Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Apr 19, 2016;	2015_365194_0028 (A1)	031205-15	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

Ontario

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

CHANTAL LAFRENIERE (194) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

The compliance date for CO #05 has been extended to July 31, 2016 at the licensee's request to accommodate completion of identified repairs.

Issued on this 19 day of April 2016 (A1)

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

Original report signed by the inspector.

Ontario

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

CHANTAL LAFRENIERE (194) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

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

This inspection was conducted on the following date(s): November 16, 17, 18, 19, 20,23,24,25,26 and 27, 2015

Inspected during the Resident Quality Inspection are the following Logs: Log #007731-14, #006626-15, #028395-15, #032651-15, #002102-15, #009024-15, #010570-15, #018385-15, #032511-15, #007008-15, #011818-15, #004080-15, #004459-15, #004545-15, #004833-15, #005280-15, #027862-15, #032865-15, #032857-15, #007018-15, #015635-15, #016142-15, #019935-15, #020272-15, #028832-15, #015525-15, #019428-15, #023370-15, #025473-15, #033207-15.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Residents, Families, Director of Quality (DOQ), Registered Nurse (RN), Resident Care Area Manager (RCAM), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Environmental Manager, Nurse Administrative Assistant, Dietary Manager, Dietitian, Occupational Therapist (OT), Housekeeping, Dietary Aide,

Also completed in the inspection: Tour of the building, observation of dining services, medication administration practices, infection control practices and staff to resident provision of care. Reviewed clinical health records of identified residents, relevant policies, licensee's internal investigations, staff educational records, relevant program evaluations, maintenance records, complaint log, Resident and Family Council minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Admission and Discharge

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Trust Accounts

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

19 WN(s)
5 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
LTCHA, 2007 s. 6. (10)	CO #002	2015_360111_0014	552

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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during inspection #2015_360111_0014, which included a written notification (WN) specific to LTCHA, 2007, s. 24 (1); with a compliance date of August 15, 2015

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

For the purpose of the definition of "abuse in subsection 2(1) of the Act, "financial abuse", means any misappropriation or misuse of a resident's money or property.

During an interview with resident #020 on November 17, 2015, the resident brought forward concerns that a total of $270.00 went missing from his/her wallet about three weeks prior, and that this was reported to the Administrator. Resident #003 also brought forward concerns that $40.00 went missing during the night and this was reported. A review of the home's complaint log could not locate any documented record in relation to the above concern for resident #020, but there was documented record for resident #003's missing funds. A review of the home's record could not locate a report submitted to the Director in relation to the above identified missing funds. An interview with the Administrator confirms that he did not complete or submit a report regarding the above identified concerns to the Director.(607)

Related to Intake #032511-15, for Resident #058:

The licensee failed to comply with LTCHA, 2007, s. 24. (1), by not ensuring a person who has reasonable grounds to suspect that abuse of a resident has occurred or may

occur shall immediately report the suspicion and the information upon which it is based to the Director, specifically as it relates to:

For the purpose of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means, the use of physical force by anyone other than a resident that causes physical injury or pain.

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident of physical abuse, which the home categorized as being "improper/incompetent treatment of a resident that results in harm or risk to a resident".

The Critical Incident Report indicated that on an identified date, two Personal Support Workers were transferring Resident #058, using a mechanical ceiling lift from wheelchair to bed, during the transfer Resident #058's medical equipment became entangled around the mechanical ceiling lift's arm bar, pulling on the medical equipment, which resulted injury to Resident #058; resident was transferred to hospital for assessment and treatment.

Director of Care indicated to the inspector the incident and subsequent injury to Resident #058 resulted from Personal Support Workers #162 and #163 not following the home's Safe Lifts and Transfers policy and practice.

Director of Care (DOC) indicated to the inspector that she was informed, by the Resident Care Area Manager, of the incident. DOC indicated that the Director was not immediately informed of the physical abuse, as she was directed by the Administrator to wait until the next day to speak with the home's Consultant (Extendicare Assist). Director of Care indicated, she is aware that the CIR was late being reported to the Director.

The Director was not informed of the physical abuse that resulted in harm to the resident until two days later.(554) [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. Related to Intake #011818-15, for Resident #62:

The licensee failed to comply with LTCHA, 2007, s. 6 (2), by not ensuring the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Resident #062 is cognitively well and ambulatory with use of a mobility aid. Resident #062 had a known falls risk.

The Director of Care submitted a Critical Incident Report to the Director, an identified date, specific to an incident that caused an injury to a resident for which the resident was taken to hospital which resulted in a significant change in a resident's health status.

Progress notes reviewed for Resident #062, during a fourteen day period detail the following:
- On an identified date Resident #062 was on the toilet, stood and the resident's legs

gave out; two Personal Support Workers (PSWs) lowered the resident to the floor, and was later assisted off the floor and into bed using a mechanical lift and four staff. Resident #062 was assessed by a Registered Nurse (RN) and found to have no injuries
- twenty five minutes later, Resident #062 complained of limb pain; RN reported that there was no swelling noted to resident's limb; an analgesic was administered for complaints of pain.
- two hours later, Resident #062 was found on the floor beside the bed. Resident was assisted off the floor by aide of three staff and a mechanical lift. Resident #62 complained of the same limb pain and indicated to Registered Practical Nurse (RPN) #177 that the pain was 10/10 (severe pain); RPN's assessment noted resident's limb was swollen and resident had increased pain with range of motion (ROM).
–An hour and half later, RPN administered 'as needed' (PRN, narcotic medication).
- Two hours and forty minutes later, Resident #062 was still complaining of pain; swelling of the limb was noted to persist. RPN elevated resident's limb in bed and applied an ice pack. RPN placed a note in the physician's book, indicating need for assessment.
- Three and a half hours later, Resident #062 continued to complain of pain and the limb continued to swell; resident requested pain medication. Resident #062 was told by Registered Practical Nurse #177 that the PRN (narcotic pain medication) was only ordered as a 'once a day medication' and medication could not be administered Resident #062 was told by RPN #177 that her next scheduled pain medication was not to be given for another hour and a half.
-Registered Nurse on day shift reported in the progress note that Resident #062 was complaining of severe pain (10/10) to the limb; resident's limb remained swollen. RPN administered routine pain medication.
- Half an hour later, Resident #062 was also complaining of being nauseated and was administered an antiemetic.
- Resident #062 was assessed by physician, new orders for ice pack to resident's limb twice daily.
- The following day, Resident #062 continued to complain of pain to the limb; progress notes indicated limb remained swollen; resident refused to go to bathroom, due to 'hurting' and was incontinent. RN indicated in the progress note that resident refused to get out of bed.
- The evening shift documented that, Resident #062 was found unresponsive; ambulance was called and resident was transferred to hospital for assessment; resident was admitted to hospital.

Registered Practical Nurse #177, who was the Charge Nurse when Resident #062

fell, indicated to the inspector that the physician was not notified, as to resident's fall and subsequent injury which resulted in pain and swelling; when the narcotic pain medications administered were ineffective, and resident continued to complain of pain, nor when there was no further PRN pain medication available to be administered. Registered Practical Nurse #177 indicated to the inspector that the physician had not been contacted during the night as the physician was expected to visit in the morning, and RPN felt the assessment of Resident #062 could wait till then.

Resident #062 remained in hospital, for a period of twelve days, discharge with multiple medical diagnoses.

Director of Care indicated to the inspector that noting Resident #062 fell and sustained a limb injury, complained of pain despite pain medications and that PRN pain medications could not be further administered due to directions for administration, Registered Practical Nurse #177 should have contacted the physician for further direction or transferred Resident #062 to hospital for assessment of additional needs.

The licensee failed to ensure that the care set out in the plan for Resident #062 was based on an assessment of the resident's needs. When the resident's was not provided with an opportunity to be assessed by the physician for further pain management interventions and potential other significant care needs related to infection and or fractures over a twenty one hour period.

Related to Intake #032511-15, for Resident #058:

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident, which the home indicated as being 'improper/incompetent treatment of a resident that results in harm or risk to a resident'.

Details of the Critical Incident Report are as follows:
- Personal Support Worker (PSW) #162 and #163 were transferring Resident #058 from wheelchair to bed, using a mechanical ceiling lift (and sling). PSW's transferred Resident #058 into bed, attached the resident's medical equipment the left side of the bed, while one staff attempted to remove the sling from under Resident #058, the second PSW, using the hand held control, returned the mechanical (ceiling) lift to its resting position; while the mechanical ceiling lift was returning to its resting position, PSW #162 and #163 heard Resident #058 cry out; PSW's observed that Resident #058's medical equipment had been entangled on the mechanical (ceiling) lift's arm,

PSW stopped the lift, observing resident was in discomfort and bleeding.

Registered Nursing Staff assessed Resident #058 following the incident; resident continued to experience bleeding and pain. Registered Practical Nurse (RPN) #113 and Registered Nurse (RN) #152 attempted to provide nursing interventions, but attempts were unsuccessful. Registered Practical Nurse #113 reported to the Registered Nursing-Supervisor #153 that attempts to provide nursing interventions were unsuccessful, RPN #113 and RN #152 were instructed by RN-Supervisor #153 to wait fifteen minutes and to attempt again.

Registered Nurse #152 and Registered Nurse-Supervisor #153 indicated (to the inspector) that Resident #058 was experiencing discomfort and bleeding following the transferring incident, both registered nursing staff indicated that Resident #058 continued to experience bleeding and discomfort when registered nursing staff were attempting to provide nursing intervention. Both registered nursing staff (#152 and #153) indicated that the doctor was not contacted for direction as Resident #058 advanced directives were noted as a Level 2, indicating resident was to be cared for in the home.

As per the progress notes, an hour and a half later, Resident #058 was observed to have a change in condition with vital signs decreasing; resident was transferred to hospital for assessment.

The hospital discharge summary indicated, Resident #058 was assessed and referred to a specialist while at the hospital. Resident #058 was transferred back to the long-care home later that day.

The Critical Incident Report indicates Resident #058 returned to the home and was found deceased four hours later.

Director of Care indicated (to the inspector) that Registered Nursing Staff should have contacted Resident #058's attending physician (or transferred resident to hospital), for further assessment due to the transfer incident, subsequent injury and when resident continued to experience bleeding and or staff's inability to provide nursing interventions.

The licensee failed to ensure that the care set out in the plan for Resident #058 was based on an assessment of the resident's needs. When the resident was not provided with an opportunity to be assessed by the physician or transferred to the

hospital for assessment related pain management, bleeding and the inability of Registered staff to provide the nursing interventions for a period of one hour and fifteen minutes.

A Compliance Order (CO #001), under LTCHA, 2007, s. 6(2) was issued during inspection #2015_293554_ 0009, specific to the care set out in the plan of care being based on an assessment of the resident's needs and preferences. The incident involving Resident #062 was prior to the compliance due date of August 14, 2015 , but the incident involving Resident #058 was after the compliance date therefore the Order will be issued for a second time.(554) [s. 6. (2)]

2. Related to Log #006626-15 for Resident #050:

The licensee has failed to ensure that the plan of care is reviewed and revised when care set out in the plan has not been effective.

The Plan of care for Resident #050 directs a fluid balance of 900-1200 mls per day as a goal for the resident.
The food and fluid intake record for Resident #050 over the period of five days was reviewed and indicate being below the identified goal range for the resident.
The Dietitian has indicated during an interview with the inspector that if a resident is below their Fluid goal range for a 1-3 day period, nursing measures would be initiated to address the condition. After 3 days a referral would be completed for the Dietitian.
The RPN #143 indicated that nights review the fluid balance records for identified residents and "flag" the day staff for follow up. RPN # 143 indicates that Resident #050 was flagged as being below the targeted fluid goal range. RPN #143 indicates that as a nursing measure "pushing fluids" would have been initiated. RPN #143 indicated that verbal direction would have been given to the PSW staff to push fluids for the resident. RPN #143 was asked how the "pushed fluids" were monitored , RPN #143 replied that the PSW staff would report at the end of shift and documentation of the intake would be in the progress notes. I reviewed the progress notes with RPN #143 for the review period and there is no documentation related to pushing of fluids. I asked RPN # 143 if any other interventions or nursing measures had been implemented for Resident #050's poor intake status and RPN #143 replied that no there was not.

Resident #050 was admitted to the hospital following the five day review period for medical interventions.

A Compliance Order (CO #002), under LTCHA, 2007, s. 6 10(c) was issued during inspection #2015_360111_0014, specific to plans of care being revised when the care set out in the plan has not been effective. Compliance with 6(10) has been established during this inspection so no further action is required at this time. The incident (described above) involving Resident #050 was prior to the compliance due date of September 28, 2015. [s. 6. (10) (c)]

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Related to Intake #032511-15, for Resident #058:

The licensee failed to comply with O. Reg. 79/10, s. 36, by not ensuring staff use safe transferring and positioning devices or techniques when assisting the resident.

The home's policy, Mechanical Lifts (#01-03) directs that prior to all transfers the arm rests and footplates are to be removed from the receiving surface (e.g. wheelchair); staff are to complete a Pre-Transfer Review, which includes resident readiness, staff readiness, environment readiness and equipment readiness, if any deficiencies are identified or suspected staff are not to proceed with the transfer and to notify the supervisor.

The home's policy (Mechanical Lifts) directs that prior to a transfer (using a mechanical lift) both staff members are to complete the 6 Point Checklist (#01-12)

which is attached to the lift (which includes, is resident able to participate in the lift, is the sling applied correctly, is the sling attached to the lift correctly, is the lift path clear and are both staff members ready and positioned correctly to complete the lift. The policy (Mechanical Lift) directs that once the 6 Point Checklist is completed the resident is to be lifted two-three inches above the departing surface (e.g. wheelchair) and staff are to once again check that the sling is positioned properly, resident is comfortable, resident is balanced under the lift mechanism, and if any deficiencies are identified resident is to be lowered, sling re-applied and 6 Point Checklist is to be completed again. The policy (Mechanical Lift) directs that the resident is to be protected from touching any part of the mechanical lift or other equipment. The home's policy (Mechanical Lift) further directs that once the resident is lowered onto the receiving surface (e.g. bed) staff are to ensure resident is comfortable and positioned correctly, then to unhook sling and return ceiling lift to the charge (docking station).

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident, which the home indicated as being 'improper/incompetent treatment of a resident that results in harm or risk to a resident'.

Details of the Critical Incident Report are as follows:
- Personal Support Worker (PSW) #162 and #163 were transferring Resident #058 from wheelchair to bed, using a mechanical ceiling lift (and sling). PSW's transferred Resident #058 into bed, attached the medical equipment onto the left side of the bed, while one staff attempted to remove the sling from under Resident #058, the second PSW, using the hand held control, returned the mechanical (ceiling) lift to its resting position; while the mechanical ceiling lift was returning to its resting position, PSW #162 and #163 heard Resident #058 cry out; PSW's observed that Resident #058's medical equipment had been entangled on the mechanical (ceiling) lift's arm, PSW stopped the lift, observing resident was in discomfort and bleeding.

Personal Support Worker #163 indicated (to the inspector) that along with PSW #162 they were transferring Resident #058 from the wheelchair into bed; PSW #163 indicated that they had attempted to place the transferring sling under Resident #058 while the resident was in the wheelchair but that the placement of the sling was difficult due to Resident #058 refusing to allow the wheelchair arms to be removed and that the space between the bed and wheelchair was small, making placement of the sling difficult. PSW #163 indicated that they had asked Resident #058 to hold onto the transfer sling handles and other medical equipment while they (PSW #162 and

#163) proceeded to transfer resident from chair to bed. PSW #163 indicated that once resident was in the sling, PSW #163 moved to the opposite side of the bed and pushed the start button (ceiling lift control); PSW #163 indicated that while the ceiling lift was still in motion (resident was over the bed), PSW #163 attempted to remove resident's shoes while still operating the lift, and it was during this time that Resident #058 began to scream. PSW #163 indicated that the medical equipment was caught on the sling handles and handles of the ceiling lift and was accidentally pulled when transferring the resident from wheelchair to bed.

Personal Support Worker #163 indicated (to the inspector) that PSW #163 and PSW #162 should have followed the home's safe transfer and lifting procedures while transferring Resident #58; PSW #163 indicated that they (PSWs) did not removed the wheelchair arm rests prior to the transfer making it difficult to place the sling under the resident and making it difficult to clearly visualize the transfer pathway; PSW #163 further indicated that Resident #058 should have been safely positioned in bed prior to removing the shoes or sling and that they (PSWs) should have been more aware of where resident's medical equipment placement prior to and during the transfer (with ceiling lift). PSW #163 indicated that PSW #163 and PSW #162 did not complete the 6 Point Checklist prior to transferring Resident #058.

The Director of Care indicated (to the inspector) that "Personal Support Workers #162 and #163 were not following the home's Safe Lifting with Care Program", specifically the Mechanical Lifts Policy (#01-03) "which contributed the incident and subsequent injury of Resident #058".

DOC indicated that PSW's #162 and #163 did not follow the home's Safe Lifting with Care Program, by not doing the following:
- remove the arm rest of Resident #058's wheelchair; indicating it is the home's policy and practice that the arm rest of the wheelchair is to be removed with all transfers involving the use of a mechanical lift, as it creates a 'blind spot' and that potentially items could become entangled around the arm of wheelchair;
- complete that six-point checklist prior to and during use of a mechanical lift, specifically PSW #162 and #163 did not ensure the mechanical lift path was clear; during the incident, Resident #058's medical equipment became entangled in the handle of the lift, and when returning the lift to its charge (docking station).
- and that following the transfer of Resident #058 from wheelchair to bed, PSW's #162 and #163 did not ensure resident was properly positioned before returning the ceiling lift to the charge (docking station).

Director of Care indicated (to the inspector) that it is the expectation that all staff, who have been trained to use the mechanical lifts are to follow the home's Safe Lifting with Care Program.

Related to Intake #015525-15, for Resident #010:

A Critical incident report indicated that on an identified date. PSW stated that when the staff pulled the Geri chair forward, resident #010 suffered an injury.

Review of the plan for Resident #010 in effect at time of incident indicated the resident has multiple diagnoses including Cognitive Impairment, is totally dependent in transferring, and fragile skin.
The plan of care related to transferring, skin integrity and comfort directs to staff to:
-Put pillows on both sides of the resident's elbows when sitting in the wheelchair/lounge chair to prevent injury.
-Assess resident's ability to transfer safely prior to each transfer.
-Protect pressure areas with pillows and heel poseys.
Resident #010's progress notes were reviewed. On an identified date RPN #188 documented that, PSW reported an injury was sustained to Resident #010. Possible cause: as per staff, when pulled up the Geri chair, resident was injured.
Interview with PSW #186 indicated that PSW #186 and PSW #187 were preparing the resident to be transferred from Geri chair to bed; PSWs removed the pillows from both side of the resident. PSW #186 indicated to inspector #570 during an interview that when the staff moved the back of the chair forward from reclining to a sitting position the back of the chair snapped back; then realized that the resident's limb was caught between back of chair and arm rest. PSW #187 should have protected the resident's limb at the time; PSW #187 indicated the chair is an old style and was not orientated on how to use it and realized after the incident the need to push the foot rest of the chair backwards for the back of the chair to lock in position.

Review of investigation notes and statement by PSW #187 indicated the staff removed the right pillow first, as the staff turned around the resident's limb was down on the side of the chair. When moving the resident limb gently blood was noticed and RPN was called. PSW #186 was on the other side of the chair. RPN #188 indicated before pulling the Geri chair forward, PSWs #186 and 187 removed the pillows and they had been instructed that they pull the pillows out last.

Review of the investigation notes and plan of care for resident #010 indicated the PSW staff did not ensure the resident's safety when removing supporting/protective

pillows while preparing the resident to transfer from chair to bed.(570) [s. 36.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

1. Related to Intake #0028395, for Resident #029:

The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

On an identified date Resident #029 was given another resident's medication in error by RPN #134. Resident #029 had a fall and was found by RPN #135 who was carrying medications for another resident when the RPN walked by Resident #029's room and found the resident on the floor. RPN #135 entered the room to ensure resident was safe, and RPN #134 also entered the room and was instructed by RPN #135 to watch the medication cup which was placed out of the resident's reach, while RPN called for help. When RPN #135 returned to the room, RPN #134 had given the medications to resident #029.

Subsequently Resident # 029 experienced a significant drop in blood pressure. [s. 131. (1)]

2. Related to Intake #007008-15, for Resident #046:

The licensee failed to comply with O. Reg. 79/10, s. 131 (2), by not ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A review of the clinical health record, for Resident #046, for the period of ten days, indicates that resident had been deemed palliative; according to progress notes, physician's orders and interviews with a Resident Care Area Manager and the Director of Care, Resident #046 was having difficulties with pain control.

On an identified date, Resident #046's attending Physician prescribed a STAT pain medication to be given subcutaneously; then routinely, subcutaneously every two hours for comfort.

According to a Critical Incident Report, Resident #046 was not administered any of the scheduled doses of pain medication, during an eight hour shift, despite a physician's order for medication to be given every two hours.

Director of Care indicated (to the inspector) that the medication incident was investigated and it was found that Registered Practical Nurse #114 who was the assigned charge nurse, did not only not administer the prescribed pain medication to Resident #046 during the identified shift, but also missed a scheduled dose of pain medication, for Resident #046, the following day.

According to the Director of Care, Registered Practical Nurse (RPN) #114 indicated Resident #046 was asleep and since resident was sleeping, the RPN felt that the medication was not required.

Director of Care indicated that Registered Practical Nurse #114 should have awakened Resident #046 to administer the pain medication especially noting resident had been experiencing pain control and management difficulties, and indicating the physician ordered the medication to be given every two hours.

2) Related to Resident #043:

According to the physician's orders, Resident #043 was prescribed pain medication every eight hours, for pain control.

A medication incident report, as well as the medication administration record and narcotic administration record, for Resident #043, provides documented evidence that Registered Practical Nurse #114 failed to administer the prescribed dose of pain medication to Resident #043 on an identified date.

Registered Practical Nurse #114 indicated to the Director of Care, that she had forgotten to administer the pain medication to Resident #043.

Director of Care indicated (to the inspector) the expectation is that physician's orders are to be followed as directed. [s. 131. (2)

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 LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (a), by not ensuring that the home, furnishings and equipment are kept clean and sanitary.

The following observations were made, during the dates of November 16, to November 20, and November 23 to the 24, 2015:
- Toilets – dark blackish-brown staining was observed surrounding base of toilet (stool) and the surrounding flooring in multiple resident washrooms and in the Birch/Maple, Pine and Linden tub/shower rooms;
- Floors – multiple resident rooms were observed to have dark brownish-black build up (query grout or dirt) along flooring seams, flooring thresholds (transition piece from hall to resident room, or resident room to washroom) and along wall/flooring edges (especially in corners), as well as in the activity room adjacent to Pine, Pine and Linden lounges, resident home area hallways (Maple, Pine, Birch and Linden), as well as the Linden and Pine tub/shower rooms. The brownish-black build up could be scraped off when scraped with a pen, by the inspector;
- Floors – visible dust and debris, especially in corners of rooms were observed in the activity room and kitchenette adjacent to Pine (resident home area), in the Pine lounge, in the Linden and Pine tub/shower rooms and in the Atrium (basement);
- Vents – observed to have thick grey film to ceiling vent in the Linden tub/shower room; observed to have blackish film on and around the ceiling vent in the Birch lounge;
- Windows / Door – cob-webs were observed lining the inside of the window and doorway of the activity room adjacent to Pine (resident home area); as well as the window located at end of the Birch (resident home area) corridor;
- Commode – observed to have brownish staining smeared along edges of commode seating and on commode rails in two resident washrooms.
- Privacy Curtain – was observed stained along the width of the curtain panel in a resident room.

Environmental Services Manager (ESM) indicated awareness of floors in the home being soiled and in need of cleaning, especially in common areas of the home, and indicated (to the inspector) that Housekeeping Staff had not been following the 'deep cleaning policies and practices' and such has resulted in cleanliness issues throughout the home. ESM indicated (to the inspector) that a new roll-out schedule, for deep cleaning, is being introduced to housekeeping staff week of November 26, 2015.

Environmental Services Manager indicated the expectation is that the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]

2. Related to Intake #009024-15 and #010570-15:

The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

An anonymous complainant contacted the Ministry of Health and Long-Term Care's Action Line indicating that windows in the Pine resident home area and in the Pine tub/shower room were broken and in need of repair. The anonymous complainant indicated that cloths were being shoved into the window opening to prevent cold air from coming into resident rooms and or tub/shower room. The anonymous caller indicated reporting this concern to the management of the home without resolution.

Window latches (opening mechanism) on windows located in the Pine tub/shower and in the activity room (adjacent to Pine) were observed broken and unable to be closed during the dates of November 16, and again November 20, 2015.

Environmental Services Manager indicated (to the inspector) that he was not made aware of the window latches being broken, until he noticed it himself on November 20, 2015; ESM indicated (to the inspector) he relies on staff (nursing and housekeepers) to alert him of deficiencies and areas in need of repair via the PM Works (electronic maintenance requisitions).

2) The home's policy, Preventative Maintenance – Maintenance Program Overview (#MNTC-01-01-01) direct that the maintenance program will maintain the building (and equipment) in a condition that provides a safe, comfortable and pleasant environment for the residents.

The following observations were made during the dates of November 16, through to November 20, 2015:
- Walls: were observed scraped, gouged, paint chipped or having wall damage (dry wall exposed, holes or corner steel beading exposed) in multiple resident rooms or washrooms; in lounges located on Pine, Linden, Birch, Aspen and Cedar; in tub/shower rooms located on Birch/Maple, Pine, Linden, Asphen and Cedar; along hallways in Pine, Asphen, and Cedar;in the main dining room; and on the wall under the severy in the Cedar dining area was 'rippled' in appearance (query water damage);
- Tiled Walls: the ceramic tiled walls in tub/spa rooms located on Linden, Asphen and

Cedar were observed cracked, chipped or having missing wall tiles; areas were wall tiles were chipped and or missing were noted to have jagged edges which were sharp; the lower edges of the wall tiles (along shower stall) and laminate flooring in the Linden, Cedar and Asphen tub/shower rooms were noted to have a blackish, moist substance along the length of the shower stall (this concern was reported to the Environmental Services Manager by the inspector, as such poses a potential infection control issue);
- Doors and Door Frames: were observed to be chipped, paint missing, holes or having jagged metal edges on doors or door frames in resident rooms/washrooms and in the lounges located on Birch, Linden and Pine;
- Closets: were observed scraped (blackish marks) and or being off the track in resident rooms.
- Wall Guard – observed loose or missing in multiple resident rooms.
- Curtains: observed to be thread-bear (worn) or having the rubber backing of the curtain cracked or torn in resident rooms;
- Counter-top Vanities: were observed chipped (exposed porous surface) or missing laminate missing in multiple resident washrooms; in the main dining room on and around the hand-sink vanity and along the severy counter;
- Chairs: home owned chairs were observed to be chipped, worn (shellac finish missing) and having blackish staining on the chair legs in resident rooms;
- Sink Vanity: the metal legs attached to the counter-top vanities in resident washrooms were observed stained (blackish) or having areas of corrosion or rust, in washrooms located in resident rooms;
- Commodes and or Shower Chairs: were observed with rusted areas or corrosion in a resident washroom and in the tub/shower room on Linden;
- Toileting Safety Rails: rust was observed on the toileting hand rails in washrooms;
- Bedside Tables: were observed to be chipped (porous surface exposed) or missing laminate surround, in resident rooms;
- Bed-rails: were observed to have paint chipped along the railing in resident rooms;
- Transfer Pole: was observed rusted, this transfer pole was located in the Pine tub/shower room;
- Baseboard Heater (rad): was observed to have the radiator cover missing in a resident room;
- Foot board (beds): observed to have the laminate lifting along the foot board edges in a resident room;
- Towel-bar: observed to be missing in resident washrooms; in all three rooms the steeling casing in place to hold the towel bar was still present and noted to have sharp edges;
- Flooring: laminate flooring was observed gouged, chipped, cracked, torn, having

holes and or lifting in areas, in multiple resident rooms or washrooms; in tub/shower rooms located on Linden, Pine, Asphen and Cedar; in the hallways on Maple and Birch; foyer entry (flooring threshold) leading from Birch into Cedar; and in the activity room (adjacent to Pine); uneven flooring poses a trip fall hazard;
- Flooring: ceramic tiled floor was observed chipped and cracked in the main foyer of the home; the brick (stone) flooring was chipped in areas of the atrium (solarium) near the stairs; and the cement threshold leading from the atrium (solarium) into the games room was observed uneven;
- Flooring – laminate flooring in the Asphen tub/shower room was observed to be lifting in areas around the floor drain, this same area was 'soggy' feeling when the inspector stepped on it and water gushed out of the flooring from around the metal floor drain; the metal floor drain was covered with a black, moist substance; this room was noted to have a stale smelling odour (this was reported to Environmental Services Manager by the inspector, as such poses a potential infection control issue);
- Metal Blinds – observed bent (several horizontal sections) in the Pine lounge;
- Window Screen: in activity room (adjacent to Pine) was observed torn, the frame of the screen was bent and hanging from window;
- Light – one light in the Birch lounge was out (not working) during the dates of November 16-19; this room was dimly lit during the dates identified.

Housekeeping Aides, Personal Support Workers and Registered Nursing Staff all indicated (to the inspector) that staff are to utilize PM Works to communicate maintenance repairs required within the home when observed; nursing staff interviewed indicated that they normally only use PM Works for equipment repairs or equipment, and or furnishings that are broken; nursing staff indicated (to the inspector) that they do not use PM Works to address wall and or flooring problems to maintenance, as they felt maintenance were aware of repairs (maintenance) needed within the building.

Environmental Services Manager indicated (to the inspector):
- being aware that there were maintenance deficiencies within the home, but indicated that he was not aware of many of the above identified repairs, as such had not been communicated to him or the maintenance department by nursing and or housekeeping staff via the PM Works (electronic maintenance requisitions); Environmental Services Manager indicated (to the inspector) that the day to day maintenance of the home (e.g. wall repairs, painting) was behind by approximately six weeks, as the maintenance workers were pulled from their daily job-schedules to work on another project in the home, therefore putting maintenance repairs behind;
- being aware of flooring replacement for three resident washrooms located in Pine

(resident home area), but he was not aware of any other flooring being replaced or repaired as of the time of this inspection.

Environmental Services Manager indicated it is an expectation that the home, furnishings and equipment are to be maintained in a safe condition and in a good state of repair, but such was difficult with the home being an older building.

Note:
The areas identified above, are random observations by inspectors and do not include all of the maintenance repairs or replacement required within the home [s. 15. (2) (c)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 005

WN #6: 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. Related to Intake #032511-15, for Resident #058:

The licensee failed to comply with O. Reg. 79/10, s. 8 (1) (b), by not ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specifically as it relates to continence care.

Under O. Reg. 79/10, s. 48 (1) 3, every licensee of a long-term care home shall ensure the following interdisciplinary programs are developed and implemented in the home, which includes, a continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.

The home's policy, Removal of Indwelling Catheter (#RESI-05-04-12) directs registered nursing staff will remove a catheter when a physician's order has been received; registered nursing staff will insert syringe into the catheter valve leading to the balloon, withdraw empty syringe and repeat action until tubing leading from the valve collapses ensuring balloon is empty. The policy (in bold lettering) notes that registered nursing staff are never to cut the valve tubing to release the solution, as there is no way of emptying the balloon once the valve is gone.

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident, which the home indicated as being 'improper/incompetent treatment of a resident that results in harm or risk to a resident'.

Details of the Critical Incident Report are as follows:
- Personal Support Worker (PSW) #162 and #163 were transferring Resident #058 from wheelchair to bed, using a mechanical ceiling lift (and sling) on an identified date. PSW's transferred Resident #058 into bed, attached the medical equipment onto the left side of the bed, while one staff attempted to remove the sling from under Resident #058, the second PSW, using the hand held control, returned the mechanical (ceiling) lift to its resting position; while the mechanical ceiling lift was returning to its resting position, PSW #162 and #163 heard Resident #058 cry out; PSW's observed that Resident #058's medical equipment had been entangled on the mechanical (ceiling) lift's arm, PSW stopped the lift, observing resident was in discomfort and at this time noted bleeding.

Registered Nursing Staff assessed Resident #058 following the incident; resident continued to experience bleeding and pain. Registered Nursing Staff attempted to provide nursing interventions, but were unsuccessful. Registered Practical Nurse #113 and Registered Nurse #152 reported to the Registered Nursing-Supervisor that

attempts to provide nursing interventions were unsuccessful, registered nursing staff were instructed by RN-Supervisor(#153) to wait fifteen minutes and to attempt again.

Registered Practical Nurse (RPN) #113 indicated (to the inspector) that RPN #113 and RN #152 were unsuccessful in providing nursing intervention, despite several attempts. RPN #113 indicated that RN #152 proceeded with actions contrary to licensee policy. RPN #113 indicated Resident #058 was complaining of pain during attempts to provide nursing interventions.

Registered Nurse #152 indicated (to the inspector) that she was unable to provide nursing intervention. RN #152 then proceeded with actions contrary to licensee policy. RN #152 indicated resident was experiencing discomfort during attempts to provide nursing intervention.

Registered Nurse – Supervisor (#153) indicated (to the inspector) that she was aware that RN #152 proceeded with action contrary to licensee policy and indicated telling RN #152 that was not the right thing to do. RN-Supervisor indicated that the doctor was not called.

Registered Nursing Staff (#113, #152 and #153) all indicated (to the inspector) that action taken by RN # 152 was not the practice or policy of the home.

Director of Care (DOC) indicated that the RN #152 should not have proceeded with action contrary to licensee policy; DOC further indicated that the registered nursing staff should have contacted the physician when nursing interventions were unsuccessful and resident continued to voice discomfort.

Resident #058 was transferred to hospital, approximately two hours later, was seen by emergency room physician and referred to a specialist. [s. 8. (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 by ensuring that the licensee's policies related to continence care are complied with., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 16, by not ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

During the initial tour of the home, on November 16, 2015, the following observations were made:
- a window in the Linden (resident home area) lounge was observed open and not having a screen in place; this window could be opened fifty-eight centimetres. The Linden lounge is located on the main floor (but is a second storey lounge) of the home.
- two other windows in the Linden lounge were observed open and not having screens in place.
- a window in Pine (resident home area) lounge was observed open and not having a screen in place.

The Administrator and the Environmental Services Manager indicated (to the inspector) no awareness of the window, in Linden lounge, opening greater than fifteen centimetres; both indicated that maintenance workers had recently removed air-conditioning units and must have forgotten to replace latching (locking) mechanisms in the window in the lounge.

Environmental Services Manager indicated (to the inspector) that the home was 'short' window screens and an order had to be placed for the replacement of window screens.

2) On November 17, 2015, a window in a resident was observed to open sixty centimetres; this room is located on the main floor (but is a two storey drop) of the home.

The Administrator indicated that the resident residing in this room frequently by-passes the locking mechanism on the window, allowing the window to open greater than fifteen centimetres. Administrator indicated that there is currently no strategy or corrective action in place to monitor that the window is secured and not able to open greater than fifteen centimetres. [s. 16.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that all windows in the home that opens to the outdoors and is accessible to residents have a screen and cannot be opened more that 15 centimeters, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 17 (1) (e), by not ensuring the resident-staff communication and response system is available in every area accessible by residents.

The library, which is located in the basement of the home, was observed by the inspector to not have a resident-staff communication and response system available for resident use.

Environmental Services Manager (ESM) indicated to the inspector that the library is a resident accessible area and is used daily by a few residents; ESM indicated no awareness that the room did not have a resident-staff communication and response system.

Administrator, who oversees the operations of the home, indicated he too was not aware that the library did not have a resident-staff communication and response system in place. [s. 17. (1) (e)]

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 by ensuring that a resident-staff communication and response system is available in every area accessible by residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. Related to Intake #018385-15, for Resident #047:

The licensee failed to comply with O. Reg. 79/10, s. 101 (2), by ensuring that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and, (f) any response made by the complainant.

The home's policy, Complaints (#09-04-06) speaks to verbal complaints that cannot be resolved within twenty-four hours do not require a written investigation report; however if the verbal complaint cannot be resolved within twenty-four hours a written record of the complaint as well as the investigation and outcome will be retained.

When a verbal complaint is received, the following will occur:
- the person receiving the complaint will obtain as many details as possible regarding the complaint;
- where possible, an investigation will be initiated immediately;
- if the verbal complaint can be resolved within twenty-four hours, the person receiving the complaint or the department manager will verbally respond to the person making the complaint the outcome/resolution;
- if the investigation cannot be initiated immediately and/or resolution cannot be obtained within twenty-four hours, then the Administrator, Department Manager or

designate will initiate an investigation into the complaint, taking notes of the investigation and at the end of the investigation, review the findings and complete a written response to the complainant.
- if the investigation is not completed within six days of receiving the complaint, the Administrator will contact the complainant, acknowledging receipt of the complaint and indicate the investigation is on-going and that the investigation will be shared as soon as possible. Once the investigation is completed, the complaint will be entered into the Complaint Log Binder.

Resident #047 contacted the Long-Term Care's Action Line on an identified date, regarding the home's Administrator not allowing the resident to have a fridge in the room. Resident #047 indicated, in the concern, other residents in the home were permitted to have fridges in their rooms; Resident #47 indicated being told by the Administrator that there was a 'grand-father rule in effect which permitted any more residents from having personal fridges in their rooms'.

Centralized Intake Assessment Triage Team (C.I. A.T.T) contacted Resident #047 to discuss the concern; the same day C.I.A.T.T contacted the home's Administrator as to Resident #047's concern; Administrator indicated to C.I.A.T.T that he would follow up with Resident #047.

Resident #047 indicated (to the inspector) that prior to the call to the Ministry of Health and Long-Term Care being told that (the resident) was not able to have a small fridge in the room due to the home's policy. Resident #047 indicated (to the inspector) that there was no discussion, only a "NO" response. Resident #047 indicated receiving a call from a Ministry of Health and Long-Term Care representative, regarding the complaint and was told that the Administrator of the home would be contacting the resident; Resident #047 indicated never hearing back from the Administrator, although he did in passing one day say to the resident "I'm coming to speak to your about the fridge".

Resident #047 did indicate (to the inspector) being permitted to have a small fridge in the room, following a call to the local Member of Parliament.

Administrator indicated (to the inspector) that the complaint from Resident #047 regarding the fridge was seen as a verbal complaint;
A review of the home's Family and Resident Complaint binder, for 2015, failed to provide documented evidence of Resident #047's verbal complaint (date, nature, action taken and or response provided to the complainant).

Administrator indicated awareness of Resident #047's concern/complaint specific to the fridge, but was unable to locate any documented record of the complaint and or follow up with Resident #047. Administrator indicated that the verbal complaint from Resident #047 which was brought to his attention should have been documented as per the home's Complaints policy; Administrator indicated being unaware of when Resident #047's complaint had been resolved but indicated at some point after he had spoken with MOHLTC.

2) Related to Intake #009024-15 and #010570-15:

Anonymous complainants contacted the Ministry of Health and Long-Term Care Action Line, on an identified date, the complainant voiced concern that the home's temperature was inconsistent; the home was either too hot or too cold. The anonymous complainants indicated to MOHLTC Action Line that the complaint regarding the temperatures in the home had been brought forward to the management team on several occasions.

A review of the home's Family and Resident Complaint binder was reviewed, but failed to provide documented records of any complaints or concerns specific to temperatures within the home.

The Administrator, Director of Care and Environmental Services Manager all indicated being aware of concerns or complaints, specific to the home being too warm, but indicated that Client Feedback Forms had not been completed for any temperature (home air temperature) as "the home was doing its best to control the temperature, but due to the age of the home and the heating system in place, it was difficult to control temperatures within the home"; all indicated "there was nothing more that could be done".

Administrator indicated (to the inspector) that it is the expectation that the home's "Complaints" policy is to be followed; indicating that for the above complaints a Client Feedback Form should have been completed and filed in the Family and Resident Complaint binder

During an interview with resident #020 on November 17, 2015, the resident brought forward concerns that a total of $270.00 went missing from his/her wallet about three weeks prior, and that this was reported to the Administrator. Resident #003 also brought forward concerns that $40.00 went missing during the night and this was

reported. A review of the home's complaint log could not locate any documented record in relation to the above concern for resident #020, but there was documented record for resident #003's missing funds. A review of the home's record could not locate a report submitted to the Director in relation to the above identified missing funds. An interview with the Administrator confirms that he did not complete or submit a report regarding the above identified concerns to the Director.(607) [s. 101. (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 by ensuring a response is provided to a person who made a written or verbal complaint to the licensee or a staff member concerning the care of a resident or operation of the home, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Related to Intake #032511-15, for Resident #058:

The licensee failed to comply with O. Reg. 79/10, s. 107 (1) 2, by not ensuring the Director was immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide.

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident, which the home indicated as being improper/incompetent treatment of a resident that results in harm or risk to a resident. Resident #058 was transferred to the hospital later that day for assessment and treatment; Resident #058 returned to the long-term care home approximately nine hours later.

Resident was found in bed, four hours later, with vital signs absent; as per the family's request, the coroner was contacted to review the death of Resident #058.

According to the Institutional Death Record, completed and signed by the Registered Nurse-Supervisor (who was in charge of the home), Resident #058’s death was considered ‘sudden and unexpected’. Registered Nurse-Supervisor indicated (to the inspector) that she was not aware that a sudden or unexpected death was immediately reportable to the Director.

Director of Care (DOC) indicated (to the inspector) that the death of Resident #058 was unexpected; at the time of the on-site inspection the cause of Resident #058's death was considered undetermined. Director of Care indicated being unaware that a sudden and unexpected death required an immediate notification, to the Director.

The Director was not immediately informed of the sudden and unexpected death of Resident #058, until fifteen hours later. [s. 107. (1) 2.]

2. Related to Intake #011818-15, for Resident #62:

The licensee failed to comply with O. Reg. 79/10, s. 107 (3) 4, by not ensuring the Director, was informed, no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident’s health condition and for which the resident is taken to a hospital.

According to the clinical health record (written plan of care, progress notes, MDS) Resident #062 is cognitively well and required limited assistance from staff with activities of daily living; the resident was ambulatory with a walking aid, able to toilet self needing assistance with hygiene and required only supervision with transfers.

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in a resident's health status.

Resident #062 fell on an identified date; resident was assessed by Registered Nurse and found to have no injuries. twenty five minutes later resident was complaining of pain; an analgesic was administered for pain complaints.

Resident #062 fell again three hours later, resident was found on the floor in front of the bed; resident complained of pain, rating pain as severe (10/10); Registered Practical Nurse #177 noted limb be swollen and area continued to swell throughout the shift; resident was given narcotic pain medications during the shift without effect.

Progress notes, reviewed for the following two days, indicated Resident #062 continued to complain of pain and was administered routine and 'as needed' narcotic pain medications. Progress notes, indicated Resident #062 refused to go to the bathroom due to pain, therefore resident was incontinent; resident refused to get out of bed the same day.

Two days after initial fall, Resident #062 was found in bed unresponsive; ambulance was called and resident was transferred to hospital.

Registered Nursing Staff were advised by the hospital that Resident #062 was being admitted to the hospital.

Resident #062 remained in hospital until discharge from the hospital fourteen days later, at which time resident returned to the long-term care home. Hospital discharge diagnoses included multiple medical diagnosis.

Director of Care indicated the home was not aware of Resident #062 having an injury, but was in agreement that Resident #062 had a significant change in health status post falls resulting in injury, continued pain, change in level of care needs, unresponsive incident which prompted assistance of 911 and admission to hospital for

a period of approximately two weeks, following the fall incidents.

The Director was not notified until eleven days after an incident that caused an injury to Resident #062, for which the resident was taken to hospital and which resulted in a significant change in a resident's health status. [s. 107. (3) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring the Director was immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide.
-by ensuring the Director, was informed, no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 9 (1) 2, by not ensuring that all doors leading to non-residential areas, are locked when they are not being supervised by staff.

The laundry room, located in the basement, was observed to be propped open (with door stop) and left unsupervised (no staff present) on November 20, 2015, from 08:13 hours until 08:18 hours. There were washers and dryers in operation at the time of this observation; as well the laundry room contains chemicals and products for laundering purposes.

During a second observation, on November 20, 2015, at 12:11 hours until 12:18 hours, the laundry room door (in basement) was observed to be propped open, and no staff were in attendance in the laundry room.

A resident was observed in the Atrium (within close proximity to the laundry area) during the time of the second observation.

Laundry Aide #155 indicated (to the inspector) that the basement is considered a resident area (contains chapel, games room, hairdressers, atrium, library and chapel), but the laundry room is considered a non-residential area and is to be locked when staff are not in attendance.

Environmental Services Manager indicated (to the inspector) that doors to all non-residential areas are to be closed and locked whenever staff are not within the room. [s. 9. (1) 2.]

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Related to Intake #07008-15, for Resident #046:

The licensee failed to comply with LTCHA, 2007, s. 20 (1), by not ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The home's policy, Resident Abuse – Staff to Resident (#OPER-02-02-04), directs that staff are to immediately report (verbally) any suspected or witnessed incidents of abuse/neglect to the Administrator or Director of Care, or their designate; in Ontario, in addition to the above, anyone who suspects or witnesses abuse/neglect that causes or may cause harm to a resident is required to contact the Ministry of Health and Long-Term Care.

The policy further directs that the Administrator, Director of Care and or designate will immediately notify any person required by law (Director) of incidents involving alleged, suspected or witnessed abuse.

The Director of Care, submitted a Critical Incident Report to the Director, on an identified date. According to details in the CIR Resident #046 was not administered any of the scheduled doses of pain medication, during an eight hour shift.

The medication administration record, as well as the narcotic record provides documentation, indicated that Resident #046 was without pain medication for eight hours, despite a physician's order for medication to be given every two hours.

A review of the home's investigational notes (including Critical Incident Report) and interviews with the Resident Care Area Manager (RCAM #151), who was in charge during the identified shift and the Director of Care all indicated that the incidents of failing to provide narcotic pain medication was considered 'neglect of care'.

RCAM #151 indicated being contacted by the oncoming shift RPN of the medication

incidents (missed medications), and RCAM #151 had contacted the Director of Nursing Services as to the incident (missed medications). RCAM #151 indicated (to the inspector) that the incident was considered neglect of care; RCAM indicated not contacting the Ministry of Health and Long-Term Care, as to the 'neglect incident' as it had been reported to the Director of Nursing Services; RCAM indicated being aware of the home's policy (Resident Abuse-Staff to Resident).

The home's policy, Resident Abuse-Staff to Resident, was not complied with as evidenced by the following:
- An incident involving alleged, suspected or witnessed neglect, which occurred on an identified date, was not immediately reported to the Director, by the Resident Care Area Manager (#151) nor the Director of Nursing Services.(554)

Related to Intake #016142-15, for Resident #051:

A Critical incident report (CIR) was submitted by the home on an identified date, following an in-service on resident abuse and reporting guidelines. PSW #127 reported to DOC that on an identified date, witnessing PSW #128 being physically abusive towards Resident #051. Both PSW #127 and #128 were providing care to the resident - the resident was agitated,resisting care and exhibiting responsive behaviours. PSW #128 grabbed the resident's cheeks, holding the resident's face back. PSW #128 was asked to leave the room by PSW #127. PSW #127 observed a bruise on the resident's cheek and reported it to the RPN #133 but, PSW #127 did not report the alleged abusive interaction with PSW #128 to the RPN or anyone else at the time.

During an Interview with DOC on November 24, 2015 at approx 11:00 hours, she acknowledged PSW #127 did not comply with the home's written policy by immediately reporting the alleged abuse incident.(552)

CIR was submitted to the Director for what the home catergorized as improper/incompetent treatment of a Resident #010. Physical abuse of Resident #010 was reported to the Director two days after the incident, contrary to the Abuse policy in the home.(570)

On November 17, 2015 during interviews with inspector #607, Resident #020 and Resident #003 indicated that missing money was reported to the Administrator of the home. The Administrator confirmed that the missing money was not report to the Director as directed in the licensee's abuse policy.(607)

CIR was submitted to the Director for what the home catergorized as improper/incompetent treatment of a Resident #058. Physical abuse of Resident #058 was reported to the Director two days after the incident, contrary to the Abuse policy in the home.(554)

A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during inspection #2015_360111_0014, which included a written notification (WN) specific to LTCHA, 2007, s.20 (1); the incidents involving Resident's #051 and #046 were prior to the compliance due date of August 15, 2015 but the incidents involving Resident's #020, #003 and #058 are after the compliance date therefore the order will be issued for a second time. [s. 20. (1)]

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. Related to Intake #015635-15, for Resident #054:

The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Critical Incident Report submitted by the home on an identified date indicating that a non staff member approached the Director of Nursing Services to report that another non staff member had witnessed an incident involving a resident the day before. During the interview, the non staff member reported the resident was crying loudly and resisting care. The resident continued to cry out and resist having care provided. The staff member continued to provide the care despite the residents resistance.

During an interview on November 24, 2015, DOC explained that an investigation into the alleged incident was immediately commenced. Following the investigation conducted by the home, the home was unable to determine if the alleged abuse had occurred but had made the decision to take disciplinary actions towards the PSWs. The Director was not notified of the outcome of the investigation into the abuse incident.

The DOC acknowledges that the ministry should have been informed of the outcome.

Related to Intake #016142-15, for Resident #051:

A Critical incident report (CIR) was submitted by the home on an identified date, following an in-service on resident abuse and reporting guidelines. PSW #127 reported to DOC that on an identified date, witnessing PSW #128 being physically abusive towards Resident #051. Both PSW #127 and #128 were providing care to the resident - the resident was agitated,resisting care and exhibiting responsive behaviours. PSW #128 grabbed the resident's cheeks, holding the resident's face back. PSW #128 was asked to leave the room by PSW #127. PSW #127 observed a bruise on the resident's cheek and reported it to the RPN #133 but, PSW #127 did not report the alleged abusive interaction with PSW #128 to the RPN or anyone else at the time.- only that the resident had a bruise.

During an interview with DOC on November 24, 2015 at approx 11:00 she explained during the investigation, head to toe assessment was completed for the resident, there were no marks or bruises observed. The resident was unable to verbalize that the incident had occurred. The home was unable to determine the incident had occurred but the accused PSW was provided with education on resident bill of rights, GPA and responsive behavior. The DOC acknowledges that the results of the abuse investigation was not reported to the Director.

A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during inspection #2015_360111_0014, which included a written notification (WN) specific to LTCHA, 2007, s. 23 (1)(a)(b); the incident involving Resident #054 and # 051 was prior to the compliance due date of August 15, 2015. [s. 23. (2)]

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

For the purpose of the definition of "abuse in subsection 2(1) of the Act, "financial abuse", means any misappropriation or misuse of a resident's money or property.

During an interview with resident #020 on November 17, 2015, the resident brought forward concerns that a total of $270.00 went missing from his/her wallet about three weeks prior, and that this was reported to the Administrator. Resident #003 also brought forward concerns that $40.00 went missing during the night and this was reported. A review of the home's complaint log could not locate any documented record in relation to the above concern for resident #020, but there was documented record for resident #003's missing funds. A review of the home's record could not locate a report submitted to the Director in relation to the above identified missing

funds. An interview with the Administrator confirms that he did not complete or submit a report regarding the above identified concerns to the Director.(607)
[s. 24. (1)]

2. The licensee failed to comply with LTCHA, 2007, s. 24. (1), by not ensuring a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, specifically as it relates to:

For the purpose of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means, the use of physical force by anyone other than a resident that causes physical injury or pain.

Related to Intake #032511-15, for Resident #058:

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident of physical abuse, which the home categorized as being "improper/incompetent treatment of a resident that results in harm or risk to a resident".

The Critical Incident Report indicated that on an identified date, two Personal Support Workers were transferring Resident #058, using a mechanical ceiling lift from wheelchair to bed, during the transfer Resident #058's medical equipment became entangled around the mechanical ceiling lift's arm bar, pulling on the medical equipment, which resulted injury to Resident #058; resident was transferred to hospital for assessment and treatment.

Director of Care indicated to the inspector the incident and subsequent injury to Resident #058 resulted from Personal Support Workers #162 and #163 not following the home's Safe Lifts and Transfers policy and practice.

Director of Care (DOC) indicated to the inspector that she was informed, by the Resident Care Area Manager, of the incident. DOC indicated that the Director was not immediately informed of the physical abuse, as she was directed by the Administrator to wait until the next day to speak with the home's Consultant (Extendicare Assist). Director of Care indicated, she is aware that the CIR was late being reported to the Director.

The Director was not informed of the physical abuse that resulted in harm to the

resident until two days later.(554) [s. 24. (1)]

3. Related to Intake #015525-15, for Resident #010:

A critical incident report was received on an identified date for an incident of improper/incompetent treatment of a resident that results in harm or risk to a resident.

The CIR indicated that on an identified date, PSW reported that resident #010 had sustained an injury. PSW stated that when the staff pulled the Geri chair forward, the resident sustained an injury.

During an interview, the DOC indicated that the CIR was reported by the former DOC and that if the incident was called in the MOHLTC it would be documented on the CIR and the progress notes.

Review of the CIR notes and clinical records of resident #010 indicated no documentation that the incident was immediately reported to the Director. The CIR was submitted to the Director two days after the incident.(570)

Related to Log # 019428-15 for Resident #057:

A critical incident report (CIR) was received on an identified date for an incident of improper/incompetent treatment of a resident that results in harm or risk to a resident.

The CIR indicated that, swelling and bruising was noted on resident #057's chest. The location of the bruising on the resident's chest led to the belief that the arm of the mechanical lift struck the resident's chest during transfer from bed to wheelchair.

Review of clinical records of resident #057 indicated that RN #105 called in the incident to MOHLTC two days after the incident.

The DOC confirmed that the incident was not reported immediately to the Director. (554)

Related to Intake #007008-15, for Resident #046:

Under O. Reg. 79/10, s. 2 (1), 'neglect' is defined as the failure to provide a resident

with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The Director of Care, submitted a Critical Incident Report to the Director on an identified date, specific to an incident of neglect of care; the incident was said to have occurred two days earlier.

Details of the CIR as a follows:
- Resident #046 who was palliative at the time, and struggling with comfort and pain control, was ordered pain medication subcutaneously (SC) every two hours; Resident #046 did not receive any pain medication for eight hours.

According to the home's investigational notes, the Director of Nursing Services received a call from Resident Care Area Manager (RCAM), indicating that Resident #046 did not receive four scheduled doses of pain medication during an identified eight hour shift.

Resident Care Area Manager (RCAM), who was the supervisor, on site at the home, when the incidents of missed pain medication was discovered indicated (to the inspector) that not administering pain medication to Resident #046 who was palliative and struggling with pain control was considered neglect of care; RCAM indicated not reporting the neglect of care incident to Ministry of Health and Long-Term Care, as it had been reported to the Director of Nursing Services; RCAM indicated it is the practice of the home, that nursing managers (Director of Care or Director of Nursing Services) would report incidents of alleged, suspected or witnessed abuse and or neglect to the Director.

Director of Care (DOC) indicated (to the inspector) she did not submit the Critical Incident Report (CIR) to the Director until two days later, as that is the date in which she was notified of the incident; DOC indicated (to the inspector) that a resident not receiving scheduled pain medication would be considered neglect of care and should have been immediately reported to the Director.

The neglect of care incident was not immediately reported to the Director, despite the Director of Nursing Services being aware of the incident on two days previous, as reported by the RCAM.(554)

A Compliance Order (CO #001), under LTCHA, 2007, s.19, was issued during

inspection #2015_360111_0014, which included a written notification (WN) specific to LTCHA, 2007, s.24(1); the incidents involving Resident's #010,#057 and #046 were prior to the compliance due date of August 15, 2015, but incidents involving Resident's #020, #003 and #058 were after the compliance date therefore the Order will be issued for a second time. [s. 24. (1)]

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The Licensee has failed to comply with LTCHA, 2007 S.O. 2007c.8., s.44 Authorization of admissions to the home

Specifically fail to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

Related to Intake #004080-15, for Resident #067:

On November 26, 2015, the inspector spoke with the home's Administrator regarding a letter sent to Community Care Access Center (CCAC) dated August 27, 2014 regarding the refusal of the application for applicant #067 to the home. The Administrator explained that applicant #067's application to the home was not accepted because of the applicant's dietary care needs and the home was unable to accommodate the applicant needs. The Administrator acknowledged refusal of Resident #067 did not meet the criteria outlined in the the legislative requirements. [s. 44. (7)]

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that written response is provided within 10 days of receiving Resident's Council advice related to concerns or recommendations.

On November 24, 2015 at 1450 hours interview of the Residents' Council President indicated that written responses to concerns identified at the meeting are not provided to the council within 10 days. The written responses are provided to the council at the following meeting when those concerns are discussed. The Residents' Council President indicated that no written responses provided to concerns identified in the minutes of October 27, 2015.

Review of the Resident Council Meeting minutes of October 27, 2015 indicated no written responses to the following concerns:
- Concerns related to Nursing and Personal Care: Resident stated that PSWs don't always want to get (the resident) ready; Staff are noticed to sleep in residents areas Residents stated that management should be coming to meetings they have been passing the invitation off to other staff in the department.
- Concerns related to environmental services: Unclean hallways; Maintenance student not wearing name tag and entering residents' rooms without permission.
Volunteers are not wearing name tags and using cell phones during their hours.
- Concerns related to Nutrition and hydration care: residents are not getting many choices in snacks; residents are getting same thing; same thing on the menu is offered all the time; residents find it hard to get things from the kitchen when they ask.

Review of the Resident Council Meeting minutes of August 21, 2015 indicated written responses were not provided within 10 to the following concerns:
- Concerns related to Nursing and Personal Care: PSWs and other staff are just walking into residents rooms without knocking first (written response dated September 24, 2015 to Residents Council concern form dated August 31, 2015); Call bells are not answered in timely manner; PSW staff state they will come back and forget (written response dated September 24, 2015 to Residents Council concern form dated August 31, 2015). After hours door bell is not being answered promptly by the Linden staff.

(written response dated September 23, 2015 to Residents Council concern form dated August 31, 2015).
- Concerns related to Restorative care: restorative have been short staffed needed to cover staff in different departments; (written response dated September 23, 2015 to Residents Council concern form dated August 31, 2015).

On November 26, 2015 at 1100 hours interview with Director of Programs indicated that written responses to concerns are not provided to the Residents' Council after management responds to identified concerns using the Resident Council Concern Form. Those forms are held till the next Residents' Council meeting when the concerns forms are reviewed by the council. [s. 57. (2)]

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

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who require assistance with eating or drinking only served a meal when someone is available to provide the assistance.

On November 23, 2015 during supper meal, Resident #061 was observed to be served an entree in advance of assistance being provided. The resident did not initiate eating the meal on his/her own. Resident is known to staff to require total assistance with feeding. Resident's plan of care related to eating identified that the resident requires total assistance for eating. An interview with the DOC and the nutrition manager confirmed that residents who require total assistance food should not be placed in front of the resident until a PSW is available to assist the resident [s. 73. (2) (b)]

WN #18: 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 drugs are stored in an area or a medication cart,
ii. that is secure and locked.

On November 20, 2015 @ 09:00 hours it was noted that the medication storage area on the Maple unit was left unlocked and accessible. Noted by the inspector inside the cupboard was the following:
-two bottles of Tylenol 325 mg tablets.
-bottles of Lactulose
-bottles of Colace liquid
-one bottle of Koffex
-one bottle of Bronchophan expectorant
-bottles of alcohol
-the medication destruction tub for the unit, with numerous medications inside. [s. 129. (1) (a)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. Related to Intake #0028395, for Resident #029:

The licensee has failed to ensure that appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs.

On an identified date Resident #029 was given another resident's medication in error by RPN #134. RPN #135 who was carrying medications for another resident, walked by Resident #029's room and observed Resident #029 on the floor. RPN #135 entered the room to ensure resident was safe. RPN #134 also entered the room and was instructed by RPN #135 to watch the medication cup which was placed out of the resident's reach, while RPN #135 called for help. When RPN #135 returned to the room RPN #134 had given the medications to resident #029.

Resident #029 was given two different muscle relaxants , pain medication and laxative in error.

RPN #135 administered the 12:00 hours scheduled medication pass to Resident #029 which included pain medication, iron and an antipsychotic medication.

Resident # 29's blood pressure was monitored between 10:20 and 13:20 and noted to be dropping, no other Blood pressure was noted until 15:00 hours. Progress notes indicate that Resident #029's Vital signs at 15:00 hours indicated blood pressure was low and resident condition was changing, Resident was difficult to rouse. At 15:30 hours, resident's condition deteriorated, writer unable to rouse resident. Supervisor present and called MD. MD agreed to sent to hospital.

During the evening shift it is documented in the progress notes that the resident's blood pressure dropped causing the home to call the ambulance, but the resident stabilized before being transferred and stayed at the home. [s. 134. (b)]

Issued on this 19 day of April 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : CHANTAL LAFRENIERE (194) - (A1)

Inspection No. / No de l'inspection : 2015_365194_0028 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 031205-15 (A1)

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

Report Date(s) / Date(s) du Rapport : Apr 19, 2016;(A1)

Licensee / Titulaire de permis : CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : Orchard Villa
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Gary Hopkins

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To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, 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_360111_0014, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee shall ensure that:

-The establishment of an effective communication protocol between Extendicare Assist and the senior management at the home related to reporting incident of abuse is implemented. The communication protocol will ensure that;

1. The Director is immediately notified of all incidents of abuse at the home. (as noted in WN#14)
2. Further education to senior management team to ensure clear understanding of current abuse policies in the home.(as noted in WN#13)

-A monitoring process is in place to assess the effectiveness of the communication protocols between Extendicare Assist and the senior management at the home, including a method;

- whereby DOC and or delegate is reviewing all communication from the front line staff to determine if any abuse has occurred in the home.

-whereby appropriate and timely follow up for any incidents of abuse documented or reported, ensuring that all legislative requirements have been fulfilled.

-whereby the licensee's Abuse policy is complied with.

- Monthly analysis of all incidents of resident abuse is completed to identify and address any deficiencies.

Grounds / Motifs :

1. A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during inspection #2015_360111_0014, which included a written notification (WN) specific to LTCHA, 2007, s. 24 (1); with a compliance date of August 15, 2015

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

For the purpose of the definition of "abuse in subsection 2(1) of the Act, "financial abuse", means any misappropriation or misuse of a resident's money or property.

During an interview with resident #020 on November 17, 2015, the resident brought forward concerns that a total of $270.00 went missing from his/her wallet about three weeks prior, and that this was reported to the Administrator. Resident #003 also brought forward concerns that $40.00 went missing during the night and this was reported. A review of the home's complaint log could not locate any documented record in relation to the above concern for resident #020, but there was documented record for resident #003's missing funds. A review of the home's record could not locate a report submitted to the Director in relation to the above identified missing funds. An interview with the Administrator confirms that he did not complete or submit a report regarding the above identified concerns to the Director.(as noted in WN #15)(607)

Related to Intake #032511-15, for Resident #058:

The licensee failed to comply with LTCHA, 2007, s. 24. (1), by not ensuring a person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, specifically as it relates to:

For the purpose of the definition of "abuse" in subsection 2(1) of the Act, "physical abuse" means, the use of physical force by anyone other than a resident that causes physical injury or pain.

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident of physical abuse, which the home categorized as being "improper/incompetent treatment of a resident that results in harm or risk to a resident".

The Critical Incident Report indicated that on an identified date, two Personal Support Workers were transferring Resident #058, using a mechanical ceiling lift from wheelchair to bed, during the transfer Resident #058's medical equipment became entangled around the mechanical ceiling lift's arm bar, pulling on the medical equipment, which resulted injury to Resident #058; resident was transferred to hospital for assessment and treatment.

Director of Care indicated to the inspector the incident and subsequent injury to

Resident #058 resulted from Personal Support Workers #162 and #163 not following the home's Safe Lifts and Transfers policy and practice.

Director of Care (DOC) indicated to the inspector that she was informed, by the Resident Care Area Manager, of the incident. DOC indicated that the Director was not immediately informed of the physical abuse, as she was directed by the Administrator to wait until the next day to speak with the home's Consultant (Extendicare Assist). Director of Care indicated, she is aware that the CIR was late being reported to the Director.

The Director was not informed of the physical abuse that resulted in harm to the resident until two days later.(as noted in WN #15)(554) [s. 19. (1)] (194)

2. On November 17, 2015 during interviews with inspector #607, Resident #020 and Resident #003 indicated that missing money was reported to the Administrator of the home. The Administrator confirmed that the missing money was not report to the Director as directed in the licensee's abuse policy.(as noted in WN#13)

CIR was submitted to the Director for what the home categorized as improper/incompetent treatment of a Resident #058. Physical abuse of Resident #058 was reported to the Director two days after the incident, contrary to the Abuse policy in the home.(as noted in WN#12)

The decision to issue an order is based on three separate incidents in November 2015, where under the legislative requirements, immediate notification to the Director was to be completed and the licensee failed to report. In two of the incidents significant amounts of money were reported by residents to be missing and the third incident resulted in actual harm to the resident. During the inspection an additional three incidents of non compliance related to reporting of abuse were identified, prior to the compliance date of the existing order. In all of the examples of abuse identified during the inspection the licensee has failed to follow their Abuse policy. A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during inspection #2015_360111_0014, which included a written notification (WN) specific to LTCHA, 2007, s. 24 (1); with a compliance date of August 15, 2015. (194)

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

Apr 30, 2016

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Linked to Existing Order / Lien vers ordre existant: 2015_293554_0009, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

the licensee shall ensure:

- To implement measures and a monitoring process to ensure that the care set out in the plan of care is based on an assessment of the resident's needs, especially for those residents with a change in condition. That appropriate and timely action is taken when the needs of the resident(s) are not being met at the home.

- to provide re-instruction to all registered nursing staff of the importance of following the home's policies, specifically "Urinary Catheterization" and "Removal of an indwelling Catheter" policies, especially when a resident is exhibiting a change in health status.

Grounds / Motifs :

1. A Compliance Order (CO #001), under LTCHA, 2007, s. 6 (2) was issued during inspection #2015_293554_ 0009, specific to the care set out in the plan of care being based on an assessment of the resident's needs and preferences, with a compliance date of August 14, 2015.

Related to Intake #032511-15, for Resident #058:

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident, which the home indicated as being 'improper/incompetent treatment of a resident that results in harm or risk to a resident'.

Details of the Critical Incident Report are as follows:
- Personal Support Worker (PSW) #162 and #163 were transferring Resident #058 from wheelchair to bed, using a mechanical ceiling lift (and sling). PSW's transferred Resident #058 into bed, attached the resident's medical equipment the left side of the bed, while one staff attempted to remove the sling from under Resident #058, the second PSW, using the hand held control, returned the mechanical (ceiling) lift to its resting position; while the mechanical ceiling lift was returning to its resting position, PSW #162 and #163 heard Resident #058 cry out; PSW's observed that Resident #058's medical equipment had been entangled on the mechanical (ceiling) lift's arm, PSW stopped the lift, observing resident was in discomfort and bleeding.

Registered Nursing Staff assessed Resident #058 following the incident; resident continued to experience bleeding and pain. Registered Practical Nurse (RPN) #113 and Registered Nurse (RN) #152 attempted to provide nursing interventions, but attempts were unsuccessful. Registered Practical Nurse #113 reported to the Registered Nursing-Supervisor #153 that attempts to provide nursing interventions were unsuccessful, RPN #113 and RN #152 were instructed by RN-Supervisor #153 to wait fifteen minutes and to attempt again.

Registered Nurse #152 and Registered Nurse-Supervisor #153 indicated (to the inspector) that Resident #058 was experiencing discomfort and bleeding following the transferring incident, both registered nursing staff indicated that Resident #058 continued to experience bleeding and discomfort when registered nursing staff were attempting to provide nursing intervention. Both registered nursing staff (#152 and #153) indicated that the doctor was not contacted for direction as Resident #058 advanced directives were noted as a Level 2, indicating resident was to be cared for in the home.

As per the progress notes, an hour and a half later, Resident #058 was observed to have a change in condition with vital signs decreasing; resident was transferred to hospital for assessment.

The hospital discharge summary indicated, Resident #058 was assessed and referred to a specialist while at the hospital. Resident #058 was transferred back to the long-care home later that day.

The Critical Incident Report indicates Resident #058 returned to the home and was

found deceased four hours later.

Director of Care indicated (to the inspector) that Registered Nursing Staff should have contacted Resident #058's attending physician (or transferred resident to hospital), for further assessment due to the transfer incident, subsequent injury and when resident continued to experience bleeding and or staff's inability to provide nursing interventions.

The licensee failed to ensure that the care set out in the plan for Resident #058 was based on an assessment of the resident's needs. When the resident was not provided with an opportunity to be assessed by the physician or transferred to the hospital for assessment related pain management, bleeding and the inability of Registered staff to provide the nursing interventions for a period of one hour and fifteen minutes

The decision to issue an order is based on Resident #058's actual harm during care and the resulting change in condition, a past history of non compliance in this area resulting in an Order being issued in report # 2015_293554_ 0009. There is continued evidence that care set out in the plan of care is not based on the assessment and needs of the resident with a change in condition.
(554)

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

Feb 29, 2016

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The home shall ensure that all staff use safe transferring and positioning devices or techniques when assisting residents by ensuring;

-re-education of staff related to the licensee's "Safe Lifting with Care Program, specifically the Mechanical Lift Policy (#01-03).
-re-education of staff related to residents requiring specific transferring techniques for safety.

Grounds / Motifs :

1. Related to Intake #032511-15, for Resident #058:

The licensee failed to comply with O. Reg. 79/10, s. 36, by not ensuring staff use safe transferring and positioning devices or techniques when assisting the resident.

The home's policy, Mechanical Lifts (#01-03) directs that prior to all transfers the arm rests and footplates are to be removed from the receiving surface (e.g. wheelchair); staff are to complete a Pre-Transfer Review, which includes resident readiness, staff readiness, environment readiness and equipment readiness, if any deficiencies are identified or suspected staff are not to proceed with the transfer and to notify the supervisor.

The home's policy (Mechanical Lifts) directs that prior to a transfer (using a mechanical lift) both staff members are to complete the 6 Point Checklist (#01-12) which is attached to the lift (which includes, is resident able to participate in the lift, is the sling applied correctly, is the sling attached to the lift correctly, is the lift path clear and are both staff members ready and positioned correctly to complete the lift. The policy (Mechanical Lift) directs that once the 6 Point Checklist is completed the resident is to be lifted two-three inches above the departing surface (e.g. wheelchair) and staff are to once again check that the sling is positioned properly, resident is

comfortable, resident is balanced under the lift mechanism, and if any deficiencies are identified resident is to be lowered, sling re-applied and 6 Point Checklist is to be completed again. The policy (Mechanical Lift) directs that the resident is to be protected from touching any part of the mechanical lift or other equipment. The home's policy (Mechanical Lift) further directs that once the resident is lowered onto the receiving surface (e.g. bed) staff are to ensure resident is comfortable and positioned correctly, then to unhook sling and return ceiling lift to the charge (docking station).

The Director of Care submitted a Critical Incident Report to the Director, on an identified date, specific to an incident, which the home indicated as being 'improper/incompetent treatment of a resident that results in harm or risk to a resident'.

Details of the Critical Incident Report are as follows:
- Personal Support Worker (PSW) #162 and #163 were transferring Resident #058 from wheelchair to bed, using a mechanical ceiling lift (and sling). PSW's transferred Resident #058 into bed, attached the medical equipment onto the left side of the bed, while one staff attempted to remove the sling from under Resident #058, the second PSW, using the hand held control, returned the mechanical (ceiling) lift to its resting position; while the mechanical ceiling lift was returning to its resting position, PSW #162 and #163 heard Resident #058 cry out; PSW's observed that Resident #058's medical equipment had been entangled on the mechanical (ceiling) lift's arm, PSW stopped the lift, observing resident was in discomfort and bleeding.

Personal Support Worker #163 indicated (to the inspector) that along with PSW #162 they were transferring Resident #058 from the wheelchair into bed; PSW #163 indicated that they had attempted to place the transferring sling under Resident #058 while the resident was in the wheelchair but that the placement of the sling was difficult due to Resident #058 refusing to allow the wheelchair arms to be removed and that the space between the bed and wheelchair was small, making placement of the sling difficult. PSW #163 indicated that they had asked Resident #058 to hold onto the transfer sling handles and other medical equipment while they (PSW #162 and #163) proceeded to transfer resident from chair to bed. PSW #163 indicated that once resident was in the sling, PSW #163 moved to the opposite side of the bed and pushed the start button (ceiling lift control); PSW #163 indicated that while the ceiling lift was still in motion (resident was over the bed), PSW #163 attempted to remove resident's shoes while still operating the lift, and it was during this time that Resident

#058 began to scream. PSW #163 indicated that the medical equipment was caught on the sling handles and handles of the ceiling lift and was accidentally pulled when transferring the resident from wheelchair to bed.

Personal Support Worker #163 indicated (to the inspector) that PSW #163 and PSW #162 should have followed the home's safe transfer and lifting procedures while transferring Resident #58; PSW #163 indicated that they (PSWs) did not removed the wheelchair arm rests prior to the transfer making it difficult to place the sling under the resident and making it difficult to clearly visualize the transfer pathway; PSW #163 further indicated that Resident #058 should have been safely positioned in bed prior to removing the shoes or sling and that they (PSWs) should have been more aware of where resident's medical equipment placement prior to and during the transfer (with ceiling lift). PSW #163 indicated that PSW #163 and PSW #162 did not complete the 6 Point Checklist prior to transferring Resident #058.

The Director of Care indicated (to the inspector) that "Personal Support Workers #162 and #163 were not following the home's Safe Lifting with Care Program", specifically the Mechanical Lifts Policy (#01-03) "which contributed the incident and subsequent injury of Resident #058".

DOC indicated that PSW's #162 and #163 did not follow the home's Safe Lifting with Care Program, by not doing the following:
- remove the arm rest of Resident #058's wheelchair; indicating it is the home's policy and practice that the arm rest of the wheelchair is to be removed with all transfers involving the use of a mechanical lift, as it creates a 'blind spot' and that potentially items could become entangled around the arm of wheelchair;
- complete that six-point checklist prior to and during use of a mechanical lift, specifically PSW #162 and #163 did not ensure the mechanical lift path was clear; during the incident, Resident #058's medical equipment became entangled in the handle of the lift, and when returning the lift to its charge (docking station).
- and that following the transfer of Resident #058 from wheelchair to bed, PSW's #162 and #163 did not ensure resident was properly positioned before returning the ceiling lift to the charge (docking station).

Director of Care indicated (to the inspector) that it is the expectation that all staff, who have been trained to use the mechanical lifts are to follow the home's Safe Lifting with Care Program.

(554)

2. Related to Intake #015525-15, for Resident #010:

A Critical incident report indicated that on an identified date. PSW stated that when the staff pulled the Geri chair forward, resident #010 suffered an injury.

Review of the plan for Resident #010 in effect at time of incident indicated the resident has multiple diagnoses including Cognitive Impairment, is totally dependent in transferring, and fragile skin.
The plan of care related to transferring, skin integrity and comfort directs to staff to:
-Put pillows on both sides of the resident's elbows when sitting in the wheelchair/lounge chair to prevent injury.
-Assess resident's ability to transfer safely prior to each transfer.
-Protect pressure areas with pillows and heel poseys.
Resident #010's progress notes were reviewed. On an identified date RPN #188 documented that, PSW reported an injury was sustained to Resident #010. Possible cause: as per staff, when pulled up the Geri chair, resident was injured.
Interview with PSW #186 indicated that PSW #186 and PSW #187 were preparing the resident to be transferred from Geri chair to bed; PSWs removed the pillows from both side of the resident. PSW #186 indicated to inspector #570 during an interview that when the staff moved the back of the chair forward from reclining to a sitting position the back of the chair snapped back; then realized that the resident's limb was caught between back of chair and arm rest. PSW #187 should have protected the resident's limb at the time; PSW #187 indicated the chair is an old style and was not orientated on how to use it and realized after the incident the need to push the foot rest of the chair backwards for the back of the chair to lock in position.

Review of investigation notes and statement by PSW #187 indicated the staff removed the right pillow first, as the staff turned around the resident's limb was down on the side of the chair. When moving the resident limb gently blood was noticed and RPN was called. PSW #186 was on the other side of the chair. RPN #188 indicated before pulling the Geri chair forward, PSWs #186 and 187 removed the pillows and they had been instructed that they pull the pillows out last.

Review of the investigation notes and plan of care for resident #010 indicated the

PSW staff did not ensure the resident's safety when removing supporting/protective pillows while preparing the resident to transfer from chair to bed.(570)

The decision to issue an order is based on two critical incidents occurring in the home between June and November 2015 where improper transfers were completed by staff resulting in actual harm to residents. (570)

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

Feb 29, 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. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

The licensee shall:

- Develop an implement a process to ensure that medication is administered to all residents in accordance with the directions for use, as specified by the prescriber; and

- Develop an implement a process to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

-Educate all registered nursing staff related to the College of Nurses of Ontario Medication Practice Standard, including administration of narcotics and appropriate action to be taken in response to any medication error.

-Development of a formal monitoring process to evaluate medication administration processes to promptly address medication administration issues
and avoid adverse medication incidents

Grounds / Motifs :

1. Related to Intake #0028395, for Resident #029:

The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

On an identified date Resident #029 was given another resident's medication in error by RPN #134. Resident #029 had a fall and was found by RPN #135 who was carrying medications for another resident when the RPN walked by Resident #029's room and found the resident on the floor. RPN #135 entered the room to ensure resident was safe, and RPN #134 also entered the room and was instructed by RPN #135 to watch the medication cup which was placed out of the resident's reach, while RPN called for help. When RPN #135 returned to the room, RPN #134 had given the medications to resident #029.

Subsequently Resident # 029 experienced a significant drop in blood pressure. [s. 131. (1)]

2. Related to Intake #007008-15, for Resident #046:

The licensee failed to comply with O. Reg. 79/10, s. 131 (2), by not ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A review of the clinical health record, for Resident #046, for the period of ten days, indicates that resident had been deemed palliative; according to progress notes, physician's orders and interviews with a Resident Care Area Manager and the Director of Care, Resident #046 was having difficulties with pain control.

On an identified date, Resident #046's attending Physician prescribed a STAT pain medication to be given subcutaneously; then routinely, subcutaneously every two hours for comfort.

According to a Critical Incident Report, Resident #046 was not administered any of the scheduled doses of pain medication, during an eight hour shift, despite a physician's order for medication to be given every two hours.

Director of Care indicated (to the inspector) that the medication incident was investigated and it was found that Registered Practical Nurse #114 who was the assigned charge nurse, did not only not administer the prescribed pain medication to Resident #046 during the identified shift, but also missed a scheduled dose of pain medication, for Resident #046, the following day.

According to the Director of Care, Registered Practical Nurse (RPN) #114 indicated Resident #046 was asleep and since resident was sleeping, the RPN felt that the medication was not required.

Director of Care indicated that Registered Practical Nurse #114 should have awakened Resident #046 to administer the pain medication especially noting resident had been experiencing pain control and management difficulties, and indicating the physician ordered the medication to be given every two hours.

2) Related to Resident #043:

According to the physician's orders, Resident #043 was prescribed pain medication every eight hours, for pain control.

A medication incident report, as well as the medication administration record and narcotic administration record, for Resident #043, provides documented evidence that Registered Practical Nurse #114 failed to administer the prescribed dose of pain medication to Resident #043 on an identified date.

Registered Practical Nurse #114 indicated to the Director of Care, that she had forgotten to administer the pain medication to Resident #043.

Director of Care indicated (to the inspector) the expectation is that physician's orders are to be followed as directed. [s. 131. (2)]

The decision to issue an order is based on Resident #29 receiving medications not prescribed for the resident resulting in a drop in blood pressure and ambulance to be called to the home. Residents #043 and # 046 not receiving narcotics as prescribed resulting in pain to the residents. The three separate incidents have occurred between April to October 2015. (194)

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

Feb 29, 2016

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that;

- A monitoring process is in place to assess the effectiveness of the housekeeping and maintenance practices in the home. The monitoring process will include a method;

-to ensure that the "deep cleaning policies and practices for the home are implemented and complied with.(as noted in WN #7)
-to ensure that re-education is provided, to all departments related to the process for "PM Works", which is the electronic Maintenance requisitions used in the home.(as noted in WN#7)
-to ensure that the ESM is conducting weekly audits related the home furnishings and equipment being kept clean, sanitary, safe and in a good state of repair.
-Monthly analysis of all PM works received, is completed to identify and address any deficiencies.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (a), by not ensuring that the home, furnishings and equipment are kept clean and sanitary.

The following observations were made, during the dates of November 16, to November 20, and November 23 to the 24, 2015:
- Toilets – dark blackish-brown staining was observed surrounding base of toilet (stool) and the surrounding flooring in multiple resident washrooms and in the Birch/Maple, Pine and Linden tub/shower rooms;
- Floors – multiple resident rooms were observed to have dark brownish-black build

up (query grout or dirt) along flooring seams, flooring thresholds (transition piece from hall to resident room, or resident room to washroom) and along wall/flooring edges (especially in corners), as well as in the activity room adjacent to Pine, Pine and Linden lounges, resident home area hallways (Maple, Pine, Birch and Linden), as well as the Linden and Pine tub/shower rooms. The brownish-black build up could be scraped off when scraped with a pen, by the inspector;
- Floors – visible dust and debris, especially in corners of rooms were observed in the activity room and kitchenette adjacent to Pine (resident home area), in the Pine lounge, in the Linden and Pine tub/shower rooms and in the Atrium (basement);
- Vents – observed to have thick grey film to ceiling vent in the Linden tub/shower room; observed to have blackish film on and around the ceiling vent in the Birch lounge;
- Windows / Door – cob-webs were observed lining the inside of the window and doorway of the activity room adjacent to Pine (resident home area); as well as the window located at end of the Birch (resident home area) corridor;
- Commode – observed to have brownish staining smeared along edges of commode seating and on commode rails in two resident washrooms.
- Privacy Curtain – was observed stained along the width of the curtain panel in a resident room.

Environmental Services Manager (ESM) indicated awareness of floors in the home being soiled and in need of cleaning, especially in common areas of the home, and indicated (to the inspector) that Housekeeping Staff had not been following the 'deep cleaning policies and practices' and such has resulted in cleanliness issues throughout the home. ESM indicated (to the inspector) that a new roll-out schedule, for deep cleaning, is being introduced to housekeeping staff week of November 26, 2015.

Environmental Services Manager indicated the expectation is that the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]
(554)

2. Related to Intake #009024-15 and #010570-15:

The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a

good state of repair.

An anonymous complainant contacted the Ministry of Health and Long-Term Care's Action Line indicating that windows in the Pine resident home area and in the Pine tub/shower room were broken and in need of repair. The anonymous complainant indicated that cloths were being shoved into the window opening to prevent cold air from coming into resident rooms and or tub/shower room. The anonymous caller indicated reporting this concern to the management of the home without resolution.

Window latches (opening mechanism) on windows located in the Pine tub/shower and in the activity room (adjacent to Pine) were observed broken and unable to be closed during the dates of November 16, and again November 20, 2015.

Environmental Services Manager indicated (to the inspector) that he was not made aware of the window latches being broken, until he noticed it himself on November 20, 2015; ESM indicated (to the inspector) he relies on staff (nursing and housekeepers) to alert him of deficiencies and areas in need of repair via the PM Works (electronic maintenance requisitions).

2) The home's policy, Preventative Maintenance – Maintenance Program Overview (#MNTC-01-01-01) direct that the maintenance program will maintain the building (and equipment) in a condition that provides a safe, comfortable and pleasant environment for the residents.

The following observations were made during the dates of November 16, through to November 20, 2015:
- Walls: were observed scraped, gouged, paint chipped or having wall damage (dry wall exposed, holes or corner steel beading exposed) in multiple resident rooms or washrooms; in lounges located on Pine, Linden, Birch, Aspen and Cedar; in tub/shower rooms located on Birch/Maple, Pine, Linden, Asphen and Cedar; along hallways in Pine, Asphen, and Cedar;in the main dining room; and on the wall under the severy in the Cedar dining area was 'rippled' in appearance (query water damage);
- Tiled Walls: the ceramic tiled walls in tub/spa rooms located on Linden, Asphen and Cedar were observed cracked, chipped or having missing wall tiles; areas were wall tiles were chipped and or missing were noted to have jagged edges which were sharp; the lower edges of the wall tiles (along shower stall) and laminate flooring in the Linden, Cedar and Asphen tub/shower rooms were noted to have a blackish,

moist substance along the length of the shower stall (this concern was reported to the Environmental Services Manager by the inspector, as such poses a potential infection control issue);
- Doors and Door Frames: were observed to be chipped, paint missing, holes or having jagged metal edges on doors or door frames in resident rooms/washrooms and in the lounges located on Birch, Linden and Pine;
- Closets: were observed scraped (blackish marks) and or being off the track in resident rooms.
- Wall Guard – observed loose or missing in multiple resident rooms.
- Curtains: observed to be thread-bear (worn) or having the rubber backing of the curtain cracked or torn in resident rooms;
- Counter-top Vanities: were observed chipped (exposed porous surface) or missing laminate missing in multiple resident washrooms; in the main dining room on and around the hand-sink vanity and along the severy counter;
- Chairs: home owned chairs were observed to be chipped, worn (shellac finish missing) and having blackish staining on the chair legs in resident rooms;
- Sink Vanity: the metal legs attached to the counter-top vanities in resident washrooms were observed stained (blackish) or having areas of corrosion or rust, in washrooms located in resident rooms;
- Commodes and or Shower Chairs: were observed with rusted areas or corrosion in a resident washroom and in the tub/shower room on Linden;
- Toileting Safety Rails: rust was observed on the toileting hand rails in washrooms;
- Bedside Tables: were observed to be chipped (porous surface exposed) or missing laminate surround, in resident rooms;
- Bed-rails: were observed to have paint chipped along the railing in resident rooms;
- Transfer Pole: was observed rusted, this transfer pole was located in the Pine tub/shower room;
- Baseboard Heater (rad): was observed to have the radiator cover missing in a resident room;
- Foot board (beds): observed to have the laminate lifting along the foot board edges in a resident room;
- Towel-bar: observed to be missing in resident washrooms; in all three rooms the steeling casing in place to hold the towel bar was still present and noted to have sharp edges;
- Flooring: laminate flooring was observed gouged, chipped, cracked, torn, having holes and or lifting in areas, in multiple resident rooms or washrooms; in tub/shower rooms located on Linden, Pine, Asphen and Cedar; in the hallways on Maple and Birch; foyer entry (flooring threshold) leading from Birch into Cedar; and in the activity

room (adjacent to Pine); uneven flooring poses a trip fall hazard;
- Flooring: ceramic tiled floor was observed chipped and cracked in the main foyer of the home; the brick (stone) flooring was chipped in areas of the atrium (solarium) near the stairs; and the cement threshold leading from the atrium (solarium) into the games room was observed uneven;
- Flooring – laminate flooring in the Asphen tub/shower room was observed to be lifting in areas around the floor drain, this same area was 'soggy' feeling when the inspector stepped on it and water gushed out of the flooring from around the metal floor drain; the metal floor drain was covered with a black, moist substance; this room was noted to have a stale smelling odour (this was reported to Environmental Services Manager by the inspector, as such poses a potential infection control issue);
- Metal Blinds – observed bent (several horizontal sections) in the Pine lounge;
- Window Screen: in activity room (adjacent to Pine) was observed torn, the frame of the screen was bent and hanging from window;
- Light – one light in the Birch lounge was out (not working) during the dates of November 16-19; this room was dimly lit during the dates identified.

Housekeeping Aides, Personal Support Workers and Registered Nursing Staff all indicated (to the inspector) that staff are to utilize PM Works to communicate maintenance repairs required within the home when observed; nursing staff interviewed indicated that they normally only use PM Works for equipment repairs or equipment, and or furnishings that are broken; nursing staff indicated (to the inspector) that they do not use PM Works to address wall and or flooring problems to maintenance, as they felt maintenance were aware of repairs (maintenance) needed within the building.

Environmental Services Manager indicated (to the inspector):
- being aware that there were maintenance deficiencies within the home, but indicated that he was not aware of many of the above identified repairs, as such had not been communicated to him or the maintenance department by nursing and or housekeeping staff via the PM Works (electronic maintenance requisitions);
Environmental Services Manager indicated (to the inspector) that the day to day maintenance of the home (e.g. wall repairs, painting) was behind by approximately six weeks, as the maintenance workers were pulled from their daily job-schedules to work on another project in the home, therefore putting maintenance repairs behind;
- being aware of flooring replacement for three resident washrooms located in Pine (resident home area), but he was not aware of any other flooring being replaced or

repaired as of the time of this inspection.

Environmental Services Manager indicated it is an expectation that the home, furnishings and equipment are to be maintained in a safe condition and in a good state of repair, but such was difficult with the home being an older building.

The decision to issue an order is based on the widespread deficiencies in housekeeping and maintenance identified during the inspection. Furthermore there are potential infection control issues and risk of harm to residents related to specific identified issues. (554)

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

Jul 31, 2016(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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 sions de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416-327-7603

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

Issued on this 19 day of April 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CHANTAL LAFRENIERE - (A1)

Service Area Office /
Bureau régional de services : Ottawa