Ontario

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

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

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

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


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

**Division de la responsabilisation et de la performance du système de santé**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 21, 2014 | 2014_294555_0015 | O-000455-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PORT PERRY)
15941 Simcoe Street, Port Perry, ON, L9L-1N5

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

GWEN COLES (555), CAROLINE TOMPKINS (166), LYNDA BROWN (111), MARIA FRANCIS-ALLEN (552), MATTHEW STICCA (553)

**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): June 2, 3, 4, 5, 9, 10, 11, 12, 13, and 16, 2014.**

**The following logs were inspected concurrently with the Resident Quality Inspection: Logs #O-002445-12 and #O-000345-14.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Programs Manager, Environmental Services Manager (ESM), Business Office Manager, Food Services Supervisor (FSS), RAI Coordinator, Special Projects/Eduction/Infection Control Nurse, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Families, Resident Council President, and Family Council President.**

**During the course of the inspection, the inspector(s) toured the home; observed dining service; observed medication passes; reviewed resident health care records; reviewed Resident Council and Family Council meeting minutes; reviewed the homes policies on Immunization of staff and residents, Resident Weight Monitoring, Activation Manual, Required Abuse and Neglect Reporting, Infection Prevention and Control, Least Restraints, Pain Management, Skin and Wound: Skin Tears; Falls Prevention, Medication Administration, Preventative Routines - Maintenance Procedures, Maintenance Service Manual, and Transfer of Function.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Recreation and Social Activities**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

**Findings of Non-Compliance were found during this inspection.**

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

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

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

**Findings/Faits saillants :**

1. The licensee failed to 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 related to skin integrity.

Observations made on Resident #4 during the inspection indicated tissue injuries to limbs. Interview conducted with Staff #100 and Staff #121 who reported resident injury occurs as a result of constant uncontrolled movement.

Interview with DOC who is aware resident has chronic tissue injury to limbs related to uncontrolled movement.

Review of most recent Head to Toe Skin assessment indicates no concerns. Review of most recent MDS assessment indicates no concerns related to skin integrity.

Review of Care Plan does not identify the injuries as a concern and does not have evidence of any related interventions. [s. 6. (2)]

2. The licensee failed to provide Resident #7 with the care specified in the plan of care regarding the application of a trunk restraint.

Review of the plan of care for Resident #7 indicated the use of a tilt wheelchair for

comfort and repositioning and a trunk restraint for support and safety when in wheelchair.

During the inspection Resident #7 was observed in a wheelchair with no truck restraint applied. Resident #7 was reclined and appeared to be sleeping. Later the same day Resident #7 was observed being transferred into the wheelchair via mechanical ceiling lift without the trunk restraint applied to the wheelchair.

Interview with Staff #113 during the inspection who indicated that the expectation is that Resident #7 will have the trunk restraint applied whenever the resident is up in the wheelchair. [s. 6. (7)]

3. The licensee failed to provide Resident #6 care as specified in the plan of care regarding the application of the Personal Assistance Services Device(PASD).

Review of plan of care for Resident #6 indicated the use of a PASD when in bed and wheelchair, and to respond promptly as part of the falls prevention program.

Resident #6 was observed during the inspection to be up in the wheelchair with no evidence of having the PASD in place. The PASD was located in Resident #6's room. Resident #6 was observed later that day  with no PASD in place. Staff #100 located the PASD after Inspector #553 indicated to Staff #100 and #109 that Resident #6 does not have a PASD. Staff #100 found the PASD in the same location it had been since Inspector #553's earlier observation. Staff #100 and Staff #109 were aware that Resident #6 is to be wearing the PASD while up in the wheelchair. [s. 6. (7)]

4. The licensee failed to ensure the plan of care was provided to the resident as specified in the plan related to completing of pain assessments.

Review of the RAI-MDS for Resident #9 under pain indicated the resident had moderate pain, less than daily, relieved with use of analgesics as needed and "current pain assessments are completed".

Review of the Medication Administration Records for a six month period for Resident #9 indicated the resident received analgesics as needed every 2-3 days.

Review of the care plan for Resident #9 indicated that the resident has occasional pain that is relieved with use of analgesics as needed. Interventions included

"completing a pain assessment monthly to ensure pain is managed/controlled".

Interview of RAI-Coordinator indicated that pain assessments are completed either electronically (on Medicare), on paper, or both. The RAI Coordinator was unable to locate any pain assessment tools completed electronically for Resident #9.

Interview of DOC indicated that staff are to complete pain assessments using the "paper" pain assessment tool that is kept in a binder in the medication rooms. The DOC was unable to locate any paper pain assessment tools completed for Resident #9.

Review of Resident #9 health record had no documented evidence of a pain assessment tool completed. The resident continued to have ongoing pain and there was no documented evidence of pain assessments completed monthly as indicated in the plan of care to ensure the pain was managed. [s. 6. (7)]

5. Related to log # 002445:

The licensee failed to ensure that the plan of care related to pain was reviewed and revised when the resident's care needs changed.

Review of the care plan for Resident #8 indicated under pain: moderate pain less than daily, administer analgesics per Doctors orders and report any increases in frequency and severity to doctor.

Review of the progress notes for Resident #8 for a four month period indicated the resident complained of ongoing pain in a specified area with increasing frequency and was treated with analgesics with good effect. However, in the fourth month the resident was transferred to hospital for "severe pain" to that specified area. The resident returned from hospital and continued complaining of moderate to severe pain at the same specified area and analgesics were given. The physician re-assessed the resident, new orders were received for pain management and a pain assessment completed. The resident indicated improved pain management with the new analgesic.

The resident's pain location, severity and frequency changed, and the plan of care was not revised to reflect this change. [s. 6. (10) (b)]

6. The licensee failed to review and revise the resident's plan of care when the care needs changed, related to a therapeutic device.

Resident #5 was observed during the inspection with a different therapeutic device in place than specified in the care plan.

Progress notes reviewed by Staff #102 indicated Resident #5 is not wearing the specified therapeutic device at this time. An interview conducted during the inspection with Staff #102 who reports the resident's therapeutic device is no longer being used. [s. 6. (10) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure 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; provide the care specified in their plan of care; and that the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.***

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**WN #2: 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).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure the homes' policy on Resident Weight Monitoring was complied with.

Under O. Reg. 79/10, s. 68 (2) Every licensee of a long-term care home shall ensure that the Nutrition and Hydration program include, (a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; (e) a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter.

Review of the Licensee's policy RCSM C-25, entitled "Resident Weight Monitoring" directs the following:
-"Residents will have monthly weights recorded and evaluated and will be re-assessed for supplement as per a defined protocol."
- "The HCS/PSW will weigh each resident monthly on their 1st bath day of the month."

Review of the weight record book for Resident #6 indicated no weights recorded for three out of seven months.

Interview with Dietitian who indicated that PSWs enter the weights into the binder which is a paper form, the registered nursing staff are then responsible to enter the weights into the computer. If there is a variance, nursing staff are to complete a liaison tool which is a referral form to alert the need of the Dietitian to assess the resident. The Dietitian stated that weights were being missed and not entered into Med-e-Care. [s. 8. (1) (a),s. 8. (1) (b)]

2. Related to log # 002445-12:

The licensee failed to ensure that the home's policy on pain management was complied with.

Under O.Reg. 79/10, s.48(1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:4. A pain management program to identify pain in resident and manage pain.

Review of the progress notes for Resident #8 for a 4 month period indicated:
-the resident complained of ongoing, moderate to severe pain and was given analgesic each time with effect.
-the resident was hospitalized for severe pain.
-after hospitalization the resident continued to complain of moderate to severe pain

and received the same analgesic.

Review of the homes policy "Pain Management" (RSL-DOC-031) indicated:
-once pain is identified, a care plan must be completed and updated by registered staff quarterly as required.
-Pain Assessment Tools (Admission Pain Assessment Form 72M-A or Pain Assessment Monitoring Form 72-B is to be used for residents able to verbalize pain and Admission Pain Assessment -Dementia (form 36M) and Pain Assessment in Advance Dementia (PAINAD) is used for those who are unable to verbalize pain.
-residents will have a pain assessment completed for any of the following: upon re-admission from hospital, when new pain is indicated by verbal or observation of behavioural changes, change in health status, and end of life or palliative care.

Review of the pain assessments indicated a pain assessment was completed for a four month period for complaints of pain and analgesic was given with effect for each episode. A pain assessment was not completed after hospitalization until the resident complained of moderate to severe pain. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee failed to ensure that the home's policy on Skin/Wound Care was complied with. Under O. Reg. 79/10, s. 50 (1) 2 the skin and wound program must, at a minimum, provide for the following: strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.

Observations made of Resident #4 on during the inspection indicates tissue injury to limbs. Review of weekly skin assessments for Resident #4 for a six week period shows no evidence of a weekly skin assessment for one week.

Observation made of Resident #11 during the inspection of a tissue injury. Review of weekly skin assessments for Resident #11 for a six week period indicated no evidence of a skin assessment being completed for one week.

Observations made of Resident #3 during the inspection noted tissue and skin integrity injuries to limbs. Review of weekly skin assessments for Resident #3 for an eight week period found no evidence of two weekly skin assessments.

Review of Policy entitled "Skin/Wound Care" RSL-DOC-035 which indicates Personal Support Worker/Health Care Aide: ...completes weekly skin assessments Form 10M (weekly skin assessments) and reports abnormal or unusual skin conditions to the

registered nursing staff (i.e. reddened or open areas, blisters, bruises, tears, scratches). Interview with DOC who reported skin assessments are done weekly on bath days by the Personal Support Workers. [s. 8. (1) (a),s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with the policies related to Resident Weight Monitoring,Pain Management and Skin/Wound Care, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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).**

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**Findings/Faits saillants :**

1. Related to Log #O-000341-14

The licensee failed to immediately report to the Director the suspected verbal, physical and emotional staff to resident abuse related to Resident #1.

Review of the Critical Incident Report (CI)indicated alleged staff to resident abuse occurred to Resident #1. The CI indicated that Resident #1 reported to staff of verbal abuse by another staff member.

A review of the progress note for Resident #1 indicated Staff #122 was made aware of an alleged verbal, physical and emotional abuse situation involving Resident #1 and Staff #120. The resident reported the occurrence happened during a specific time frame. There is no evidence that Staff #122 did report this immediately to the Director, Administrator or DOC.

Interview with the Administrator indicated that she was not notified of the incident until the next day. During an interview with the DOC who stated that the Director was notified at time of submission of the Critical Incident Report to the Ministry of Health, which was over 24 hours from the time of the alleged incident. [s. 24. (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 related to immediately report the suspicion of abuse and the information on which it is based to the Director, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.**

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

**s. 29. (1) Every licensee of a long-term care home,**
**(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).**
**(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the written policy to minimize the restraining of residents is complied with.

Resident #4 was observed during the inspection with two trunk restraints in place while in the wheelchair.

Review of licensee policy entitled "Least Restraint Policy – Physical Restraints" RSL-SAF-35 which indicated:
- types of restraints include safety belts, tray or table tops; and full or ¾ side rails.
- "The ongoing use of the restraint will be evaluated at least quarterly by registered staff, documented in the multidisciplinary progress notes, plan of care and RAPS and the initial and annual care conference notes."
- "The written informed consent will be update annually at a minimum."

There was no documented evidence for a six month period, or at the annual care conference of evaluation of the ongoing use of two trunk restraints for Resident #4.

Review of restraint consents for Resident #4 indicated there was no documented evidence of an annual review of the consent for restraints. [s. 29. (1) (b)]

***Additional Required Actions:***

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

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

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

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act as per O. Reg 79/10, s. 110 (7) 3 is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: The person who made the order, what device was ordered, and any instructions relating to the order.

Review of Physician's order states "Restraint order signed" however the order does not specify type of restraint or any instructions relating to the order. Review of licensee's Policy entitled "Least Restraint Policy - Physical Restraints" RSL-SAF-35 states "The physicians' order for the use of restraints will include: the type of restraint, purpose of use and frequency of use."

Resident #4 was observed during the inspection with two trunk restraints in place while in wheelchair. Review of the Care plan for Resident #4 indicates under "Restraints: restraints when in bed, two trunk restraints when in wheelchair". [s. 110. (7) 3.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance related to requirements regarding restraining by a physical device are only applied as ordered; is documented and that the following are documented: The person who made the order, what device was ordered, and any instructions relating to the order, to be implemented voluntarily.***

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

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

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug related supplies, and that is secured and locked.

The room beside the Stewart Lane tub room (which is used to store personal care supplies) was observed with the door open. This room contained a plastic container with 16 physician prescribed resident treatment creams. Observation of the Stewart Lane tub room had a unlocked cupboard with 1 resident treatment cream prescribed by a physician.

Interview of the DOC and the RPN indicated that all treatment creams were not to be left in the storage or tub rooms and returned to the nurse after application of treatment creams.

Inspector #555 observed on the LaFontaine unit a medication cart unlocked and unsupervised in the hallway with several residents in close proximity. Staff #102 returned to the medication cart and reported that the expectation was for the cart to be secured when staff are not in attendance, the cart was then secured. [s. 129. (1) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug related supplies, and that is secured and locked, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

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

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

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**Findings/Faits saillants :**

1. The licensee failed to ensure that the right to have his or her Personal Health Information (PHI) within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

During an observation of a medication pass on Stewart Lane (2nd floor) RPN #112 was observed disposing of the medication strip pack for Resident#10 which contains resident PHI in the garbage without removing the PHI.

During an observation of a medication pass on Lafontaine Lane (3rd floor) RPN #102 was observed disposing of the medication strip pack for Resident #1 and #2 which contained resident PHI in the garbage without removing the PHI. [s. 3. (1) 11. iv.]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings**

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

**s. 12. (2)The licensee shall ensure that,**
**(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).**
**(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).**
**(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).**
**(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).**
**(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).**
**(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that each resident has a comfortable easy chair provided in the resident's bedroom.

Observations of several rooms which have two residents in a room had no chairs available. Observations of several rooms which have four residents in a room had only two chairs available. [s. 12. (2) (e)]

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

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

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

**Findings/Faits saillants :**

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

Observations made during the inspection by Inspector(s) #166, 555 and 553 indicated flickering overhead lighting in a bedroom and bathroom. Mutiple potlights located in the middle of the main hallway on Scugog Way (3rd floor) and Dymond (2nd floor) were not working. Interview conducted with the Environmental Services Manager (ESM) who reported was aware of the lighting issues. [s. 15. (2)]

2. Observation of the tub room on Stewart Lane(2nd floor) indicated:
- a damaged wall area approximately 4 feet long x 4 inches high along the back side wall.
- there was damage to the lower edge of the floor with plaster missing near door frame approximately 10 x10 inches in diameter.
- there was wall damage with plaster missing approximately 5x5 inches on the ceiling bulk head just above the entrance into the tub room doorway.

Observation of the tub room on Lafontaine Way (3rd floor) indicated:
-Arjo (Alenti) tub lift with an approximate 2x3 inch broken-off piece on the base of the lift.

Interview of the Environmental Services Manager (ESM) who indicated the nursing staff should record any maintenance issues in the maintenance log book located at

the nursing station on the unit and the ESM checks the logs daily for maintenance required. The ESM also indicated that a quarterly review is completed of routine and preventative maintenance required but was not aware of any ceiling or wall damage in the tub room on Stewart Lane or damage to the tub lift on Lafontaine Way.

Review of the maintenance log book for the unit Stewart Lane for a six month period had no indication of wall or ceiling damage to the Stewart lane tub room or tub lift on 3rd floor. Review of the "Environmental Quarterly Report" indicated under building maintenance: tub rooms-acceptable and under housekeeping procedures, hydrotherapy, tubs, shower chairs and lift chairs cleaned between each use.

Interview of the Administrator indicated that all areas in the Stewart Lane tub room had been plastered as a result of the inspection and would be painted when the plaster was dried.

3. Observation made during the inspection indicated there was a large amount of water on the floor around the tub on Stewart Lane (2nd floor).

Interview of ESM indicated that there was a burst/leaking pipe that occurred during the evening shift during the inspection. The ESM indicated the kitchen staff noted a leak in the ceiling tiles in the following morning. The ESM indicated the tub room was not in use, a plumber was called and would be repaired (#552).

Review of the maintenance log book for the unit Stewart Lane for a six month period had no indication of wall or ceiling damage to the Stewart lane tub room. [s. 15. (2) (c)]

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that equipment is used according to the manufacturers' instructions.

Observation of the tub room on Stewart Lane(2nd floor) during the inspection indicated an Arjo Alenti tub lift was in use but had no seat belt available.

Observation of tub room on Lafontaine Way (3rd floor) during the inspection indicated an Arjo Alenti tub lift was in use but had no seat belt available.

Interview of a PSW#107 on Stewart Lane indicated a seat belt was not used on the Arjo lift when bathing residents but the arm is put down for safety. Interview of PSW #108 on Lafontaine Way indicated no awareness of use of a seat belt or location of a seat belt to be used when bathing residents with Arjo lift.

Review of the Arjo Alenti Manufacturers' instructions indicated:
- under actions before first use:check that all parts of the product are supplied. If any part is missing or damaged, DO NOT use the product.
-under safety belt: use the safety belt at all times, to avoid falling, make sure the that the resident is positioned correctly and that the safety belt is being used, properly fastened and tightened. [s. 23.]

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

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

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #3 was observed during the inspection with altered skin integrity, dressed with a clear dressing. One week later the resident was observed with no dressing in place and the skin healed.

Review of health records for Resident #3 found no evidence of an electronic or paper skin assessment using a clinically appropriate assessment instrument. [s. 50. (2) (b) (i)]

**WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council**

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

**s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that concerns or recommendations received from the Family Council are responded to in writing within 10 days.

Review of Family Council Minutes for a six month period indicated concerns with the telephones not working and missing laundry.

Interview of the Family Council President indicated all concerns that have been identified at the meetings are only discussed verbally with the Administrator and no response in writing. Interview of the Administrator confirmed that all concerns brought forward by the Family Council are discussed verbally with the Family Council but no response is provided in writing to the Family Council. [s. 60. (2)]

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**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes**
**Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:**

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

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**Findings/Faits saillants :**

1. The licensee failed to ensure that residents with the following weight changes are assessed using an interdiscplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over six months.
4. Any other weight change that compromises their health status.

The licensee failed to ensure that when Resident #6 experienced a weight loss of 7.5% or more, over 3 months that Resident #6 was assessed.

Review of Resident #6 weight for a four month period indicated no recorded weights for two out of four months. Over the above listed time frame, Resident #6 lost 9.1% of their body weight.

Interview with Staff #111 who indicated that PSWs will enter the weights into the binder which is a paper form, the registered nursing staff are then responsible to enter the weights into the computer. If there is a variance, nursing staff are to complete a liaison tool which is a referral form to alert the need of the dietitian (Staff #111) to assess the resident. Staff #111 stated that weights were being missed and subsequently not being entered into Med-e-Care.

Review of the Nursing/Dietary Liaison Tools for Resident #6 for one year provided no indication of a tool being filled out to address the weight loss experienced by Resident #6.

Staff #111 indicated that a dietary quarterly review of Resident #6 was completed within the last quarter.[s. 69]

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**WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

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

**s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that they seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

Interview of the Administrator indicated that the satisfaction survey is completed by an off-site company who create the survey, submit the survey and review the results of the survey and then forward the results to the home. The Administrator indicated there is no involvement of the Family Council in the development or carrying our of the survey. [s. 85. (3)]

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**WN #15: 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 log # 002445-12:

The licensee failed to ensure that a documented record was kept in the home that includes, the nature of each verbal or written complaint; the date the complaint was received; including the date of the action, and every date on which any response was provided to the complainant.

Interview of Administrator could not recall if any complaints were received regarding Resident #8 in 2012 or 2013. The Administrator was unable to provide a documented complaint record for 2012.

Review of the complaint record for 2013 & 2014 indicated the following were not identified:
-who the complainants were.
-the dates the complaints were received.
-the dates of the actions taken and every date on which any response was provided.
[s. 101. (2)]

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**Issued on this 24th day of July, 2014**

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