the resident had lost weight since admission. A progress note by the RD indicated that the resident had lost six percent body weight since admission and that while not significant, it was undesirable and a plan was in place to promote weight gain.

Review of the medical record with Registered Nurse #120 confirmed that weekly weights were to have been completed and recorded in Point Click Care, but were not completed for resident #034 for specified weeks in 2015.

The licensee failed to ensure that care set out in the plan of care was provided to resident #034 when weekly weights were not completed. (192)

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

The plan of care for a specified resident, indicated under Nutritional Risk High, a recommended fluid requirement per day and that a referral to the Registered Dietitian was to be completed if the resident's intake was less than 50% of the meal or if fluid intake was less than required for three consecutive days.

Review of the intake record for the resident between specified dates in 2016 identified that the residents intake was less than the identified required amount on 28 of 32 days.

Review of the medical record identified that no dietary referral had been completed in relation to the fluid intake of the resident between the specified dates in 2016. It was noted that a Nutrition Reassessment was last completed in 2015 and a referral related to weight loss of 26.6% body weight over three months was completed in 2016.

The resident was observed to be left in bed without being offered food or fluid on a specified date in 2016, and interview with Registered Practical Nurse #118 identified that on the specified date in 2016, the resident was provided their morning nourishment with breakfast.

Interview with Director of Care #101 confirmed that dietary referrals would be found under the assessment tab on point click care. DOC #101 confirmed that dietary referrals had not been completed when the resident had not taken their required amount of fluid for three consecutive days and indicated that the Registered Dietitian (RD) was aware of the risks for the resident.

The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan when the specified resident was not referred to the RD when fluid intake was less than the identified required amount

on 28 or 32 days in 2016. (192)

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

The plan of care for a specified resident identified on the Treatment Administration Record (TAR) that the resident was to have specified devices in place.

On a specified date the resident was observed between 1139 hours and 1415 hours continuously; at 1530 hours and at 1630 hours in the presence of Director of Care #101, with no specified device in place.

Interview with Registered Practical Nurse (RPN) #118 identified that the resident was to have specified devices in place and confirmed that the specified devices were to have been applied for the resident in the morning by Personal Support Workers providing care and should be replaced at bedtime when care was provided.

RPN #118 indicated that physiotherapy had initiated an alternative device in 2015, but the resident developed altered skin integrity and the device was put on hold. At that time staff were instructed to use the specified device.

Interview with Personal Support Worker #125 confirmed that the resident was to have the specified device in place and and that the device was not present.

Interview with Personal Support Worker #126, confirmed that they had been unable to put the device in place.

Review of the medical record failed to identify that the resident had refused care. Interview with RPN #118 confirmed that care refused would be documented in the progress notes in Point Click Care.

The resident was observed on a subsequent date without the specified device in place.

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

This area of non-compliance was previously issued March 30, 2015, as a compliance order. Concerns identified in 2015, included failing to refer a resident to the Registered Dietitian when their food and fluid intake was less than required for three consecutive days, failing to change rolled cloths in a resident's contracted hands and failing to use bed rails according to the plan of care. Voluntary Plans of Corrective Action were previously issued at inspections conducted July 17, 2013 and March 5, 2014. There was potential risk for resident #030 in that the resident had recently healed areas of altered skin integrity to their hands and both residents identified had sustained actual harm in that they had undesirable weight. The non-compliance is identified to be isolated. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 19, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that air heating systems within the home are working effectively to maintained temperatures in all areas of the home at a minimum of 22 degrees Celsius and that where electronic systems are used to monitor air temperatures, these systems are working effectively.

The plan is to include a monitoring process to ensure that temperatures in all resident areas of the home are maintained at a minimum of 22 degrees Celsius.

The plan shall be submitted electronically to Debora Saville, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Long-Term Care Homes Inspection Division, London Service Area Office, 130 Dufferin Avenue, 4th Floor, London, Ontario, at debora.saville@ontario.ca by June 1, 2016.

Grounds / Motifs :

1. The licensee failed to ensure the temperature in the home was maintained at a minimum of 22 degrees Celsius (C).

During observations and interview of residents and staff, throughout the Resident Quality Inspection, it was revealed residents and staff complained of being cold, specifically on Schneider House. Residents were observed in their rooms/dining rooms/lounges wearing sweaters, fleece jackets, shawls and fleece blankets.

On February 9, 10, 11 and 16, 2016, Inspector #137 monitored air temperatures on Schneider House and air temperatures were not at the required minimum temperature of 22 degrees Celsius.

Temperatures were recorded to be between 19C and 21C in common areas and resident rooms. Residents and staff interviewed identified that they felt cold.

The Executive Director (ED) #100 was made aware that the temperatures were not at the required minimum of 22 degrees Celsius, on February 11, 2016, at 1203 hours. When touring the home area with Inspector #137, four residents expressed to the Executive Director that they were cold. During the tour of Schneider House, the ED indicated they could feel the temperature difference from other areas of the home.

On February 11, 2016, at 1415 hours, the Environmental Services Manager (ESM) #117 shared that the automated electronic monitoring system was showing the temperatures as being satisfactory but that cooler temperatures were physically felt when the ESM conducted a tour of the home area and confirmed that there was a problem with the system. The ESM shared that the Air Make-Up System was blowing cold air to the area and the ESM recorded air temperatures between 19.7 and 20.5 C.

The ESM shared that the designer of the building's automation system visited the home on February 11, 2016, and indicated the system was not working properly. A previously submitted proposal to repair the system had not yet received a response from the corporate office. The ESM confirmed the temperatures did not meet the legislative requirements and the expectation was the home should be maintained at a minimum temperature of 22C, as per the legislative requirements.

There is no previous history related to this legislation. The severity is identified to be a level 2 as residents expressed discomfort related to air temperatures in the home. A pattern was identified in that resident's on the identified home area, complained on four of nine days inspectors were in the home and during two of two weeks, about the temperature of the home. (137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 14, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears and wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The plan will include but will not be limited to:

i) review of the skin and wound care program related to the completion of weekly wound assessments.

ii) retraining of staff on the completion of weekly wound assessments including where they are to be documented and what information is to be included in the documentation.

iii) an auditing process to ensure that residents with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff.

The plan shall be submitted electronically to Debora Saville, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Long-Term Care Homes Inspection Division, London Service Area Office, 130 Dufferin Avenue, 4th Floor, London, Ontario, at debora.saville@ontario.ca by May 19, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Review of the medical record for resident #034 identified that the resident sustained specified areas of altered skin integrity.

Interview with the Associate Director of Care responsible for the Skin and Wound Program confirmed that when an area of altered skin integrity was identified it was to be recorded in the progress notes and added to the Treatment Administration Record to remind registered staff to reassess the area weekly. Weekly assessments would be recorded in the progress notes for skin tears and altered skin integrity that was less than a stage II.

Review of the medical record with Registered Nurse #120 confirmed that weekly assessments of these areas of altered skin integrity were not documented within the progress notes.

The licensee failed to ensure that resident #034 who exhibited altered skin integrity was reassessed at least weekly by a member of the registered nursing staff. (192)

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #006 was observed on a specified date in 2016, to have an area of altered skin integrity with a dressing applied.

Review of the medical record identified that resident #006 sustained areas of altered skin integrity on specified dates.

Interview with Assistant Director of Care (ADOC) #104 identified that when altered skin integrity occurs registered staff were to complete a progress note in Point Click Care that included the location of the altered skin integrity, measurements of the area of altered skin integrity, notification of the Power of Attorney and treatment provided. The area of altered skin integrity was to be added to the Treatment Administration Record (TAR) and weekly assessments of the area of altered skin integrity would be included in a progress note.

Review of the medical record for resident #006 with ADOC #104 for altered skin integrity sustained on a specified date in 2015, identified that weekly wound assessments were not completed on three specified dates in 2015. Review of the TAR identified that the area of altered skin integrity continue to be documented as having been checked daily, three months after it was acquired and a dressing remained in place although no open area was noted. The progress notes failed to identify that the area of altered skin integrity had healed and no weekly wound assessments were completed.

Review of the TAR for January 2016, identified that the resident sustained altered skin integrity that was to be checked daily to ensure the dressing was intact. Review of the progress notes failed to identify weekly assessments of

this area of altered skin integrity on four specified dates in 2016. It was noted that daily checks were stopped, however the progress notes failed to identify that the area of altered skin integrity had healed.

Interview with ADOC #104 confirmed that weekly wound assessments were not completed in relation to altered skin integrity sustained by resident #006.

This area of non-compliance was previously issued as a Written Notification in February 2014 and as a Voluntary Plan of Corrective Action in February 2015. Non-compliance was identified to be widespread in that three of three residents reviewed failed to have weekly wound assessments completed and there was a potential for actual harm for residents with altered skin integrity. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall ensure that a specified resident and all other residents are offered a minimum of three meals daily.

Grounds / Motifs :

1. The licensee has failed to ensure that a specified resident was offered a minimum of three meals daily.

The plan of care for a specified resident identified that the resident was at high nutritional risk, ate in the dining room, in an upright position and required total assistance to eat meals and beverages.

Interview with Director of Care #101 confirmed that the expectation would be for the resident to receive three meals daily and additional snacks as ordered by the Registered Dietitian.

During continuous observation for two hours and thirty-five minutes over the noon meal time, the resident was observed in bed, positioned on their right side, facing the door of the room. No staff member entered the room to check on the resident's status, offer to get the resident up for their meal or to bring a tray to the room for the resident. A staff member from the evening shift was observed to look in on the resident and shortly thereafter two staff members entered the room to reposition the resident on their left side.

Review of the medical record for the resident identified that point of care

documentation indicated "Resident Not Available" for the lunch meal. Documentation on Point of Care for two subsequent days in 2016, also indicated "Resident Not Available" for the noon meal.

Interview with Personal Support Worker #126 identified that "Resident Not Available" meant that the resident was not in the Dining Room for lunch. The PSW indicated that the resident had not been having lunch and that if sleeping the resident was not wakened for lunch.

Interview with Personal Support Worker #126 and #127 indicated that if the resident was sleeping they do not provide the resident with lunch.

Review of the weights for the resident identified that they had sustained weight loss over a three month period.

Dietary referrals were completed in relation to the weight loss and interventions were in place. Progress notes completed by the Registered Dietitian indicated that the resident had lost 26.6 percent body weight in three months and that weight loss was likely due to declined intake at meals. Intake was on average Poor (25-50%) to Fair (50-75%) but the resident often missed one meal per day.

The licensee failed to ensure that a specified resident was offered, at a minimum, three meals daily.

O.Reg 79/10 s. 71 was previously issued as a Written Notification in March 2014 and February 2015. The scope is isolated and the severity is actual harm in that the resident sustained significant weight loss. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 19, 2016

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee shall ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices.

Grounds / Motifs :

1. The licensee has failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On a specified date in 2016, a specified resident was observed with Director of Care #101 in a common area. The resident was observed to have a potential symptom of infection. Review of the progress notes and shift report on a subsequent date in 2016, for the resident, failed to identify documentation of the potential symptom of infection. DOC #101 confirmed that the presence of the specified symptom, would be considered a symptom of a potential infection and had not been recorded in the progress notes. Interview with Registered Practical Nurse (RPN) #118 confirmed that they had not been made aware of the presence of a potential infection for the resident.

Interview with Associate Director of Care #103, identified that any resident with sign and symptoms of infection should have documentation of the specific signs and symptoms within the progress notes. Review of the twenty-four hour shift report is completed each morning Monday to Friday, excluding holidays and when ADOC #103 is not absent from the home, by ADOC #103 and the surveillance record is completed. ADOC #103 confirmed that they would not be

aware of any resident with infection if the registered staff on the home area failed to document the signs and symptoms of infection within the progress notes. ADOC #103 also confirmed that the surveillance record is not maintained in their absence. Review of the Surveillance Record for February with ADOC #103 failed to identify the presence of signs and symptoms of a potential infection for the specified resident.

During observation on a specified House it was observed that resident #003 voiced complaints of feeling unwell, with specified symptoms. The resident was assisted to their room, medication provided for symptom relief. The next day, at the noon meal resident #003 continued to complain of symptoms of infection, refusing their meal and taking only fluids. This information was shared with DOC #101 following which the resident did appear on the surveillance record, although the progress notes failed to identify the signs and symptoms of potential infection exhibited by resident #003.

A resident was observed by inspector #192 for nutritional intake and was noted to exhibit signs and symptoms of a potential infection. This information was reported to DOC #101. The progress notes failed to identify the presence of signs and symptoms of infection for the resident and the resident was not included on the surveillance record.

During observation on a specified House, resident #036 was observed sitting in a common area. The resident complained of signs and symptoms of an infection. Interview with Registered Practical Nurse #118 confirmed that the resident had signs and symptoms of infection, similar to another resident in the home area (#037) and that both residents were on the physician list to be seen in relation to these signs and symptoms of infection. RPN #118 confirmed that signs and symptoms of infection for residents on the home area were not recorded on a surveillance record maintained in the home area.

Interview with Registered Practical Nurse #147 identified that resident #035 had symptoms of an infection that had been identified by the staff member the previous evening. Interview confirmed that the identified symptoms of infection had not been recorded in the progress notes and review of the surveillance record confirmed that the signs and symptoms of infection for resident #035 had not been included on the surveillance record when first identified.

Interview with ADOC #103 confirmed that surveillance records are not kept on

the home areas. Interview with Registered Nurse #145 identified that they act as the charge nurse for the home in the absence of management staff. In the event that a resident was exhibiting signs and symptoms of infection in the absence of ADOC #103, charge nurses on the home area would manage signs and symptoms of infection. If more than one resident presented with signs and symptoms of infection, or if a resident presented with symptoms that the registered staff member could not manage, then the registered staff would call the charge nurse for guidance. RN #145 confirmed that it would be the responsibility of registered staff on the home area to complete documentation in relation to any change in a residents condition.

The licensee failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and if there are none, in accordance with prevailing practices.

O. Reg 79/10 s. 229 was previously issued as a Voluntary Plan of Corrective Action in March 2014. A pattern was identified in that residents on three of six home areas were identified with signs and symptoms of infection that had not been included on the daily surveillance record and the severity was identified as a potential for actual harm in relation to the daily surveillance record not being completed and monitored.

(192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 27th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEBORA SAVILLE

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