Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 2, 2016	2016_467591_0007	013962-16	Resident Quality Inspection

Licensee/Titulaire de permis

DEVONSHIRE ERIN MILLS INC.
195 DUFFERIN AVENUE SUITE 800 LONDON ON N6A 1K7

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

ERIN MILLS LODGE NURSING HOME
2132 DUNDAS STREET WEST MISSISSAUGA ON L5K 2K7

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

NATASHA JONES (591), BERNADETTE SUSNIK (120), DARIA TRZOS (561), MICHELLE WARRENER (107), ROMELA VILLASPIR (653), SAMANTHA DIPIERO (619)

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): May 10, 11, 12, 13, 16, 17, 18, 19, 20, 24, 25, 26, 27, 30, 31, June 1, 2, 3, and 7, 2016.

The following Critical Incident inspection was completed simultaneously during this Resident Quality Inspection (RQI):
000111-16 related to improper transfer

The following Complaint Inspections were completed simultaneously during this RQI:
003850-14 related to complaint process
003918-14 related to continence care
006859-14 related to abuse and care
003034-15 related to abuse and care
003347-15 related to abuse and care
003502-15 related to admission process and housekeeping
004319-16 related to continence and skin care

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care(DOC), Resident Assessment Instrument(RAI) Coordinator/Assistant Director of Care(ADOC), Food Services Supervisor(FSS), Programs Manager, Nutrition Manager(NM), Physiotherapist(PT), Registered Dietitian(RD), Registered Nursing Staff, Personal Support Workers(PSWs), Family and Residents' Council representatives, Recreation Therapists, Maintenance staff, Dietary Aides, Residents and Residents' family members.

During the course of the inspection, inspectors reviewed resident health records, investigative notes, complaints logs and files, maintenance logs and audits, infection control surveillance documentation, staff files, menus and dietary sheets, staff education records, program evaluations, policies and procedures, toured the home, and observed dining services, residents and care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
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
Residents' Council
Safe and Secure Home
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.
- **25 WN(s)**
- **11 VPC(s)**
- **9 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) A review of the home’s policy #RCM02-01-01, titled “Admission Nursing Assessment/24-Hour Care Plan”, effective in 2014, indicated that each resident would have an admission nursing assessment completed on the day of their arrival into the home. There were two forms used for the admission assessment including the “Admission Checklist” and the “Admission Nursing Assessment/ 24-Hour Care Plan”. The two forms were reviewed in resident #046's chart and the "Admission Checklist" which identified the tasks to be completed on days one through seven were not completed. On day one, only five steps out of 22 were completed and signed by the registered staff. On day two and three, none of the tasks were completed. The resident was discharged on the third day.
A review of the “Admission Nursing Assessment/ 24-Hour Care Plan” indicated the resident was not assessed for sleep patterns, transfers, pain, activity tolerance, dressing, grooming or toileting.
Registered staff #106 was interviewed and stated that as per the home's policy the “Admission Checklist” should have been completed. The DOC confirmed that the “Admission Checklist” and the “Admission Nursing Assessment/ 24-Hour Care Plan” were not completed and the policy was not complied with.

B) A review of the home’s policy #RCM10-01-20, titled “Oxygen Therapy/Suction Therapy”, effective date December 2014, indicated, "2. Notify the physician of the change in the resident’s condition, 3. Follow physician’s orders for oxygen flow rate, 4. Oxygen orders will be part of the Medication Administration Record (MARs)".
The health records were reviewed and progress notes in 2015, indicated that resident #046 complained of shortness of breath and oxygen was administered to the resident as their oxygen saturation was low. There was no indication that the physician was notified and an order for oxygen therapy was not obtained. The MAR was reviewed and the oxygen order was not entered into the MAR. Registered staff #106 was interviewed and indicated that they would only obtain an order from the physician if the resident required as needed (PRN) or had scheduled oxygen therapy but not if they required it on only one occasion. The DOC indicated that the registered staff could administer oxygen right away if needed but after administration they were expected to call the physician to get an order and were expected to add it to the MAR.

C) A review of the home's policy, #RNC03-03-05, titled "Hydration", effective date December 2014, stated that residents would be referred to the Registered Dietitian (RD) if their hydration was less than 75% of their calculated target over a three day period.
Resident #040’s written plan of care identified a minimum fluid requirement. The resident consumed less than 75% of their minimum fluid requirement on several days in 2016; however, a referral to the RD for poor hydration did not occur.
Registered staff #128 in an interview stated that referral forms for the RD were in the RD referral binder and that the RD would sign the forms when completed and put the completed forms into the resident's chart. A copy of a referral to the RD was not in the resident's clinical health record. The RD confirmed a referral was not received for that time period.

D) The home's policy, #RNC03-03-05, titled "Hydration", effective date December 2014, stated that residents would be referred to the RD if their hydration was less than 75% of their calculated target over a three day period.
Resident #026's written plan of care identified a minimum fluid requirement in 2016. The resident consumed less than 75% of their minimum fluid requirement on specific days in 2016; however, a referral to the RD for poor hydration did not occur. Registered staff #128 stated that referral forms for the RD were in the RD referral binder and that the RD would sign the forms when completed and put the completed forms into the resident's chart. There were no referrals to the RD for several months in 2016, in the resident's clinical health record. A referral was sent to the RD on a specific day in 2016, notifying the RD that the resident had symptoms including weight loss. There were no referrals to the RD for poor hydration and the RD confirmed a referral was not received for that time period related to poor hydration.
The home's policy, "Referrals to Registered Dietitian RCM03-03-03", effective date December 2014, directed the Food Services Manager or DOC/ADOC to provide the RD with a list of the residents no less than monthly who had a change in appetite or refusal to eat, poor fluid intake, constipation, difficulty chewing or swallowing, altered skin integrity, and dementia or behavioural issues affecting intake.
A review of progress notes identified the resident had responsive behaviours related to meals, specific skin conditions, an ongoing medical condition, query of a medical event on a specific day, and several ailments in specific months in 2016. Documentation on the resident's, "Dietary Report", where the resident's food and fluid intake were recorded, reflected that the resident only consumed a specific percent (half or less) of their meals for several months.
A referral to the RD related to specific nutritional concerns was not available in the resident's clinical health record, with the exception of one condition and a downgrade in

their diet texture.
The RD confirmed they were not aware of the nutritional concerns and did not receive a referral related to the concerns.

E) The home's policy #RNC03-03-05, titled "Hydration", 2014, stated that residents would be referred to the RD if the residents' hydration was less than 75% of their calculated target over a three day period.
Resident #025's written plan of care identified a minimum fluid requirement. Nursing staff would be required to refer the resident to the RD at a specific quantity. The resident consumed less than 75% of their minimum fluid requirement over three days during specific time periods; however, a referral to the RD for poor hydration did not occur.
Registered staff #128, in an interview, stated that referral forms for the RD were in the RD referral binder and that the RD would sign the forms when completed and put the completed forms into the residents' chart.
A copy of a referral to the RD for the noted dates was not in the resident's clinical health record. The RD confirmed a referral for poor hydration was not received for that time period.
The home's policy #RCM03-03-05, titled "Referrals to Registered Dietitian", effective date December 2014, directed the Food Services Manager or DOC/ADOC to provide the RD with a list of the residents no less than monthly who had a change in appetite or refusal to eat, and poor fluid intake. A referral was not provided to the RD when there was a decline in resident #025's food and fluid intake. The resident had a decline in their food intake of a specific percentage (half or less) of their meals on specific days in 2016. A referral related to the decline in intake was not made to the RD. The resident was also not meeting their hydration target on any day during a specific period of time in 2016, and a referral was not initiated related to the poor hydration. A referral was made on a specific day in 2016, related to significant weight change; however, the referral did not reflect the decline in intake or poor hydration. Registered staff #128 stated that referral forms for the RD were in the RD referral binder and that the RD would sign the forms when completed and put the completed forms into the residents' chart.
A copy of a referral related to the decline in intake/poor hydration was not in the resident's clinical health record. The RD confirmed a referral was not received for poor intake/hydration.
The home failed to comply with the above mentioned policies. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used that the residents' bed system was evaluated and that residents were assessed in accordance with prevailing practices, to minimize risk to the resident.

A) The residents' bed systems were not all evaluated in accordance with Health Canada's guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Latch Reliability, and Other Hazards". The guidelines established included that bed systems be re-evaluated after changes were made to the bed, such as a mattress change or when the mattress began to age and soften. According to records maintained by the licensee, the bed systems in the home were last evaluated by maintenance staff for entrapment zones during a specific time period in 2012, using an approved bed safety device measurement tool as per Health Canada's guidelines. The results of the evaluation identified that over 40 beds failed one or more entrapment zones 2, 3 or 4 and approximately 40 other beds were not evaluated. The bed systems that were not tested in 2012 were not evaluated in 2013, 2014 or 2015. According to the Administrator, the home received 10 new electric beds in 2013 and 20 new mattresses in 2015. The beds that received the new mattresses were not re-evaluated. On an identified date in 2016, records were provided that indicated that seven beds with new mattresses were

evaluated for entrapment zones and all seven failed entrapment zone 4 (the space at the end of the rail). An evaluation of all of the bed systems in the home was not completed.

B) The licensee did not ensure that all residents who used one or more rails, were assessed in accordance with prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada). According to the guideline, residents were to be evaluated by an interdisciplinary team, over a period of time while in bed. To guide the assessors, a series of questions would be completed to determine whether the bed rail(s) were a safe device for resident use. The guideline also emphasized the need to document clearly whether alternative interventions to the use of bed rails were trialed prior to their application and if the interventions were appropriate or effective, if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would be the residents’ medical status, cognition, behaviours, medication use, mobility and any involuntary movements, falls risks, toileting habits, sleeping patterns or habits (if next to a rail and along edge of bed), environmental factors and the status of the residents’ bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessors in making a decision, with either the resident or their Substitute Decision Maker (SDM) about the necessity and safety of a bed rail (medical device). The final conclusion would then be documented as to why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.
The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not fully developed in accordance with prevailing practices as identified in the above noted guideline. According to the licensee's policies, no direction had been developed to clinically assess residents for entrapment and other bed rail hazards. Their policies related to bed rails included “RCM09-01-01 Restraints” and “RCM09-01-02D PASD Assessment”, both dated 2014. These policies focused on whether the resident could or would use a bed rail for a specified reason (typically bed mobility, transfers from and to bed and repositioning) or if the bed rails would serve as restraints for the resident. No safety evaluations were included. Verification was made with the ADOC that the "PASD Assessment" was completed for all residents; however, the questions and processes identified in the prevailing practice guidelines identified above were not fully included. No reference was made in the policy regarding a conclusion of potential risk, whether their bed system passed or failed any entrapment

zones and how to ensure that the bed rail was safe for the resident in their assessed condition. According to the ADOC, she was not aware of the above noted guideline and therefore did not incorporate it into their clinical process of reviewing residents in their bed systems for hazards associated with bed rail use.
At the time of inspection, several residents were observed lying in bed, each with one or more bed rails in use. The rest of the beds in the home were unoccupied at the time of observation and more than 70% had one bed rail either in the transfer position or in the guard position. Verification was made that for the residents identified below, bed rails were determined to be required as a personal assistance services device (PASD). None of the residents' assessments identified what safety risks the use of a bed rail posed (if any) to the resident and what interventions were necessary to reduce those risks.

- Resident #038 was not in bed at the time of observation but their bed was observed to have the left side assist rail in the transfer position and the right side assist rail in the guard position. The resident was interviewed and said that they did not know why the staff kept leaving one of their bed rails in the guard position. The resident's written plan of care indicated that the resident was independent for bed mobility and verified that a bed rail was used for repositioning. The resident's "Personal Assistance Services Device (PASD) Assessment" form was blank when reviewed in the chart. The resident's bed was not evaluated for entrapment zones. The licensee provided a binder titled "Bed Entrapment Audit Binder" with the bed measurement test results for all of their beds. However, the "Bed system measurement device test results worksheet" for the bed was not found in the binder.
- Resident #056 was not in bed at the time of observation but had their left side assist rail in the transfer position and their right side assist rail was in the guard position. The resident had an identified mattress on the frame. The resident's written plan of care indicated that the resident required two bed rails up when in bed, although the type of rail was not identified. It was also indicated that the resident required half rails as a PASD. As per an identified "Personal Assistance Services Device (PASD) Assessment" document, found in the resident's chart, a PASD was considered for positioning and to off load pressure. The resident's bed was not did not appear to be evaluated for entrapment zones. In 2012, the bed was not tested for entrapment zones as evidenced by the blank "Bed system measurement device test results worksheet" found in the home's "Bed Entrapment Audit Binder".
- Resident #054 was not in bed at the time of observation but had their left side assist rail in the transfer position and their right side assist rail in the guard position. The resident's written plan of care indicated under the specific task of "transferring" that the resident required the use of bed rails for bed mobility or transfer. While under the task of "bed

mobility", it indicated that resident was to be encouraged to grab onto the bed rail when staff assisted the resident to turn over in bed. The resident's identified "Personal Assistance Services Device (PASD) Assessment" document, found in their chart was not fully completed. The document indicated "assist bed rails" under the bullet "Why is a PASD being considered?" The resident's bed did not appear to have been evaluated for entrapment zones. The "Bed system measurement device test results worksheet" for this bed was not found in the home's "Bed Entrapment Audit Binder".
- Resident #055 was not in bed at the time of observation but their bed was observed to have their left side assist rail in the transfer position and the right side assist rail was in the guard position. The resident had an identified mattress on the frame. The resident's written plan of care indicated that the resident was required to use assist bed rails as PASD, for bed mobility, turning and positioning. As per an identified "Personal Assistance Services Device (PASD) Assessment" document, PASD was considered for bed mobility such as turning and re-positioning and that the assist bed rails were to be used during day, evening and nights. The resident's bed did not appear to have been evaluated for entrapment zones. In 2012, the bed was not tested for entrapment zones as evidenced by the blank "Bed system measurement device test results worksheet" found in the home's "Bed Entrapment Audit Binder".
- Resident #039 was observed lying in bed on an identified mattress. Their left assist rail was in the transfer position and their right assist rail was in the guard position. There was no information in the resident's care plan regarding the use of bed rails. The ADOC confirmed that bed rails were not included in the resident's current written plan of care but should have been. As per an identified "Personal Assistance Services Device(PASD) Assessment" document, found in the resident's chart, a PASD was considered for mobility and that quarter sized bed rails were to be used when the resident was in bed. However, the assessment sheet did not identify the quantity of bed rails to be used or on what side. The resident's bed did not appear to have been evaluated for entrapment zones. In 2012, the bed was not tested for entrapment zones as evidenced by the blank "Bed system measurement device test results worksheet" found in the home's "Bed Entrapment Audit Binder".
- Resident #018 was observed lying in bed on an identified mattress with identified side assist rails in the guard position. The resident's written plan of care indicated that the resident required assist rails as a PASD for bed mobility. There was no information in the resident's written plan of care that indicated the reason for the identified side rails. According to the ADOC, the rationale was to prevent identified injuries. As per an identified "Personal Assistance Services Device(PASD) Assessment" document, found in the resident's chart, a PASD was considered for bed mobility/ turning/ positioning and also indicated that assist bed rails were to be used day/ evening/ night. The resident's

bed did not appear to have been evaluated for entrapment zones. "Bed system measurement device test results worksheet" for this bed was not found in the home's "Bed Entrapment Audit Binder".
The safety status of the above noted beds, whether they passed or failed any zones of entrapment, could not be determined. The risk of entrapment was present for all of the above residents as they had not been adequately evaluated and did not have their bed systems evaluated. [s. 15. (1) (a)]

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. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee failed to ensure that the lighting requirements set out in the lighting table were maintained.

The home was built prior to 2009 and therefore the section of the lighting table that was applied was titled "In all other areas of the home". A hand held non-digital light meter was used (Sekonic Handi Lumi) to measure the lux levels in a three-bed ward bedroom, one private room and one semi-private room, tub and shower rooms, several resident ensuite washrooms and corridors on both 3 East and 3 West. The meter was calibrated before use and held a standard 30 inches above and parallel to the floor. Window coverings were drawn in the resident bedrooms measured and lights were turned on five minutes prior to measuring. Areas that could not be measured due to natural light infiltration were dining rooms. Outdoor conditions were bright during the measuring procedure. The minimum required lux for all resident areas is a general 215.28 lux (bedrooms, washrooms, lounges, dining rooms, showers, tub rooms). The areas specifically measured were areas where activities of daily living occurred such as walking, dressing, bathing, reading and care at bedside. The minimum required lux for all corridors is a continuous and consistent lux of 215.28. The minimum required lux level under any reading light or over bed light is 376.73 lux.
The home was configured with two home areas, one on the east side of the building with 27 resident rooms and one on the west side of the building with 18 resident rooms. The lighting fixtures were different on each side. The bedrooms on the east side did not have any central ceiling light fixtures in resident bedrooms with the exception of an identified room. The bedrooms on the west side were equipped with central ceiling light fixtures however they were not capable of producing enough light to meet the minimum requirement of 215.28 lux. Resident ensuite washrooms all had compliant lighting levels on both east and west sides.

A) East side
- An identified private bedroom was measured on an identified date in 2016, and was similarly equipped as all of the other private rooms on the east side. The identified room had a small square wall mounted reading light (located above and to the side of each bed) consisting of either one incandescent light bulb or a compact fluorescent bulb and a recessed pot light with a compact fluorescent light bulb at the entrance to the room. The entrance into the bedroom was 150 lux under the pot light and the entrance way was over five feet long. The centre of the room was 20 lux with all of the lights on. The lux under the over bed light was 220. The lux in and around the bed was 20-100 lux.

- An identified three-bed ward bedroom was measured on an identified date in 2016, and was similarly equipped with the same light fixtures as all of the other three-bed ward bedrooms. The identified room had a small square wall mounted reading light consisting of either one incandescent light bulb or a compact fluorescent bulb and a recessed pot light with a compact fluorescent light bulb at the entrance to the room. The entrance into the bedroom was adequate; however, the centre of the room or near the foot end of two beds and between the two beds was 50-100 lux. The third bed was in a separate area of the room. The over bed lux level for bed 1 was 390 and for beds two and three, the lux was 290. All three had a compact fluorescent light bulb in the fixture.
- Semi-private rooms were all equipped with the same light fixtures as the private and three-bed ward bedrooms with the exception of one identified room which was equipped with two pot lights in the room and fluorescent tube reading lights located over the beds. The identified room was compliant for illumination levels. The other semi-private rooms were not compliant for general room light or reading light levels based on the levels achieved in the private bedroom and three-bed ward bedrooms noted above.
- The two corridors on the east side were equipped with troffer (slightly above the ceiling tiles with an opaque lens that was flush with the ceiling tiles) light fixtures with four foot long fluorescent tubes each. The corridor also included fluorescent tubes above each resident bedroom entry with a louvered lens. The troffer fixtures were spaced 14-20 feet apart thereby creating a very inconsistent lux level. The areas between the troffer fixtures were 100 lux between two identified rooms. The area across from one of the identified rooms was 175 lux. The lux under the troffer fixtures was adequate at over 600.
- The east side shower room was equipped with two separate shower stalls, the walls covered in dark green tiles (which will absorb a lot of light). Just outside both stalls, a fluorescent ceiling fixture was provided which was 410 lux, however the lux inside of each stall dropped to 50-100 lux. This measurement did not include closing the privacy curtain for each stall and standing inside.

B) West Side
- An identified private bedroom was measured on an identified date in 2016, and was similarly equipped as all of the other private rooms on the west side. The identified room had an over bed reading light equipped with a fluorescent tube, no entry light and a central ceiling mounted light with opaque lens. The lux directly under the central light was 110 lux. The foot of the bed was 180 lux and the side of the bed was 150 lux. The over bed light was adequate at 400 lux.
- The semi-private and three bed ward bedrooms on the west side were not compliant for general room light based on the levels achieved in the private bedroom noted above.
- The two corridors on the west side were equipped with troffer light fixtures with four foot

long fluorescent tubes each. The corridor also included wall mounted sconce lights between the troffer fixtures. The illumination levels were adequate as the troffer fixtures were spaced 10 feet apart and the sconce lighting increased lux levels between troffer fixtures. One area, located near an identified room was not adequate. The ceiling consisted of two pot lights for a length of approximately 12 feet. The lux in this area was approximately 100-150.
- The shower/tub room was equipped with one tub and two shower stalls. The light fixtures provided included 2 semi-flush ceiling mounted fixtures. The lux over the tub was 110, the lux over the sink was 120, the lux in the roll in shower stall was 50 and the lux for the shower stall with the raised floor was 135.
Illumination levels would need to be verified throughout the home at a time whereby the outdoor natural light would not impede the light meter readings where residents have access to ensure compliance with the lighting table. [s. 18.]

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. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were bathed, at a minimum, twice a week by the method of their choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) Resident #018 had a written plan of care indicating that the resident received a bath twice a week and as necessary (PRN) and was totally dependent on the staff. The resident was not interviewable. PSW #103 who provided direct care to the resident was interviewed and indicated that the resident received a bath on Thursdays only.

Registered staff #101, in an interview, stated that the resident was supposed to receive a bath on Tuesdays and Fridays. Staff were to document in point of care (POC) once they received a shower or bath. The POC was reviewed for a specific period of time in 2016, and there was documentation indicating the resident received a bath on four days in 2016. There was no documentation indicating that the resident refused.
Resident #018 was not bathed at minimum twice a week as indicated in their written plan of care.

B) On a specific day in 2016, resident #034 was interviewed and indicated that they received a shower only once a week, and that they were not offered a choice between a bath and a shower. The resident stated they would prefer to get a bath in the tub. The clinical health records were reviewed and indicated that the "Admission Nursing Assessment/24 HR Care Plan" form did not specify the resident's preference for either a bath or a shower. The documentation was incomplete in identifying the resident's preference.
On a specific day in 2016, resident #005 was interviewed and indicated that they got a shower twice a week but the home did not ask their preferred method of bathing. The Admission Nursing Assessment/24 HR Care Plan form was reviewed and the preference for a bath or shower was not documented.
PSW #107 was interviewed and stated that the tub on a specific unit had not been used in 14 years. PSW #102 also indicated that the tub on the unit had not been used in a long time.
PSW #108 stated that they did not think that the tub was even connected and residents did not receive tub baths on an identified unit.
PSW #115 on a specific unit stated that none of the residents on the unit received tub baths and the tub had not been used for the past two years.
PSW #116 on a specific unit stated that none of the residents received tub baths and that they had never used the tub.
PSW #117 stated that the tub on a specific unit had not been in use in a long time and the reason might have been that the water pressure was too low.
Registered staff #106 was interviewed and indicated that the tub on a specific unit was not functioning and that it was the only one that staff had access to. The residents did not receive tub baths.
The home's policy # RCM05-01-04, titled "Bathing preference", effective December 2014, indicated that, "every resident will be bathed at a minimum twice a week, by the method of his or her choice, and more frequently as determined by the resident's hygiene requirements. On admission, ask resident/SDM the resident's preferred bath type".
The Administrator was interviewed and indicated that the residents should have a choice

between a bath or a shower offered to them on admission. The Administrator confirmed that the tubs on all units were functioning and staff were expected to use the tubs if residents preferred to be bathed in the tub. [s. 33. (1)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

An interview with resident #035 revealed the staff did not cut their toenails and they were unable to cut them as a result of their medical condition. The resident stated their toenails had not been cut in several weeks, and they had been informed by the home there was a monthly charge for nail cutting. The resident confirmed that they were not diabetic and did not have brittle toenails or any other conditions of their feet.
Review of the resident's written plan of care indicated that they required extensive assistance and should receive a visit from the foot care nurse every six weeks.
Registered staff #104, in an interview, stated that residents' toenails were not cut by staff as it was a paid service from an outside contract service. Registered staff #106 stated the registered staff should cut the residents' toenails.
PSW #117 stated toenail cutting for residents was not done by staff as it was a paid service only.

PSW #108 stated staff did not cut resident #035's toenails.
Review of policy #RCM05-02-06, titled "Nail Care – Toenails", effective date December 2014, stated "Each resident will receive preventative and basic foot care services including cutting of toenails, to ensure comfort and prevent infection" and "Direct care staff do not cut: thickened or brittle nails, nails of diabetic residents', residents' who have contracted an outside service eg. We Care/Arvan".
The Administrator and the DOC confirmed registered staff were expected to cut all non-diabetic residents' toenails, including resident #035, unless they paid for the outside service. [s. 35. (1)]

2. The licensee failed to ensure that residents received fingernail care, including the cutting of fingernails.

A) During a family interview on behalf of the resident who was unable to participate in an interview, it was indicated by the substitute decision maker (SDM) that finger nail care was not provided to the resident by direct care providers in the home. The SDM indicated that the family trimmed resident #026's finger nails when they became too long.
An interview with PSW #113 indicated that for non-diabetic residents, PSW's or registered staff were supposed to trim all residents' nails on bath days twice weekly, and as required. Registered staff #104 stated that the nail care that may have been provided by staff to resident #026 had not been documented and was unsure of the last time a staff member provided nail care to this resident.
A review of the home's policy #RCM05-02-05, titled "Nail Care – Fingernails", effective date December 2014, stated that "nail care will routinely be done after resident's bath".
Interview with the DOC confirmed that staff were to provide nail care unless otherwise indicated and that the staff did not provide fingernail care to resident #026.(619)

B) During stage one of the inspection, resident #021 was observed to have fingernails that were long and dirty. The resident indicated that staff trimmed their nails only upon request. The written plan of care indicated that their fingernails needed to be trimmed short but did not indicate when they should be trimmed.
In an interview, PSW #112 indicated that all residents' fingernails were trimmed by the Charge Nurse, not the PSW staff.
The home's policy # RCM05-02-05, titled "Nail Care – Fingernails", effective date December 2014, indicated that fingernails were to be routinely done after the resident's bath and to document nail care on flow sheets.
The PSW flow sheets were reviewed for specific months in 2016. The flow sheets did not have a section to document nail care and on a specific flow sheet it was documented that

staff completed nail care only on one day in a specific month in 2016.
The DOC confirmed in an interview that the fingernail care was to be done by registered staff, except for residents who had diabetes.
Resident #021 did not receive fingernail care including cutting of their fingernails.(561)

C) During stage one of the inspection, resident #021 was observed to have fingernails that were long and dirty.
An interview with the resident revealed the staff did not cut their nails. They stated their nails had not been cut in several weeks, and they had been informed that there was a charge for nail cutting.
A review of the "Flow sheet" for an identified time period in 2016 for resident #035 revealed that for the entire month, there was no documentation completed to confirm their fingernails had been cut, or that the resident had refused to have their fingernails cut except on one identified date.
Review of the residents written plan of care indicated that they required extensive assistance and should receive a visit from the foot care nurse every six weeks.
Review of the home's policy #RCM05-02-05, titled "Resident Care – Nail care – Fingernails", effective date December 2014, indicated, "review resident's plan of care prior to procedure; procedure will routinely be done after the resident's bath; document nail care on the Daily Flow Sheet".
In an interview, PSW #108 stated that staff, nor the resident's spouse cut their nails. They confirmed that the resident required extensive assistance with hygiene care.
In an interview, registered staff #106 and the DOC confirmed the PSW staff were expected to cut the residents' fingernails on shower days and as needed and to document the care. (591) [s. 35. (2)]

Additional Required Actions:

CO # - 005, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

A) Observations on a specific day in 2016, revealed registered staff #104 and PSW #112 transferred resident #021 from a wheelchair to an armchair in their room. A "sit-to-stand" mechanical lift was used to transfer the resident.
The resident was interviewed and indicated that the staff used the "sit-to-stand" lift for transfers and indicated that they sustained an injury during the transfer.
The progress notes were reviewed and confirmed the incident. Resident #021's written plan of care indicated that the resident was assessed by the Physiotherapist on a specific day in 2016, and their transfer status was changed from "sit-to-stand" lift to a "hoyer" lift.
The Physiotherapist was interviewed and confirmed that they had assessed the resident and the "sit-to-stand" lift was unsafe to use for this resident. The written plan of care was updated and indicated that the "sit-to-stand" lift was unsafe to use.
In an interview, both registered staff #104 and PSW #112 indicated that the resident was to be transferred using a "sit-to-stand" lift. Registered staff #104 had revised the written plan of care indicating that a "sit-to-stand" lift may be used "if resident insists".
A review of the home's 2015 training records for lifts and transfers indicated that only seven out of 24 registered staff (29 percent) completed training on lifts and transfers.
An interview with the DOC revealed that registered staff were not required to attend education on lifts and transfers as they did not use the lifts and did not transfer residents. However, resident #021 was observed being transferred by a registered staff member with a PSW using the mechanical lift as mentioned above.
An interview with the DOC confirmed that the registered staff did not follow the Physiotherapist's assessment and should not have revised the written care plan. The written plan of care was revised the same day to reflect the transfer status as assessed by the Physiotherapist.(561)

B) Resident #049 had two falls in 2016:
- On a specific day PSW #131 transferred resident #049. The mechanical lift malfunctioned and the resident had a fall, resulting in the resident being injured.
- On another specific day, PSW #132 transferred resident #049 from their bed to their wheelchair using the mechanical lift without assistance. During the transfer, the mechanical lift malfunctioned and the resident had a fall, resulting in the resident being injured.
A review of the resident's written plan of care effective at the time of the injury, indicated

the resident was to be transferred safely by two staff using a mechanical lift.
A review of the home's policy #HS-04-02-06, titled "Minimal Lift Policy and Procedures" effective January 2013, indicated that, "Two persons are required when using the mechanical lift; one person to operate the device and one person to support and guide the resident".
During an interview, PSW #131 confirmed that they transferred resident #049 using a mechanical lift on their own, while they were waiting for another PSW to come and assist them. PSW #131 confirmed that two staff were required when transferring residents using the mechanical lift.
During an interview, the DOC stated that both of the above mentioned falls sustained by resident #049 in 2016, were a result of unsafe transfers; where the staff mentioned, performed the transfers independently instead of with two persons while using a mechanical lift. The DOC stated that during the home's internal investigation of the first incident, PSW #131 confirmed they did not have a second person during the transfer.
The DOC confirmed that the home's internal investigation of the second incident revealed that PSW #132 transferred resident #049 using a mechanical lift by themself.
The DOC stated that upon completion of their investigation, action was taken.
The DOC confirmed that the home's expectation was that two staff should have transferred resident #049 with a mechanical lift, and both PSWs mentioned above did not safely transfer the resident on both incidents.(653) [s. 36.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: 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.

Findings/Faits saillants :

1. The licensee failed to ensure that action was taken and outcomes were evaluated for significant weight changes and any other weight change that compromised the residents' health status.

A) Resident #026 had significant weight loss over several months on two occasions in 2016. Action was not taken to address the significant weight loss and the resident's written plan of care was not revised with strategies to ensure adequate nutritional intake during that period. The resident had poor intake of both food and poor hydration (the resident had met their hydration target on only four days during a specific period in 2016).
The RD identified the resident's significant weight loss was positive and continued with the same plan of care, and had not evaluated the resident's poor hydration and poor intake in relation to the significant weight loss.

B) A review of resident #047's written plan of care identified a goal for weight loss closer to the resident's goal weight range. The goal had been in place for over one year. The resident continued to gain weight with weight increase over one year from a specific period of time between 2015 and 2016, with the resident's weight at an "Obese Class II" status. The resident had gained an specific amount of their body weight since admission in 2014. Strategies related to weight management had been in place prior to a specific period of time in 2015, and had not been revised thereafter.
In an interview, the RD confirmed that the strategies on the resident's written plan of care had not been effective for weight loss and that the strategies or goals had not been revised when the plan had not been effective. Action was not taken to address the ongoing weight gain and outcomes were not evaluated in relation to goals specified on the resident's written plan of care. [s. 69.]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee failed to ensure that residents were not charged for goods and services that a licensee was required to provide to residents using funding that the licensee

received from the Minister under section 90 of the Act.

Observations throughout the inspection revealed several residents with long toenails.
In an interview, resident #005 stated that staff had not offered to cut their toenails since their admission to the home, and the resident confirmed that they were not diabetic nor did they have brittle nails or any other conditions with their feet or toenails. This information was confirmed by review of the resident's clinical health record. The resident's toenails were observed to be long and dirty.
In an interview, resident #027 stated that they paid the home a sum of money monthly for their toenails to be cut by an outside service as they had been instructed that staff at the home did not cut resident toenails. The resident also confirmed that they were not diabetic and did not have brittle or thickened toenails, or any issues with their feet or toenails. This information was confirmed by review of the resident's clinical health record.
In an interview, resident #021 stated that they had paid the home a sum of money monthly for an outside service to cut their toenails as they understood that staff at the home did not cut toenails. The resident also confirmed that they were not diabetic and did not have brittle or thickened toenails, or any issues with their feet or toenails. This information was confirmed by a review of the resident's clinical health record.
In an interview, registered staff #104 stated that residents' toenails were not cut by staff as it was a paid service from an outside contract service. Registered staff #106 stated that the registered staff should cut the residents' toenails. PSW #117 stated toenail cutting for residents was not done by staff as it was a paid service only. PSW #100 stated staff do not cut residents' toenails.
A review of policy #RCM05-02-06, titled "Nail Care – Toenails", effective date December 2014, stated, "Each resident will receive preventative and basic foot care services including cutting of toenails, to ensure comfort and prevent infection" and "Direct care staff do not cut: thickened or brittle nails, nails of diabetic residents, residents who have contracted an outside service. The policy did not include direction for staff to cut non-diabetic, non-brittle, or non-thickened residents' toenails.
A review of the document titled "Foot Care Consent and Authorization" stated, "Basic foot care includes assessing the condition of the feet, nail trim and cleanse….authorize Erin Mills Long Term Care to bill me the amount including applicable taxes per treatment and I agree to pay this monthly bill as full and appropriate payment for this Basic foot care service".
A request was made for the home to provide an updated copy of the total number of residents who gave consent for the contracted service provider to cut their toenails. A review of the document titled "Foot Care Consent List" provided by the home revealed that 51 of 83 residents gave consent for the contracted service to cut their toenails.

In an interview, the DOC stated that on admission, residents were offered foot care service through the contracted provider to provide care every four to six weeks. If they wanted the service, they were expected to sign a consent form. They confirmed that not all of the residents who provided consent were diabetic or had thickened or brittle nails, and further confirmed that residents who were not diabetic or do not have thickened or brittle nails should not be expected to pay for the care, and should have their toe nails cut by the registered staff.
In an interview with the contracted service provider, the company owner confirmed that residents were billed an identified sum of money monthly for a foot care nurse from their company to provide "advanced", not "basic", foot care to consenting residents every four to six weeks.
In an interview, the Administrator stated that the home's expectation was that basic foot care should be performed by the registered staff, and if the resident was diabetic or had brittle nails, they should be referred to the physician who would cut their toenails unless they had paid for the contracted service. The Administrator confirmed that this direction was not included in the related policy. They stated that though the "Foot care Consent and Authorization" form stated "Basic Foot care service", the care provided to the residents was in fact "advanced" foot care. The Administrator stated that of the charges to the residents, a portion of the charges went to the home and a portion went to the contracted service each month and when combined, totaled the amount charged to the residents.
During the course of the inspection, the Administrator provided a document titled "Erin Mills Lodge – Provision of toenail Care; 2016 Plan for improvement of Process for Toenail care provision" and also an updated "Foot Care Consent and Authorization" form.

The licensee charged for basic toenail care that they were required to provide to residents using funding that the licensee received from the Minister under section 90 of the Act. [s. 245. 1. ii.]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the residents' rights to be afforded privacy in treatment and in care for his or her personal needs, were fully respected and promoted.

A) On a specific day and time in 2016 in the dining room on a specific unit, resident #041 was observed sitting in their wheelchair with their dress untied, exposing their body. Other residents were sitting close to the resident in the dining room and staff members were also present. The Inspector informed a PSW staff of the exposure and they immediately fixed the resident's clothing, and covered them. The staff confirmed that the resident should not be exposed.
Resident #041 was not afforded privacy by the staff in caring for their personal needs. (561)

B) On a specific day and time in 2016, an Inspector walked by a room and saw from the hallway that resident #051 was uncovered while their brief was being changed by PSW #123. The door to the room was ajar, the curtains around the resident's bed had not been pulled, and the resident was visible from the hallway and to their roommate who was also in bed at the time.
The PSW in an interview stated that another staff had left and they had not closed the curtains, and confirmed the curtains should have been closed.
The resident was not afforded privacy by staff in caring for their personal needs.(107)

C) Resident #035 in an interview stated that PSW #111 when they assisted them to the shower daily, draped a towel over them which often fell off or would get caught in the wheelchair wheels, exposing their body to other residents in the corridor to the bathroom.

PSW #111 in an interview stated they undressed the resident and draped a towel over their lap to transport them to the bathroom which had fallen off on occasion.
The DOC, as a result of an investigation, confirmed resident #035 had been exposed on occasion as a result of the drape placed on them by PSW #111 falling off and confirmed privacy was not adequately provided for the resident.(591) [s. 3. (1) 8.]

2. The licensee failed to ensure that every resident had the right to 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.

A) An Inspector observed the nursing office room door on a specific unit beside the nursing station was ajar. The medication cart was stored inside the room and in the garbage attached to the medication cart were empty medication boxes and bottles that contained residents' personal health information, which included their name, date of birth, the type of medication, dosage, and administration instructions.
Registered staff #101 in an interview confirmed that the door to the nursing office was always open and confirmed that the labels from the medication boxes and bottles should have been taken off and shredded.
The licensee did not ensure that residents' personal health information was kept confidential in accordance with the Act.(561)

B) An Inspector observed three mobile x-ray requisitions taped to the photocopier in plain sight on a specific unit. The requisitions included the personal health information of

residents #050, #051, and #052 including their full name, birthday, health card number, type of x-ray requested, and reason for diagnostic imaging.
An interview with registered staff #109 revealed that the x-Ray requisitions were taped to the photocopier for the mobile x-Ray technician to collect on arrival and confirmed that the requisitions should be stored out of public sight. The staff immediately removed the requisitions from the area.
An interview with the DOC confirmed that the registered staff should meet with the external service provider prior to the administration of tests at which point the registered staff should provide the x-Ray requisitions to the mobile x-Ray technician. The DOC confirmed that the residents' personal health information was not protected.(619) [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs and,

to ensure that every resident has 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, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

s. 6. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 plan of care set out clear directions to staff and

others who provide direct care to the residents.

The Personal Assistance Services Device (PASD) Assessment for resident #021, indicated that the resident had two bed rails engaged while in bed.
PSW #112 who provided direct care for the resident was interviewed and was not certain how many bed rails for the resident were to be engaged, and thought only one was to be applied.
The resident was interviewed and indicated that both rails were engaged while they were in bed.
A review of the resident's written plan of care directed staff to "use quarter bed rail for bed mobility".
The DOC in an interview confirmed that the written plan of care, used as a guide to instruct staff how to provide resident care should give clear directions to staff, and if the above mentioned resident required two bed rails, it should be stated as such in their in written plan of care.
The home did not ensure that the written plan of care set out clear direction to staff that provided direct care to resident #021. [s. 6. (1) (c)]

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

In an interview of family conducted on behalf of resident #026, they stated that the resident and family would prefer to have the home's staff provide nail care.
A review of the resident's written plan of care did not include any documentation related to the provision of nail care.
PSW #113 indicated that the resident was incapable of trimming their finger nails on their own and required assistance from staff to complete this task and that they were not aware of the family's preference for staff to complete this task.
Registered staff #104 in an interview stated that finger nail care was not included in the resident's written plan of care, and was unable to provide documentation to confirm staff were providing the care to resident #026.
The DOC in an interview confirmed that the resident was not receiving nail care from the home's staff as per the resident's and their family's preference, and that the written plan of care was not based on an assessment of resident #026's needs and preferences. [s. 6. (2)]

3. The licensee failed to ensure that the staff and others involved in the different aspects of care of the residents collaborated with each other in the assessment of the residents

so that their assessments were integrated, consistent and complemented each other; and in the development and implementation of the plan of care so that the different aspects of care were integrated and consistent and complement each other.

A review of clinical health records indicated resident #042 was transferred to the hospital on a specific day in 2016, for a medical condition.
A review of the resident's 2015 PSW flow sheets indicated 14 occasions where the resident experienced the medical condition over a period ranging from four to nine consecutive days.
A review of the resident's 2015 written plan of care did not include the medical condition.
A review of the resident's quarterly MDS assessments from 2015 to 2016, indicated that the medical condition was not identified.
A review of the resident's progress notes indicated that in 2015, the physician documented an assessment which included orders. A review of a home policy related to the resident's medical condition, directed staff to "Complete nursing and medical assessment to determine cause and then appropriate intervention(s) as indicated. Document assessment findings in the progress notes and update the plan of care as required. Assessment to include resident's history, physical examination, review of an identified record and referral to the Dietitian for assessment".
During an interview, registered staff #104, the FSM and PSW #112 stated that the resident had a history of the medical condition. According to registered staff #104 and the FSM, resident #042 was hospitalized prior for the medical condition.
During an interview with registered staff #106, they confirmed that the medical condition was not addressed on the resident's written plan of care prior to their hospitalization in 2016. Registered staff #106 also confirmed that the medical condition was not identified in resident #042's quarterly MDS assessments between 2015 and 2016.
Registered staff #104 and #106 confirmed that a dietary referral should have been completed related to the resident's medical condition, but a referral was not made.
Registered staff #106 confirmed that the interdisciplinary team did not collaborate in assessing the resident in relation to their medical condition, and the condition was not added to the written plan of care when it was identified.
During an interview, the DOC confirmed that if the resident had the medical condition on going, a dietary referral should have been completed and the problem identified in the written plan of care with relevant interventions. The staff involved in the different aspects of care of resident #042, did not collaborate with each other in the assessment of the resident, and in the development and implementation of her written plan of care.(107) [s. 6. (4) (a)]

4. The licensee failed to ensure that the care set out in the plan of care for residents were provided to the residents as specified in the plan.

A) In 2016, the RD identified that resident #025 was to receive a nutrition intervention after meals which the resident did not take on three specific days in 2016, and the lunch meal on nine other days in 2016. The intervention was not provided as per the directions from the RD. The resident had weight loss in one month, further weight loss in another month, and they were below their goal weight range with a goal for weight maintenance. (107)

B) A review of progress notes indicated resident #048 was assessed by the Speech Language Pathologist (SLP) in 2015, who recommended staff should not provide the resident with an item at meals and snacks. The resident had a medical condition and was at risk for a medical event.
A review of the resident's written plan of care indicated the item was to be provided to the resident. In 2015, documentation in the progress notes identified staff provided the resident with the item, which was contrary to the direction indicated in the resident's written plan of care and the recommendations from the SLP. The family directed staff not to provide the resident with the item, as per the progress notes.

C) Observations during the afternoon snack pass in 2016, revealed not all residents received the snacks as set out in their written plans of care.
A review of the written plan of care for residents #058 and #034 indicated that they required a choice of beverage at snacks and that staff were not to offer juice. During an observation of the snack pass by an Inspector, staff did not ask either resident their preference of beverage and gave them both a glass of juice.(107)

D) An interview with resident #035 revealed they required assistance with toileting and when toileted by staff, were left unattended for long periods of time. The resident stated they had waited a long time for assistance after ringing the call bell, and that sitting on the toilet for extended periods of time had caused them pain. They further stated on two occasions they had slid to the floor from the toilet as they were unable to tolerate the discomfort.
A review of the resident's written plan of care indicated the resident required extensive assistance with toileting and was not to be left unattended when on the toilet but provided with privacy.
An interview with PSW #108 revealed the resident was assisted to the toilet, and they were left with instructions to ring the bell when they were finished, to provide them with

privacy as requested. The PSW confirmed they cared for other residents until the resident called for assistance, at which time they would return to assist them.
In an interview with the DOC, PSW #111 stated that they had left resident #035 on the toilet to care for other residents and returned when the resident rang the bell. The DOC also confirmed the resident should not be left unattended, but staff should remain outside the bathroom to provide for privacy until the resident was finished and further confirmed that care was not provided to resident #035 as per their written plan of care.(591) [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the residents care needs changed or care set out in the plan was no longer necessary.

Resident #025's room was observed during stage two of the inspection and there was a signage above the resident's bed indicating that the resident required a ceiling lift for transfers. The resident's clinical health records were reviewed and their written plan of care indicated that the resident used a hoyer lift for transfers. No recent transfer and lift re-assessments could be found.
PSW #112 was interviewed and indicated that they used the ceiling lift to transfer the resident. PSW #108 was interviewed and stated that they could not remember when the resident started to use the ceiling lift. Registered staff #104 was interviewed and indicated that the resident required a ceiling lift. The registered staff could not recall when the type of transfer was changed from the hoyer lift to ceiling lift and stated that they would make the change in the written plan of care.
The DOC was interviewed and confirmed that the written plan of care should have been updated when there was a change in the type of lift used for resident #025. [s. 6. (8)]

6. The licensee failed to ensure that the residents plan of care was revised at least every six months and at any other time when the residents care needs changed or care set out in the plan was no longer necessary.

A) Resident #004 was admitted to the home in 2015. Their "Admission Nursing Assessment/24 HR Care Plan" form indicated that the resident required assistance with the set up to clean their own teeth.
A review of an MDS Assessment completed in 2016, indicated that the resident required total dependence on staff for personal hygiene care including oral care.
In an interview the resident indicated that they did not always receive oral care in the evening.

PSW #118 was interviewed and indicated that the resident required assistance for oral care in the evening but they refused many times.
Registered staff #101 indicated that the resident was not able to do their own oral care and required assistance from staff.
A review of the written plan of care indicated that the resident needed a lot of encouragement to brush their own teeth. The written plan of care was not revised with the current needs for oral care and as indicated in the MDS assessment.
The DOC confirmed in an interview that the written plan of care should have been revised when there was a change in resident #004's oral status.(561)

B) A review of resident #025's written plan of care indicated that the resident used two bed rails as Personal Assistance Services Device (PASD) while in bed.
PSW #112 was interviewed and indicated that the resident used only one bed rail while in bed.
The DOC was interviewed and confirmed that the written plans of care should be reviewed by the PSW in point of care (POC) to guide care.(561)

C) Resident #044 was admitted to the hospital for a procedure in 2014, and then returned to the home. The resident's health records were reviewed and indicated that they had a physician's order for a procedure to be done in the home related to a medical condition.
The written plan of care was reviewed and did not include the procedure or any interventions related to the medical condition. A specific home policy provided instruction to update the written plan of care related to the procedure.
The DOC confirmed in an interview that it was the home's expectation that staff were to update written plans of care when there was a change in a residents condition.(561)

D) Resident #048 had a decline in their condition in 2015, as per documentation in the progress notes, which resulted in their hospitalization.
During a specific period of time, the resident was not reassessed in relation to their swallowing ability. The RD confirmed that the resident's swallowing ability was not assessed at the nutrition reviews. The resident's diet texture was not downgraded until requested by a specific person and a physician's order was written. The RD stated that there was no re-assessment of the resident's swallowing or acceptability of the diet texture/fluid consistency after the diet texture was downgraded.
A referral to the Speech Lanaguage Pathologist (SLP) did not occur when there was a significant change in the resident's ability to swallow and eat.
The SLP had been following resident #048 and upgraded their diet; however, when the

resident had a decline in condition, they were not re-assessed in relation to their swallowing ability or acceptability of the diet/feeding strategies.(107) [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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,

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,

to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other,

to ensure that the care set out in the plan of care is provided to the resident as specified in the plan,

to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, and

to 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 the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was properly calibrated so that the level of sound was audible to staff.

The resident-staff communication and response system was designed to use sound to alert staff when an activation station was activated. The sound system on the third floor in the west side of the building was tested and was transmitted from a single source located at the nurse's station which was located at the junction of two long corridors. When tested, the sound could not be heard while standing just inside a resident's room located at the end of each corridor. At the time of the test, very little competing noise was heard that could have masked the sound of the system.
The sound system for the resident-staff communication and response system on the third floor in the east side of the building was heard very well throughout the corridors; however, was highly pierced and quite disruptive.
Discussion with the Administrator was held regarding the need to ensure sound systems were calibrated adequately to not only be heard by staff but to ensure that the sound did not disturb or agitate residents by equalizing it. [s. 17. (1) (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that,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, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

In an interview with resident #043's family member, they stated that they were notified of an incident by PSW #133 to the resident by someone other than staff of the home. Review of the home's investigation notes revealed that PSW #134 confirmed they had witnessed the incident on two occasions in 2014. Investigation notes revealed registered staff #135 confirmed they witnessed the incident between the staff and the resident. Interview with the DOC revealed the investigation confirmed the incident between resident #043 and PSW #133, and actions were taken. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident is protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure any actions taken with respect to residents under a program, including assessments, reassessments, interventions and the residents responses to interventions were documented.

A) A review of the MDS Assessment dated 2016, for resident #004 indicated that the resident required total assistance for oral care.
In an interview, PSW #118 and registered staff #101 confirmed that the resident required assistance from staff for oral care.
PSW #118 indicated that the resident refused oral care in the evenings many times and it was an expectation that staff document the refusal in POC. The staff should then inform the registered staff about the refusal.
The PSW flow sheets were reviewed and indicated that for 28 days, on various shifts, it was not documented whether the resident received or refused oral care.
In an interview, the ADOC confirmed that it was the home's expectation that staff document the care provided to resident #004 in POC.(561)

B) A review of the "Dietary Report" for resident #040, which included the resident's daily

food and fluid intake, revealed documentation was incomplete; specifically for food intake at the afternoon and evening snack pass. In a specific month in 2016, documentation was incomplete on 24/29 days and 22/29 days for the afternoon and evening snack passes. In another month in 2016, documentation was incomplete on 25/31 days and 17/31 days at the afternoon and evening snack passes. In another month in 2016, documentation was incomplete on 19/30 days and 18/30 days at the afternoon and evening snack passes. On a specific day in 2016, documentation was incomplete on 22/27 days and 15/26 days for the afternoon and evening snack passes.
The Nutrition Manager(NM) and the DOC confirmed in an interview that documentation on the "Dietary Report" for resident #040 was incomplete.(107)

C) A review of the "Dietary Report" for resident #026, which included the resident's daily food and fluid intake, revealed documentation was incomplete; specifically for food intake at the afternoon and evening snack pass. In a specific month in 2016, documentation was incomplete on 20/29 days and 21/29 days for the afternoon and evening snack passes. In another month in 2016, documentation was incomplete on 25/31 days and 26/31 days at the afternoon and evening snack passes. In another month in 2016, documentation was incomplete on 28/30 days and 19/30 days at the afternoon and evening snack passes. In another month in 2016, documentation was incomplete on 28/30 days and 23/30 days for the afternoon and evening snack passes.
The Nutrition Manager(NM) and the DOC confirmed in an interview that documentation on the "Dietary Report" for resident #026 was incomplete.(107)

D) A review of the "Dietary Report" for resident #025, which included the resident's daily food and fluid intake, revealed documentation was incomplete; specifically for food intake at the afternoon and evening snack pass. In a specific month in 2016, documentation was incomplete on 24/29 days and 24/29 days for the afternoon and evening snack passes. In another month in 2016, documentation was incomplete on 24/31 days and 21/31 days at the afternoon and evening snack passes. In another month in 2016, documentation was incomplete on 25/30 days and 20/30 days at the afternoon and evening snack passes. In another month in 2016, documentation was incomplete on 21/26 days and 18/26 days for the afternoon and evening snack passes. Documentation on fluid intake at snacks was also incomplete for the morning, afternoon and evening snack passes (37 entries in a specific month, 36 entries in another month, 17 entries another month , and 26 entries for another month).
The Nutrition Manager(NM) and the DOC confirmed in an interview that documentation on the "Dietary Report" for resident #025 was incomplete.

E) A review of the "Dietary Report for resident #048, which included the resident's daily food and fluid intake, revealed documentation was incomplete; specifically for food intake at the afternoon and evening snack pass. In a specific month in 2015, documentation was incomplete on 26/28 days and 24/28 days for the afternoon and evening snack passes. In another month in 2015, documentation was incomplete on 26/31 days and 11/31 days at the afternoon and evening snack passes.
The Nutrition Manager(NM) and the DOC confirmed in an interview that documentation on the “Dietary Report” for resident #048 was incomplete.

F) Resident #046 was admitted to the home on an identified date in 2015, and was discharged on an identified date in 2015. The health care records were reviewed and indicated that the resident was not set up on the Electronic Medication Administration Record (EMAR). The Pharmacy Technician was interviewed and indicated that there was a system error with Medicare and the resident did not get set up in EMAR until a specific day in 2015; however, staff should have used the paper copy of the MAR for administration and signing of the medications.
The resident’s chart was reviewed and the "Medication Reconciliation and Admission Order" form and the MAR were completed. The MAR included all the medications, continued and discontinued. There were no times identified for medications to be administered. The Medication Reconciliation and Admission Order Form and the MAR both indicated that a specific medication and dosage by mouth, one tablet four times daily was discontinued. The MAR indicated that the registered staff signed for this medication that it had been administered at 1600 and 2000 hours on two days in 2015. A specific medication and dosage by inhalation was signed for as given only once daily on two days in 2015. All other medications were not signed for as given. The progress notes did indicate that medications were administered from the pouch in the morning on a specific day in 2015 but were not signed as given in the MAR.
Registered staff #106 was interviewed and confirmed the signature on the MAR but could not recall the details of what happened.
The DOC was interviewed and confirmed that if the resident was not set up on EMAR, the paper copy of the MAR should have been used and medications should have been signed for manually by the registered staff as given.
The licensee failed to ensure that the administration of medication to resident #046 was documented.(591) [s. 30. (2)]

Additional Required Actions:

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

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents received oral care to maintain the integrity of the oral tissue that included physical assistance to help the residents who could not, for any reason, brush their own teeth.

Resident #040 had a history of a disease and required extensive assistance by one staff for all activities of daily living including personal hygiene and grooming.
The resident indicated in an interview that they required assistance with oral care as they were physically unable to brush their own teeth. A review of the resident's oral care flow sheet indicated that the resident was not provided oral care in the evening for 12 days in a specific month in 2016.
An interview with PSW #112 revealed that they were aware that the resident required oral hygiene care at minimum twice daily and that should the resident refuse care to document it and report to the charge nurse.
Registered staff #106, in an interview, stated that the resident was dependent on staff to complete this task daily and confirmed that the resident did not regularly refuse oral hygiene care in the evenings.
The DOC confirmed in an interview that on the above mentioned dates, oral care was not provided to resident #040 who required physical assistance. [s. 34. (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 to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were offered a snack in the afternoon and evening.

An Inspector observed afternoon snack pass on a specific day in 2016, not all residents were offered a snack in addition to a beverage.
PSW #100 stated that residents on a specific unit did not receive a snack and were only to receive a beverage. A beverage was prepared and available for residents #024, #021, #034, #002, and #041.
A review of the written plans of care for those residents indicated that staff were to offer either the standard snack or a labeled snack. None of the residents' written plans of care indicated that they were to receive only a beverage and not a snack at the afternoon snack pass.
The Inspector observed on a specific unit that not all residents were offered a snack in addition to a beverage on a specific day in 2016:

- Resident #060 was offered a beverage only. The resident's written plan of care directed staff to offer a regular standard snack (a cherry tart).
- Resident #061 was offered a beverage only. The resident's written plan of care directed staff to offer a standard pureed snack.
- Resident #062 was offered a beverage only. The resident's written plan of care directed staff to offer a pureed standard snack.
- Resident #049 was offered a beverage only. The resident's written plan of care directed staff to offer the standard pureed snack.
- Resident #057 was offered a beverage only. The resident's written plan of care directed staff to offer a labelled snack at the afternoon snack pass.
- Resident #029 was offered a beverage only. The resident's written plan of care directed staff to offer a regular standard snack.
- Resident #035 was offered a beverage only. The resident's written plan of care directed staff to offer a regular standard snack.
- Resident #032 was offered a beverage only. The resident's written plan of care directed staff to offer a regular standard snack.

The standard snacks of the day on the snack cart were a mini cherry tart, and a bowl of fresh fruit. Pureed cherry tart or unsweetened apples sauce were also available for residents on texture modified menus.
PSW #124, who was delivering the snacks, stated that not all residents were offered a snack because some of the residents could not chew the tart. When the Inspector inquired about the pureed snacks available, the PSW stated that none of the residents

liked the pureed snack. The pureed snack was not offered to the residents and a dislike to cherry tart or applesauce was not indicated on those residents' written plans of care. Residents #047, #005, and #035, were interviewed and identified they were not offered snacks at the afternoon or evening snack passes. Documentation reflected a snack, in addition to a beverage, were not consistently being offered to the residents as per documentation on the residents' food and fluid intake records.
A review of the "Dietary Report" records for resident #005, where food and fluid intake were recorded, did not reflect any documentation of the afternoon snack pass on 28/31 days in one month in 2016, and 27/30 days in another month. Documenation did not reflect that a snack was offered to the resident on 23/31 days for the evening snack pass in one month in 2016 and 28/30 days in another month.
The "Dietary Report" records for resident #035, where food and fluid intake were recorded, did not reflect any documentation for the afternoon snack pass on 12/31 days in one month in 2016, and 11/30 days in another month. Documentation did not reflect that a snack was offered to the Resident on 16/31 days for the evening snack pass in one month in 2016, and 21/30 days in another month in 2016.
The "Dietary Report" records for resident #047, where food and fluid intake were recorded, did not reflect any documentation for the afternoon snack pass on 4/30 days in one month in 2016, and 4/30 days in another month in 2016. Documentation did not reflect that a snack was offered to the resident on 8/30 days at the evening snack pass in one month in 2016, and 4/30 days in another month in 2016. [s. 71. (3) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident is offered a minimum of a snack in the afternoon and evening, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that schedules and procedures were in place for preventive maintenance related to the home's furnishings (beds).

The licensee failed to ensure that a procedure or preventive schedule was in place to ensure that the beds in the home were monitored regularly to ensure that they remained in good condition and in accordance with the manufacturer's recommendations.
An observation by an Inspector revealed a bed in a room in the west wing had rotating assist rails in the transfer or assist position that appeared to be bowed outwards. When tested, the bed rail was so loose that it appeared that it might fall off the bed frame. The bolt and associated hardware was observed to be very loose. Other bed rails were randomly tested and noted to be loose in seven other rooms.
The maintenance staff and the Administrator in interviews confirmed there were no procedures developed that included the bed manufacturer's instructions for care and maintenance of the beds in the home. When the instructions were reviewed, the manufacturer required that the beds be inspected yearly and that any loose bolts or parts be replaced or tightened.
According to the maintenance staff, who was hired approximately 14 months prior, no bed inspections had been completed by them.
Records reviewed and maintained by the maintenance staff identified that the beds were inspected in the past; however, the process did not continue. The licensee's bed maintenance program included a remedial component which was largely based on health care staff reporting disrepair. When the maintenance logs were reviewed from January to May 2016, several bed rails were identified as either broken or loose on both 3 west and 3 east and were remediated; however, those identified in the rooms above were not included.

Discussion was held with the Administrator regarding the level of knowledge health care or housekeeping staff may or may not have regarding how to test bed rails and when to report problems with the bed rails. The Administrator confirmed no specific training had been provided to staff. [s. 90. (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 to ensure that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

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

An observation by an Inspector in 2016, of the tub room on a specific unit revealed the door did not have a lock and Virex II 256 disinfectant/cleaner was found on the tub. Virex II 256 disinfectant/ cleanser was observed again on a cart beside the tub in the unlocked tub room on another day.
Registered staff #104, in an interview, confirmed that the disinfectant/cleaner should not have been in an area accessible to the residents. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents substitute decision makers (SDM) and any other persons specified by the residents were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

In an interview with resident #043's family member, who was their legal power of attorney (POA) for personal care, revealed that they were not notified when the home became aware of an incident involving the resident and PSW #133. They stated that they were made aware of the incident by someone other than staff from the home.
The DOC confirmed that they had notified the person of the incident in error, and did not notify the resident's POA. [s. 97. (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 to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

A) An Inspector while touring the home in 2016, observed that a specific room had a "contact precautions" sign on the door. The Personal Protective Equipment (PPE) was available on the door inside the room. PSW #103 was providing direct care to resident #018 and they did not wear a gown.
A review of the home's policy #IC02-01-01B, titled "Routine Practices, Appendix G: Contact Precautions", indicated "wear a long sleeve gown for direct care when skin or clothing may become contaminated, direct care meaning such as bathing, changing clothing, continence care washing etc.".

Registered staff #101 was interviewed and confirmed that the resident was on contact precautions and the staff who provided direct care to the resident should have worn gloves and a gown when providing their care.

B) An Inspector observed the afternoon snack pass on a specific day in 2016, and observed PSW #124 assisted residents to eat and drink, delivered snacks to residents, and touched beds and equipment in residents' rooms that had “contact precaution” signage, without washing or sanitizing their hands between tasks and between residents. The PSW also handled food from the snack cart with their hands after they completed such tasks.
The PSW in an interview stated that they only had to wash their hands if they provided personal care to residents and did not feel that hand hygiene was necessary.
A review of the home's policy # IC02-01-02, titled "Hand Hygiene " did not provide specific direction related to when staff were to wash their hands; however, the Infection Prevention and Control Lead confirmed that the PSW was required to wash their hands after they touched equipment and items in residents rooms, especially for contact precautions, when they handled food and between residents when they assisted with feeding them.(107) [s. 229. (4)]

2. The licensee failed to ensure that resident #053, who was admitted to the home in 2016, was screened for tuberculosis within 14 days of admission, unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee.

The Infection Prevention and Control Coordinator stated that the home's screening practice for tuberculosis for residents 65 years of age and over was to obtain a chest x-ray on admission unless there was evidence that the resident had previously had an x-ray within 90 days of admission to the home. Information on the Community Care Access Centre (CCAC) admission information identified the resident's last chest x-ray was on a specific day in 2015.
A consent form for a chest x-ray was signed by the resident on a specific day in 2016; however, there was no evidence that a chest x-ray was completed after admission to the home.
Registered staff #106 confirmed that there was no evidence of a screening chest x-ray in the resident's clinical health record and registered staff #104 called the x-ray company, who confirmed that they did not have an x-ray on file for the resident.
The resident confirmed they had not had a chest x-ray since admission. [s. 229. (10) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program and that each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of residents dental and oral status, including oral hygiene.

In an interview, resident #021 indicated that they had dentures which were soaked at night and brushed by the staff in the morning.
A review of the resident's written plan of care indicated that the resident had their own teeth, could take care of them on their own and oral care was to be completed after each meal, in the morning and at bedtime.

PSW #112 was interviewed and indicated that the resident had their own teeth.
The written plan of care was not based on an assessment of resident #021’s dental and oral status. [s. 26. (3) 12.]

2. The licensee failed to ensure that the Registered Dietitian, who was a member of the staff of the home, assessed residents nutritional status, including height, weight and any risks related to nutrition care, and hydration status, and any risks related to hydration.

A) A review of the quarterly MDS assessment reviews in 2016, and the referral for significant weight loss in 2016, revealed the RD did not assess resident #040’s hydration status. Documentation did not reflect an assessment of the resident's hydration status and the RD confirmed that they were not aware of the resident's poor hydration status. The RD in an interview stated that they did not consistently review the food and fluid intake documentation and relied upon the coding in the MDS assessment or dietary referrals for identification of hydration concerns.
A review of the resident's written plan of care indicated they required a specific amount of fluids daily. For a specific month in 2016, the resident met their minimum hydration target on four days of the month; in three other months in 2016, the resident met their hydration target on five days of the month. The RD did not assess the resident's poor hydration below their target fluid requirement at any of the assessments completed in three specific months in 2016.
The resident had a significant weight loss over specific months in 2016. In another month in 2016, the RD initiated a nutrition intervention for prevention of further weight loss. A review of the documentation on the resident's food and fluid intake records reflected the resident was not consistently following the taking the nutrition intervention. The RD did not review the food and fluid intake documentation prior to initiating strategies to prevent further weight loss to determine if the strategy would be an effective measure.
The resident had a decline in their meal consumption between an identified month and another identified month in 2016, with a significant weight loss identified the beginning of an identified month in 2016. A review of the documentation did not reflect an assessment of the decline in the resident's food and fluid intake. The RD confirmed in an interview that food and fluid intake records were not always consistently reviewed as part of the nutrition assessment process.

B) A review of the written plan of care for resident #026 identified a minimum daily fluid requirement between two months. The resident met their hydration requirement on one day in one month, no day the following month, and two days in the month after that.
A review of the documentation on the resident's, "Dietary Report", where the resident's

food and fluid intake were recorded, reflected that they took a specific amount of their meals (half or less) for specific months. The resident had significant weight loss between 2015 and 2016.
The resident was reviewed by the RD on six days between 2015 and 2016. The resident's written plan of care was not revised during that time and the RD identified the continued weight loss was positive. An assessment of the resident's decline in intake and poor hydration was not documented and the RD confirmed that food and fluid intake records were not routinely reviewed as part of the nutritional assessment process. In an interview, the RD stated that they did not consistently review the food and fluid intake documentation and relied upon the coding in the MDS assessment or dietary referrals for identification of hydration concerns.
The MDS quarterly reviews in 2016 triggered a dehydration Resident Assessment Protocol (RAP); however, the RAP did not identify the resident's current hydration intake in relation to the fluid goals identified on the resident's written plan of care. An assessment of the resident's actual fluid intake was not included as part of the RAP.
A review of the progress notes also identified the resident had responsive behaviours related to meals, two skin conditions, and several ongoing medical conditions in specific months in 2016. The resident's nutritional status in relation to the potential nutritional problems were not included in the RD's reviews, with the exception of one of the conditions.

C) A review of the written plan of care for resident #025 identified a minimum daily fluid requirement. The resident did not meet their hydration requirement on any day in two specific months, and half of another month in 2016.
The RD received a referral related to significant weight loss on a specific day in 2016. An assessment of the resident's hydration was not included in the RD's assessment and they stated they were not aware of the resident's poor hydration. In an interview the RD stated that they did not consistently review the food and fluid intake documentation and relied upon the coding in the MDS assessment or dietary referrals for identification of hydration concerns.

D) Resident #048 had a decline in condition beginning on a a specific day, as per documentation in the progress notes and the resident had documented ongoing difficulty swallowing.
At a review in 2015, the RD initiated a nutritional supplement. The RD confirmed that an assessment of the resident's hydration status was not completed as part of the review.
The resident was not meeting their hydration requirement on 14/17 days in a specific time period in 2015, prior to the review by the RD. The quantity of nutritional

supplement, would not have been enough to increase the resident's hydration to meet their minimum daily requirement on the three days prior to the nutritional assessment and would not have met the caloric deficit based on food and fluid intake records. For a specific month in 2015, the resident's took a specific amount of their meals (half or less) and the resident did not consume food snacks. In an interview the RD confirmed that a swallowing assessment was not completed and an assessment of the current diet texture and fluid consistency was not included as part of the assessment and there was no referral to the Speech Language Pathologist for assessment of the resident's swallowing.

At the review by the RD on a specific day in 2015, there was no assessment of the resident's swallowing ability or referral to the SLP for assessment of the resident's swallowing ability after continued documentation in the progress notes of difficulty swallowing and pocketing food. An assessment of the resident's hydration was not completed as part of the nutrition assessment. The resident's fluid intake for the three days prior to the assessment was below their daily minimum requirement. [s. 26. (4) (b)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that residents received individualized personal care, including hygiene care and grooming on a daily basis.

Observations of resident #035 on several days during stage one of the inspection revealed they were not shaved.
An interview with resident #035 revealed the PSW staff did not shave them at all. The resident stated the staff had told them to shave themselves but they were unable to do so without assistance related to their medical condition. The resident stated they would like to be shaved daily.
PSW #108 in an interview stated the PSW staff did not shave resident #035 as the resident was able to do it themselves. PSW #111 also stated that they had never shaved the resident as they were able to shave themselves with set-up.
Review of a "Flow sheet" for an identified period in 2016 for resident #035 revealed there was no area for documentation related to shaving.
Review of the resident's written plan of care revealed they required extensive assistance with shaving but did not include direction to assist the resident with shaving.
Review of the home's policy #RCM05-02-04, titled "Resident Care – Grooming and Shaving", 2014, indicated "review resident's plan of care to determine preferences and level of assistance required; all male residents are to be shaved daily; report to charge nurse ie. any rash or irritation, change in level of assistance, resistance to care etc".
Registered staff #106 and the DOC confirmed resident #035 was unable to shave themselves related to their medical condition and the PSW staff were expected to shave the resident daily. They further confirmed there was no area on the PSW flow sheets to document the care. [s. 32.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the programs included a weight monitoring system to measure and record with respect to each resident, (ii) body mass index and height upon admission and annually thereafter.

Record review revealed that several residents on two identified units did not have their heights recorded annually in their records:
- Resident #027 did not have their height taken in 2014, refused in 2015.
- Resident #034 had their height taken in 2013 and 2016 but not in 2014 and 2015.
- Resident #040's height was taken in 2014 only.
Interviews with registered staff revealed that heights were taken only on admission and when there was a significant change in residents' health condition.

The home's policy #RCM08-01-11, titled "Weight and Height Monitoring", effective date December 2014, indicated that each residents' height should be taken on admission and annually. The home did not ensure that staff were monitoring and recording height annually.

ADOC #127 in an interview confirmed that resident heights were not taken annually. [s. 68. (2) (e) (ii)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**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 failed to ensure that proper techniques were used to assist the residents with eating.

An observation by an Inspector of the lunch meal on a specific day in 2016, revealed that resident #041 was tilted back in their tilt wheelchair with their chin extended upwards. The resident was being fed thickened fluids by registered staff #104 and the resident was coughing.
The registered staff in an interview stated the resident did not need to be fully upright during feeding.
A review of the resident's written plan of care indicated staff were to position the resident at 90 degrees in an upright position during feeding. The Inspector instructed the staff to reposition the resident.
Proper positioning was not used by staff when assisting resident #041 with eating. [s. 73. (1) 10.]

2. The licensee failed to ensure that staff were available to provide feeding assistance to residents when serving their meals.

An observation by an Inspector of the lunch meal on a specific day in 2016, revealed resident #025 was served their soup at 1318 hours. The resident sat in-front of their soup without eating and fell asleep until staff came to sit with the resident at 1334 hours the resident's soup was placed on the table 16 minutes prior to assistance being provided to the resident. The resident required full assistance with eating at that meal. [s. 73. (2) (b)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee failed to ensure that procedures were implemented for cleaning of the home.

An Inspector observed in 2016 that the kitchen floor was significantly soiled with blackened areas around the equipment, in the main thoroughfares and work spaces, in corners, around doorways, and also had caked on food debris that had not been cleaned. Large black areas with patterns from the floor mats could be seen on all of the floor areas.
The Nutrition Manager (NM) and dietary staff for the shared long term care home and retirement home kitchen were not able to provide a written detailed procedure as to how floors were maintained and monitored, by whom and what equipment and cleaning solutions were used. However, the NM provided a copy of a daily cleaning schedule and a deep cleaning schedule with some written instructions. The deep cleaning schedule titled "Cleaning List" directed staff to steam clean the floors using a steamer or mop room hose every two weeks.
Documentation was not available to confirm when the floors had last been steam cleaned as staff were not required to sign that duties were completed, however, the NM was certain the floor had not been steam cleaned for over four weeks. The cleaning procedures were therefore not implemented. [s. 87. (2) (a) (ii)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

An inspection by an Inspector on a specific day in 2016 of a medication cart in the medication room on a specific unit revealed three empty glasses cases, a hearing aid kit and a watch.
An interview with registered staff #106 confirmed the above mentioned glasses cases and watch belonged to residents and the items were stored in the medication cart so they would not get lost. The staff further confirmed the items were not drug – related supplies. [s. 129. (1) (a)]

Issued on this 22nd day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NATASHA JONES (591), BERNADETTE SUSNIK (120), DARIA TRZOS (561), MICHELLE WARRENER (107), ROMELA VILLASPIR (653), SAMANTHA DIPIERO (619)
Inspection No. / No de l'inspection :	2016_467591_0007
Log No. / Registre no:	013962-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 2, 2016
Licensee / Titulaire de permis :	DEVONSHIRE ERIN MILLS INC. 195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7
LTC Home / Foyer de SLD :	ERIN MILLS LODGE NURSING HOME 2132 DUNDAS STREET WEST, MISSISSAUGA, ON, L5K-2K7
	MARY WHALEN

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

To DEVONSHIRE ERIN MILLS INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with. The plan shall include but is not limited to:

1. A review of the home's hydration policy to ensure that it is consistent with current practices in the home.

2. Education for nursing staff related to the home's hydration policy.

3. A review of the home's policy related to referral to the Registered Dietitian (RD) to ensure that it is current and reflects the current practices at the home.

4. Education for nursing staff related to the home's policy for referral to the RD.

5. Quality management activities, including monitoring and evaluation, to ensure that the home's policies are complied with by staff.

The plan shall be submitted to Long Term Care Inspector Home's Inspector Michelle Warrener by September 15, 2016, via e-mail to: Michelle.Warrener@ontario.ca.

Grounds / Motifs :

1. Judgement Matrix

- Non-Compliance Severity: Minimal harm or potential for actual harm
- Non-Compliance Scope: Widespread
- Compliance History: Despite Ministry of Health (MOH) action, non-compliance (NC) continues with original area of NC.

2.The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) A review of the home's policy, #RNC03-03-05, titled "Hydration", effective in December, 2014, directed that residents would be referred to the Registered Dietitian (RD) if their hydration was less than 75% of their calculated target over a three day period.
Resident #040's written plan of care identified a minimum fluid requirement. The resident consumed less than 75% of their minimum fluid requirement on several days in 2016; however, a referral to the RD for poor hydration did not occur. Registered staff #128 in an interview stated that referral forms for the RD were in the RD referral binder and that the RD would sign the forms when completed and put the completed forms into the resident's chart. A copy of a referral to the RD was not in the resident's clinical health record. The RD confirmed a referral was not received for that time period.

B) A review of the home's policy, #RNC03-03-05, titled "Hydration", effective date December 2014, directed that residents would be referred to the RD if their hydration was less than 75% of their calculated target over a three day period. Resident #026's written plan of care identified a minimum fluid requirement in 2016. The resident consumed less than 75% of their minimum fluid requirement on specific days in 2016; however, a referral to the RD for poor hydration did not occur. Registered staff #128 stated that referral forms for the RD were in the RD referral binder and that the RD would sign the forms when completed and put the completed forms into the resident's chart. There were no referrals to the RD for several months in 2016, in the resident's clinical health record. A referral was sent to the RD on a specific day in 2016, notifying the RD that the resident had symptoms which included weight loss. There were no referrals to the RD for poor hydration and the RD confirmed a referral was not received for that time period related to poor hydration.
A review of the home's policy, # RCM03-03-03, titled "Referrals to Registered Dietitian ", effective in December, 2014, directed the Food Services Manager or DOC/ADOC to provide the RD with a list of the residents no less than monthly who had a change in appetite or refusal to eat, poor fluid intake, constipation,

difficulty chewing or swallowing, altered skin integrity, and dementia or behavioural issues affecting intake.
A review of progress notes identified the resident had responsive behaviours related to meals, specific skin conditions, an ongoing medical condition, query of a medical event on a specific day, and several ailments in specific months in 2016. Documentation on the resident's, "Dietary Report", where the resident's food and fluid intake were recorded, reflected that the resident only consumed a specific amount (half or less) of their meals for several months. A referral to the RD related to specific nutritional concerns was not in the resident's clinical health record, with the exception of one condition and a downgrade in their diet texture. The RD confirmed they were not aware of the nutritional concerns and did not receive a referral related to the concerns.

C) A review of the home's policy, #RNC03-03-05, titled "Hydration", effective in December , 2014, directed that residents would be referred to the RD if the residents' hydration was less than 75% of their calculated target over a three day period.
Resident #025's written plan of care identified a minimum fluid requirement. Nursing staff would be required to refer the resident to the RD at a specific quantity. The resident consumed less than 75% of their minimum fluid requirement over three days during specific time periods; however, a referral to the RD for poor hydration did not occur.
Registered staff #128, in an interview, stated that referral forms for the RD were in the RD referral binder and that the RD would sign the forms when completed and put the completed forms into the residents' chart.
A copy of a referral to the RD for the noted dates was not in the resident's clinical health record. The RD confirmed a referral for poor hydration was not received for that time period.
The home's policy #RCM03-03-05, titled "Referrals to Registered Dietitian", effective date December 2014, directed the Food Services Manager or DOC/ADOC to provide the RD with a list of the residents no less than monthly who had a change in appetite or refusal to eat, and poor fluid intake. A referral was not provided to the RD when there was a decline in resident #025's food and fluid intake. The resident had a decline in their food and fluid intake of a specific amount (half or less) of their meals on specific days in 2016. A referral related to the decline in intake was not made to the RD. The resident was also not meeting their hydration target on any day during a specific period of time in 2016, and a referral was not initiated related to the poor hydration. A referral was made on a specific day in 2016, related to significant weight change; however,

the referral did not reflect the decline in intake or poor hydration. Registered staff #128 stated that referral forms for the RD were in the RD referral binder and that the RD would sign the forms when completed and put the completed forms into the residents' chart. A copy of a referral related to the decline in intake/poor hydration was not in the resident's clinical health record. The RD confirmed a referral was not received for poor intake/hydration.

The home failed to comply with the above mentioned policies.

(107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

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

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall do the following:

1. Ensure that all bed systems are evaluated to determine their entrapment status in accordance with Health Canada's guideline titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Latch Reliability, and Other Hazards". The status of each bed shall be documented along with any repairs or amendments made to the bed systems and the results provided to the clinical team who will be assessing each resident who uses one or more bed rails.

2. Develop policies and procedures that clearly summarize the tasks and roles of various staff members or departments in ensuring that the bed systems are evaluated and that each resident is assessed to minimize risk related to their bed system.

3. Amend or redevelop the home's current "Bed Rail Use Assessment" form to include bed system safety questions contained in the prevailing practices document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". The form shall guide the assessor in deciding if one or more bed rails is or will be a viable and safe option for the resident after bed rail alternatives have been trialled.

4. Reassess all residents who use one or more bed rails by applying the amended or redeveloped "Bed system safety questionnaire" and "Decision tree". Document the results, alternatives trialled and the names of the persons who participated in the reassessments.

5. Update the residents' written plans of care with the outcome of the reassessments as necessary. Include when a bed rail (medical device) is to be applied, on what side of the resident and why.

6. Provide bed safety education to all staff that provide care to residents. The education at a minimum shall include information related to bed entrapment zones 1-4, when to apply bed rails, how staff will be informed as to when to apply bed rails, how to recognize when the bed system is unsafe, how and when to report bed safety concerns, how residents are assessed for bed rail use and how and when to apply any entrapment zone interventions if necessary.

Grounds / Motifs :

1. Judgement Matrix
- NC Severity: Minimal harm or potential for actual harm
- NC Scope: Widespread
- Compliance History: One or more unrelated NC in the last three years.

2. The licensee failed to ensure that where bed rails were used that the residents' bed system was evaluated and that residents were assessed in accordance with prevailing practices, to minimize risk to the resident.

A)The residents' bed systems were not all evaluated in accordance with Health Canada's guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Latch Reliability, and Other Hazards". The guidelines established included that bed systems be re-evaluated after changes were made to the bed, such as a mattress change or when the mattress began to age and soften. According to records maintained by the licensee, the bed systems in the home were last evaluated by maintenance staff for entrapment zones during a specific time period in 2012, using an approved bed safety device measurement tool as per Health Canada's guidelines. The results of the evaluation identified that over 40 beds failed one or more entrapment zones 2, 3 or 4 and approximately 40 other beds were not evaluated. The bed systems that were not tested in 2012 were not evaluated in 2013, 2014 or 2015. According to the Administrator, the home received 10 new electric beds in 2013 and 20 new mattresses in 2015. The beds that received the new mattresses were not re-evaluated. On a specificday in 2016, records were provided that indicated that seven beds with new mattresses were evaluated for entrapment zones and all seven failed entrapment zone 4 (the space at the end of the rail). An evaluation of all of the bed systems in the home was not completed.

B) The licensee did not ensure that all residents who used one or more rails, were assessed in accordance with prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada). According to the guideline, residents were to be evaluated by an interdisciplinary team, over a period of time while in bed. To guide the assessors, a series of questions would be completed to determine whether the bed rail(s) were a safe device for resident use. The guideline also emphasized the need to document clearly whether alternative interventions to the use of bed rails were trialed prior to their application and if the interventions were appropriate or effective, if they were previously attempted

and determined not to be the treatment of choice for the resident. Other questions to be considered would be the residents' medical status, cognition, behaviours, medication use, mobility and any involuntary movements, falls risks, toileting habits, sleeping patterns or habits (if next to a rail and along edge of bed), environmental factors and the status of the residents' bed (whether passed or failed zones 1-4), all of which could more accurately guide the assessors in making a decision, with either the resident or their Substitute Decision Maker (SDM) about the necessity and safety of a bed rail (medical device). The final conclusion would then be documented as to why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.
The licensee's bed rail use clinical assessment process was reviewed and it was determined that it was not fully developed in accordance with prevailing practices as identified in the above noted guideline. According to the licensee's policies, no direction had been developed to clinically assess residents for entrapment and other bed rail hazards. Their policies related to bed rails included "RCM09-01-01 Restraints" and "RCM09-01-02D PASD Assessment", both dated 2014. These policies focused on whether the resident could or would use a bed rail for a specified reason (typically bed mobility, transfers from and to bed and repositioning) or if the bed rails would serve as restraints for the resident. No safety evaluations were included. Verification was made with the ADOC that the "PASD Assessment" was completed for all residents; however, the questions and processes identified in the prevailing practice guidelines identified above were not fully included. No reference was made in the policy regarding a conclusion of potential risk, whether their bed system passed or failed any entrapment zones and how to ensure that the bed rail was safe for the resident in their assessed condition. According to the ADOC, she was not aware of the above noted guideline and therefore did not incorporate it into their clinical process of reviewing residents in their bed systems for hazards associated with bed rail use.

At the time of inspection, several residents were observed lying in bed, each with one or more bed rails in use. The rest of the beds in the home were unoccupied at the time of observation and more than 70% had one bed rail either in the transfer position or in the guard position. Verification was made that for the residents identified below, bed rails were determined to be required as a personal assistance services device (PASD). None of the residents'

assessments identified what safety risks the use of a bed rail posed (if any) to the resident and what interventions were necessary to reduce those risks.

- Resident #038 was not in bed at the time of observation but their bed was observed to have the left side assist rail in the transfer position and the right side assist rail in the guard position. The resident was interviewed and said that they did not know why the staff kept leaving one of their bed rails in the guard position. The resident's written plan of care indicated that the resident was independent for bed mobility and verified that a bed rail was used for repositioning. The resident's "Personal Assistance Services Device (PASD) Assessment" form was blank when reviewed in the clinical health record. The resident's bed was not evaluated for entrapment zones. The licensee provided a binder titled "Bed Entrapment Audit Binder" with the bed measurement test results for all of their beds. However, the "Bed system measurement device test results worksheet" for the bed was not found in the binder.

- Resident #056 was not in bed at the time of observation but had their left side assist rail in the transfer position and their right side assist rail was in the guard position. The resident had a specific mattress on the frame. The resident's written plan of care indicated that the resident required two bed rails up when in bed, although the type of rail was not identified. It was also indicated that the resident required half rails as a PASD. As per a "Personal Assistance Services Device (PASD) Assessment" document, found in the resident's clinical health record, a PASD was considered for positioning and to off load pressure. The resident's bed was not did not appear to be evaluated for entrapment zones. In 2012, the bed was not tested for entrapment zones as evidenced by the blank "Bed system measurement device test results worksheet" found in the home's "Bed Entrapment Audit Binder".

- Resident #054 was not in bed at the time of observation but had their left side assist rail in the transfer position and their right side assist rail in the guard position. The resident's written plan of care indicated that the resident required the use of bed rails for bed mobility or transfer. In another area of the written plan of care, it indicated that the resident was to be encouraged to grab onto the bed rail when staff assisted the resident to turn over in bed. The resident's identified "Personal Assistance Services Device (PASD) Assessment" document, found in their clinical health record was not fully completed. The resident's bed did not appear to have been evaluated for entrapment zones. The "Bed system measurement device test results worksheet" for this bed was not

found in the home's "Bed Entrapment Audit Binder".

- Resident #055 was not in bed at the time of observation but their bed was observed to have their left side assist rail in the transfer position and the right side assist rail was in the guard position. The resident had a specific mattress on the frame. The resident's written plan of care indicated that the resident was required to use assist bed rails as PASD, for bed mobility, turning and positioning. As per a "Personal Assistance Services Device (PASD) Assessment" document, a PASD was considered for bed mobility such as turning and re-positioning and that the assist bed rails were to be used during day, evening and nights. The resident's bed did not appear to have been evaluated for entrapment zones. In 2012, the bed was not tested for entrapment zones as evidenced
by the blank "Bed system measurement device test results worksheet" found in the home's "Bed Entrapment Audit Binder".

- Resident #039 was observed lying in bed on a specific mattress. Their left assist rail was in the transfer position and their right assist rail was in the guard position. There was no information in the resident's written plan of care regarding the use of bed rails. The ADOC confirmed that bed rails were not included in the resident's current written plan of care but should have been. As per a "Personal Assistance Services Device(PASD) Assessment" document, found in the resident's clinical health record, a PASD was considered for mobility and that quarter sized bed rails were to be used when the resident was in bed; however, the assessment sheet did not identify the quantity of bed rails to be used or on what side. The resident's bed did not appear to have been evaluated for entrapment zones. In 2012, the bed was not tested for entrapment zones as evidenced by the blank
"Bed system measurement device test results worksheet" found in the home's "Bed Entrapment Audit Binder".

- Resident #018 was observed lying in bed on a specific mattress with side assist rails in the guard position. The resident's written plan of care indicated that the resident required assist rails as a PASD for bed mobility. There was no information in the resident's written plan of care that indicated the reason for the side rails. According to the ADOC, the rationale was to prevent injuries. As per a "Personal Assistance Services Device(PASD) Assessment" document, found in the resident's clinical health record, a PASD was considered for bed mobility/ turning/ positioning and also indicated that assist bed rails were to be used day/

evening/ night. The resident's bed did not appear to have been evaluated for entrapment zones. "Bed system measurement device test results worksheet" for this bed was not found in the home's "Bed Entrapment Audit Binder".

The safety status of the above noted beds, whether they passed or failed any zones of entrapment, could not be determined. The risk of entrapment was present for all of the above residents as they had not been adequately evaluated and did not have their bed systems evaluated.

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 30, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the lighting requirements set out in the Table to this section are maintained. The plan shall include, but is not limited to:

1. The illumination levels in the home, evaluated by a person with adequate knowledge of illumination standards and measuring techniques, when natural outdoor conditions do not impact the illumination levels inside of the home.

2. A plan to address illumination levels that do not meet the minimum requirements in the lighting table under the section titled "all other homes".

The plan shall be submitted to Bernadette.susnik@ontario.ca by December 30, 2016.

Grounds / Motifs :

1. Judgment Matrix
- NC Severity: Minimal risk
- NC Scope: Widespread
- Compliance History: One or more related NC in the last three years

2. The licensee failed to ensure that the lighting requirements set out in the lighting table were maintained.

The home was built prior to 2009 and therefore the section of the lighting table that was applied was titled "In all other areas of the home". A hand held non-digital light meter was used (Sekonic Handi Lumi) to measure the lux levels in a three-bed ward bedroom, one private room and one semi-private room, tub and shower rooms, several resident ensuite washrooms and corridors on both 3 East and 3 West. The meter was calibrated before
use and held a standard 30 inches above and parallel to the floor. Window coverings were drawn in the resident bedrooms measured and lights were turned on five minutes prior to measuring. Areas that could not be measured due to natural light infiltration were dining rooms. Outdoor conditions were bright during the measuring procedure. The minimum required lux for all resident areas is a general 215.28 lux (bedrooms, washrooms, lounges, dining rooms, showers, tub rooms). The areas specifically measured were areas where activities of daily living occurred such as walking, dressing, bathing, reading and care at bedside. The minimum required lux for all corridors is a continuous and consistent lux of 215.28. The minimum required lux level under any reading light or over bed light

is 376.73 lux. The home was configured with two home areas, one on the east side of the building with 27 resident rooms and one on the west side of the building with 18 resident rooms. The lighting fixtures were different on each side. The bedrooms on the east side did not have any central ceiling light fixtures in resident bedrooms with the exception of an identified room. The bedrooms on the west side were equipped with central ceiling light fixtures however they were not capable of producing enough light to meet the minimum requirement of 215.28 lux. Resident ensuite washrooms all had compliant lighting levels on both east and west sides.

A) East side
- A private bedroom was measured on a specific day in 2016, and was similarly equipped as all of the other private rooms on the east side. The room had a small square wall mounted reading light (located above and to the side of each bed) consisting of either one incandescent light bulb or a compact fluorescent bulb and a recessed pot light with a compact fluorescent light bulb at the entrance to the room. The entrance into the bedroom was 150 lux under the pot light and the entrance way was over five feet long. The centre of the room was 20 lux with all of the lights on. The lux under the over bed light was 220. The lux in and around the bed was 20-100 lux.
- A three-bed ward bedroom was measured on a specific day in 2016, and was similarly equipped with the same light fixtures as all of the other three-bed ward bedrooms. The room had a small square wall mounted reading light consisting of either one incandescent light bulb or a compact fluorescent bulb and a recessed pot light with a compact fluorescent light bulb at the entrance to the room. The entrance into the bedroom was adequate; however, the centre of the room or near the foot end of two beds and between the two beds was 50-100 lux. The third bed was in a separate area of the room. The over bed lux level for bed 1 was 390 and for beds two and three, the lux was 290. All three had a compact fluorescent light bulb in the fixture.
- Semi-private rooms were all equipped with the same light fixtures as the private and three-bed ward bedrooms with the exception of one room which was equipped with two pot lights in the room and fluorescent tube reading lights located over the beds. The room was compliant for illumination levels. The other semi-private rooms were not compliant for general room light or reading light levels based on the levels achieved in the private bedroom and three-bed ward bedrooms noted above.
- The two corridors on the east side were equipped with troffer (slightly above the ceiling tiles with an opaque lens that was flush with the ceiling tiles) light

fixtures with four foot long fluorescent tubes each. The corridor also included fluorescent tubes above each resident bedroom entry with a louvered lens. The troffer fixtures were spaced 14-20 feet apart thereby creating a very inconsistent lux level. The areas between the troffer fixtures were 100 lux between two rooms. The area across from one of the rooms was 175 lux. The lux under the troffer fixtures was adequate at over 600.
- The east side shower room was equipped with two separate shower stalls, the walls covered in dark green tiles (which will absorb a lot of light). Just outside both stalls, a fluorescent ceiling fixture was provided which was 410 lux; however, the lux inside of each stall dropped to 50-100 lux. This measurement did not include closing the privacy curtain for each stall and standing inside.

B) West Side
- A private bedroom was measured on a specific day in 2016, and was similarly equipped as all of the other private rooms on the west side. The room had an over bed reading light equipped with a fluorescent tube, no entry light and a central ceiling mounted light with opaque lens. The lux directly under the central light was 110 lux. The foot of the bed was 180 lux and the side of the bed was 150 lux. The over bed light was adequate at 400 lux.
- The semi-private and three bed ward bedrooms on the west side were not compliant for general room light based on the levels achieved in the private bedroom noted above.
- The two corridors on the west side were equipped with troffer light fixtures with four foot long fluorescent tubes each. The corridor also included wall mounted sconce lights between the troffer fixtures. The illumination levels were adequate as the troffer fixtures were spaced 10 feet apart and the sconce lighting increased lux levels between troffer fixtures. One area, located near an identified room was not adequate. The ceiling consisted of two pot lights for a length of approximately 12 feet. The lux in this area was approximately 100-150.
- The shower/tub room was equipped with one tub and two shower stalls. The light fixtures provided included 2 semi-flush ceiling mounted fixtures. The lux over the tub was 110, the lux over the sink was 120, the lux in the roll in shower stall was 50 and the lux for the shower stall with the raised floor was 135.

Illumination levels would need to be verified throughout the home at a time whereby the outdoor natural light would not impede the light meter readings where residents have access to ensure compliance with the lighting table.

(120)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents are bathed at a minimum, twice a week by the method of their choice, including tub baths, showers and full body sponge baths, and more frequently as determined by the residents' hygiene requirements, unless contraindicated by a medical condition. The plan shall include, but is not limited to:

1. Ensuring that residents are offered a preference of baths or showers and receive them twice weekly.

2. A review and revision of all written plans of care plan to reflect residents' preference for baths or showers in any combination.

3. Education for staff on the correct documentation procedures in POC reflecting the care provided to each resident.

The plan shall be submitted electronically to Long Term Care Homes Inspector, Daria Trzos, by September 2, 2016, to: daria.trzos@ontario.ca.

Grounds / Motifs :

1. Judgement matrix
Non-Compliance Severity: Minimal Harm or Potential for harm or risk
Non-Compliance Scope: Widespread
Compliance History: one or more unrelated non-compliance in the last three years

2.The licensee failed to ensure that residents were bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) Resident #018 had a written plan of care indicating that the resident received a bath twice a week and as necessary (PRN) and was totally dependent on the staff. The resident was not interviewable. PSW #103 who provided direct care to the resident was interviewed and indicated that the resident received a bath on Thursdays only. Registered staff #101, in an interview, stated that the resident was supposed to receive a bath on Tuesdays and Fridays. Staff were to document in point of care (POC) once the resident received a shower or bath. The POC was reviewed for a specific period of time in 2016, and there was documentation indicating the resident received a bath on four days in 2016. There was no documentation indicating that the resident refused. Resident #018 was not bathed at minimum twice a week as indicated in their written plan of care.

B) On a specific day in 2016, resident #034 was interviewed and indicated that they received a shower only once a week and that they were not offered a choice between a bath and a shower. The resident stated they would prefer to get a bath in the tub. The clinical health records were reviewed and indicated that the "Admission Nursing Assessment/24 HR Care Plan" form did not specify the resident's preference for either a bath or a shower. The documentation was incomplete in identifying the resident's preference. On a specific day in 2016, resident #005 was interviewed and indicated that they got a shower twice a week but the home did not ask their preferred method of bathing. The Admission Nursing Assessment/24 HR Care Plan form was reviewed and the preference for a bath or shower was not documented. PSW #107 was interviewed and stated that the tub on a specific unit had not been used in 14 years. PSW #102 also indicated that the tub on the unit had not been used in a long time. PSW #108 stated that they did not think that the tub was even connected and residents did not receive tub baths on a specific unit. PSW #115 on a specific unit stated that none of the residents on the unit received tub baths and the tub had not been used for the past two years. PSW #116 on a specific unit stated that none of the residents received tub baths and that they had never used the tub. PSW #117 stated that the tub on a specific unit had not been in use in a long time and the reason might have been that the water pressure was too low. Registered staff #106 was interviewed and indicated that the tub on a specific

unit was not functioning and that it was the only one that staff had access to. The residents did not receive tub baths.
The home's policy # RCM05-01-04, titled "Bathing preference", effective December 2014, indicated that, "every resident will be bathed at a minimum twice a week, by the method of his or her choice, and more frequently as determined by the resident's hygiene requirements. On admission, ask resident/SDM the resident's preferred bath type".

The Administrator was interviewed and indicated that the residents should have a choice between a bath and a shower offered to them on admission. The Administrator confirmed that the tubs on all units were functioning and staff were expected to use the tubs if residents preferred to be bathed in the tub.

(561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall do the following:

1. Ensure that all residents receive basic toenail care and receive it from direct care staff.

2. Ensure that residents' written plans of care are updated to include clear direction related to toenail care.

3. Ensure that all toenail care provided to residents is documented.

4. Ensure that all direct care staff receive, including registered staff, receive annual training on the provision of toenail care.

5. Ensure that no resident is charged any fee for basic toenail care.

6. Ensure that the home's toenail care policy is revised accordingly to include clear direction related to toenail care.

Grounds / Motifs :

1. Judgement Matrix
- NC Severity: Minimal harm or potential for actual harm
- NC Scope: Pattern
- Compliance History: One or more unrelated NC in the last three years

2.The licensee failed to ensure that residents received preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

An interview with resident #035 revealed the staff did not cut their toenails and they were unable to cut them as a result of their medical condition. The resident stated their toenails had not been cut in several weeks, and they had been informed by the home there was a monthly charge for nail cutting. The resident confirmed that they were not diabetic and did not have brittle toenails or any other conditions of their feet. Review of the resident's written plan of care indicated that they required extensive assistance and should receive a visit from the foot care nurse every six weeks. Registered staff #104, in an interview, stated that residents' toenails were not cut by staff as it was a paid service from an outside contract service. Registered staff #106 stated the registered staff should cut the residents' toenails. PSW #117 stated toenail cutting for residents was not done by staff as it was a paid service only. PSW #108 stated staff did not cut resident #035's toenails.
Review of policy #RCM05-02-06, titled "Nail Care – Toenails", effective date December 2014, stated "Each resident will receive preventative and basic foot care services including cutting of toenails, to ensure comfort and prevent infection" and "Direct care staff do not cut: thickened or brittle nails, nails of diabetic residents', residents' who have contracted an outside service eg. We Care/Arvan".
The Administrator and the DOC confirmed registered staff were expected to cut all non-diabetic residents' toenails, including resident #035, unless they paid for the outside service.
(591)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 16, 2016

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall do the following:

1. Ensure that all residents who require finger nail care receive it from direct care staff.

2. Ensure that all written plans of care for residents' requiring finger nail care are updated to reflect the residents' or SDMs' nail care choices and preferences.

3. Ensure that all finger nail care provided to residents' is documented.

4. Ensure that all direct care staff receive annual training on the provision of finger nail care.

5. Ensure that no resident is charged any fee for basic nail care.

Grounds / Motifs :

1. Judgement Matrix
- NC Severity: Minimal harm or potential for actual harm
- NC Scope: Pattern
- Compliance History: One or more unrelated NC in the past three years

2. The licensee failed to ensure that residents received fingernail care, including the cutting of fingernails.

A) During a family interview on behalf of the resident who was unable to participate in an interview, it was indicated by the substitute decision maker (SDM) that finger nail care was not provided to the resident by direct care

providers in the home. The SDM indicated that the family trimmed resident #026's finger nails when they became too long. An interview with PSW #113 indicated that for non-diabetic residents, PSW's or registered staff were supposed to trim all residents' nails on bath days twice weekly, and as required. Registered staff #104 stated that the nail care that may have been provided by staff to resident #026 had not been documented and was unsure of the last time a staff member provided nail care to this resident. A review of the home's policy #RCM05-02-05, titled "Nail Care – Fingernails", effective date December 2014, stated that "nail care will routinely be done after resident's bath".
An interview with the DOC confirmed that staff were to provide nail care unless otherwise indicated and that the staff did not provide fingernail care to resident #026.(619)

B) During stage one of the inspection, resident #021 was observed to have fingernails that were long and dirty. The resident indicated that staff trimmed their nails only upon request. The written plan of care indicated that their fingernails needed to be trimmed short but did not indicate when they should be trimmed. In an interview, PSW #112 indicated that all residents' fingernails were trimmed by the Charge Nurse, not the PSW staff. The home's policy # RCM05-02-05, titled "Nail Care – Fingernails", December 2014, indicated that fingernails were to be routinely done after the resident's bath and to document nail care on flow sheets. The PSW flow sheets were reviewed for specific months in 2016. The flow sheets did not have a section to document nail care and on a specific flow sheet it was documented that staff completed nail care only on one day in a specific month in 2016. The DOC confirmed in an interview that the fingernail care was to be done by registered staff, except for residents who had diabetes. Resident #021 did not receive fingernail care including cutting of their fingernails. (561)

C) During stage one of the inspection, resident #021 was observed to have fingernails that were long and dirty. An interview with the resident revealed the staff did not cut their nails. They stated their nails had not been cut in several weeks, and they had been informed that there was a charge for nail cutting. A review of the "Flow sheet" for an identified time period in 2016 for resident #035 revealed that for the entire month, there was no documentation completed to confirm their fingernails had been cut, or that the resident had refused to have their fingernails cut except on one identified date. Review of the resident's written plan of care indicated that they required extensive assistance and should receive a visit from the foot care nurse every six weeks. Review of the home's

policy #RCM05-02-05, titled "Resident Care – Nail care – Fingernails", effective date December 2014, indicated, "review resident's plan of care prior to procedure; procedure will routinely be done after the resident's bath; document nail care on the Daily Flow Sheet". In an interview, PSW #108 stated that staff, nor the resident's spouse cut their nails. They confirmed that the resident required extensive assistance with hygiene care. In an interview, registered staff #106 and the DOC confirmed the PSW staff were expected to cut the residents' fingernails on shower days and as needed and to document the care.
(591)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 16, 2016

Order # / Ordre no : 007

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

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 licensee shall prepare, submit and implement a plan to ensure that staff use safe transferring and positioning techniques when assisting residents. The plan shall include, but is not limited to:

1. A revision of the home's lift and transfer policy to include mandatory annual education to all direct care staff including registered staff.

2. Education for all staff who provide direct care to residents including all registered staff, on safe lifts and transfers.

3. A review and revision of all residents' written plans of care including the proper transfer technique as assessed by Physiotherapist/registered staff and ensure direct care staff are aware of the contents of the written plans of care.

4. An audit of all residents' rooms to ensure that the proper logo is placed in residents' rooms indicating proper transfer technique.

The plan shall be submitted electronically to Long Term Care Homes Inspector, Daria Trzos, by September 15, 2016, to: daria.trzos@ontario.ca.

Grounds / Motifs :

1. Judgement Matrix
- NC Severity: Actual harm/risk
- NC Scope: Pattern
- Compliance History: One or more unrelated NC in the past three years

2. The licensee failed to ensure that staff used safe transferring and positioning

devices or techniques when assisting residents.

A) Observations on a specific day in 2016, revealed registered staff #104 and PSW #112 resident #021 from a wheelchair to an armchair in their room. A "sit-to-stand" mechanical lift was used to transfer the resident.
The resident was interviewed and indicated that the staff used the “sit-to-stand” lift for transfers and indicated that they sustained an injury during the transfer. The progress notes were reviewed and confirmed the incident. Resident #021’s written plan of care indicated that the resident was assessed by the Physiotherapist on a specific day in 2016, and their transfer status was changed from “sit-to-stand” lift to a “hoyer” lift. The Physiotherapist was interviewed and confirmed that they had assessed the resident and the “sit-to-stand” lift was unsafe to use for this resident. The written plan of care was updated and indicated that the “sit-to-stand” lift was unsafe to use. In an interview, both registered staff #104 and PSW #112 indicated that the resident was to be transferred using a “sit-to-stand” lift. Registered staff #104 had revised the written plan of care indicating that a “sit-to-stand” lift may be used “if resident insists”. A review of the home’s 2015 training records for lifts and transfers indicated that only seven out of 24 registered staff (29 percent) completed training on lifts and transfers.
An interview with the DOC revealed that registered staff were not required to attend education on lifts and transfers as they did not use the lifts and did not transfer residents; however, resident #021 was observed being transferred by a registered staff member with a PSW using the mechanical lift as mentioned above.
An interview with the DOC confirmed that the registered staff did not follow the Physiotherapist’s assessment and should not have revised the written care plan. The written plan of care was revised the same day to reflect the transfer status as assessed by the Physiotherapist.(561)

B) Resident #049 had two falls in 2016:
- On a specific day PSW #131 transferred resident #049. The mechanical lift malfunctioned and the resident had a fall, resulting in the resident being injured.
- On another specific day, PSW #132 transferred resident #049 from their bed to their wheelchair using the mechanical lift without assistance. During the transfer, the mechanical lift malfunctioned and the resident had a fall, resulting in the resident being injured.
A review of the resident’s written plan of care effective at the time of the injury indicated the resident was to be transferred safely by two staff using a

mechanical lift. A review of the home's policy #HS-04-02-06, titled "Minimal Lift Policy and Procedures", effective January 2013, indicated that, "Two persons are required when using the mechanical lift; one person to operate the device and one person to support and guide the resident".
During an interview, PSW #131 confirmed that they transferred resident #049 using a mechanical lift on their own, while they were waiting for another PSW to come and assist them. PSW #131 confirmed that two staff were required when transferring residents using the mechanical lift.
During an interview, the DOC stated that both of the above mentioned falls sustained by resident #049 in 2016, were a result of unsafe transfers; where the staff mentioned, performed the transfers independently instead of with two persons while using a mechanical lift. The DOC stated that during the home's internal investigation of the first incident, PSW #131 confirmed they did not have a second person during the transfer.
The DOC confirmed that the home's internal investigation of the second incident revealed that PSW #132 transferred resident #049 using a mechanical lift by themselves. The DOC stated that upon completion of their investigation, action was taken.

The DOC confirmed that the home's expectation was that two staff should have transferred resident #049 with a mechanical lift, and both PSWs mentioned above did not safely transfer the resident on both incidents.(653)
(653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2016

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. 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.

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that actions are taken and outcomes are evaluated for significant weight changes and any other weight change that compromises the resident's health status.

The plan shall include but is not limited to:

1. A review of all residents with significant weight changes to ensure that actions were/are taken to address significant weight changes and interventions are evaluated for effectiveness.

2. A review of the nutrition assessment process to ensure that all relevant information is assessed and included in the documentation.

3. A review of the home's policy related to referral to the Registered Dietitian to ensure the policy is current and reflects the home's current practices.

4. Education for nursing staff related to the policy for referral to the Registered Dietitian.

5. Quality management activities, including auditing and evaluation, to ensure that actions are taken to address weight changes.

The plan shall be submitted to Long Term Care Inspector Michelle Warrener by September 15, 2016, via e-mail to: Michelle.Warrener@ontario.ca.

Grounds / Motifs :

1. Judgement Matrix
- NC Severity: Minimal harm or potential for actual harm
- NC Scope: Pattern
- Compliance History: One or more unrelated NC in the last three years

2. The licensee failed to ensure that action was taken and outcomes were evaluated for significant weight changes and any other weight change that compromised the residents' health status.

A) Resident #026 had significant weight loss over several months on two occasions in 2016. Action was not taken to address the significant weight loss and the resident's written plan of care was not revised with strategies to ensure adequate nutritional intake during that period. The resident had poor intake of both food and fluids (the resident had met their hydration target on only four days during a specific period in 2016).
The RD identified the resident's significant weight loss was positive and continued with the same plan of care, and had not evaluated the resident's poor hydration and poor intake in relation to the significant weight loss.

B) A review of resident #047's written plan of care identified a goal for weight loss closer to the resident's goal weight range. The goal had been in place for over one year. The resident continued to gain weight with weight increase over one year from a specific period of time between 2015 and 2016, with the resident's weight at an "Obese Class II" status. The resident had gained a specific amount of their body weight since admission in 2014. Strategies related to weight management had been in place prior to a specific period of time in 2015, and had not been revised thereafter.

In an interview, the RD confirmed that the strategies on the resident's written plan of care had not been effective for weight loss and that the strategies or goals had not been revised when the plan had not been effective. Action was not taken to address the ongoing weight gain and outcomes were not evaluated in relation to goals specified on the resident's written plan of care.(107)
(107)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2016

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 009

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 245. The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act.
O. Reg. 79/10, s. 245.

Order / Ordre :

The licensee shall do the following:

1. Immediately cease charging residents for basic toenail care.

2. For every resident that has paid for the contracted service for basic toenail care prior to this inspection, the home shall reimburse total/full charges paid (fees paid to the home including fees forwarded to the contracted service provider) since the acquisition of the home by Schlegel corporation.

3. Notify and explain the reason for the reimbursement of charges for toenail care and include the name of the individual (resident/SDM) to whom this discussion was provided to in documentation in the health record.

4. Obtain signature of receipt of total fees reimbursed to each resident.

5. Revise the "Foot Care Consent and Authorization" form to include information related to the assessed necessity for advanced foot care by an outside contractor, what care is provided, when it will be provided, the cost of the care, total cost, and any other information deemed necessary.

6. Obtain new written consent using the approved, revised consent form as outlined above, for those residents assessed as requiring the contracted service provider to provide them with advanced foot care and retain a copy of the consent in the residents health record (former consent forms shall be made null and void).

7. Ensure that no deductions from payment for the contracted service for advanced foot care are retained by the home; ensure that fees as set by the contracted service provider are paid in full to the contracted service provider.

8. Include details on admission and in the admission package related to basic toenail care, and outline the procedure and any related costs for advanced foot care.

Grounds / Motifs :

1. Judgement Matrix
- NC Severity: Minimal harm or potential for actual harm
- NC Scope: widespread
- Compliance History: One or more unrelated NC in the last three years

2. The licensee failed to ensure that residents were not charged for goods and services that a licensee was required to provide to residents using funding that the licensee received from the Minister under section 90 of the Act.

Observations throughout the inspection revealed several residents with long toenails.
In an interview, resident #005 stated that staff had not offered to cut their toenails since their admission to the home, and the resident confirmed that they were not diabetic nor did they have brittle nails or any other conditions with their feet or toenails. This information was confirmed by review of the resident's clinical health record. The resident's toenails were observed to be long and dirty.

In an interview, resident #027 stated that they paid the home a sum of money monthly for their toenails to be cut by an outside service as they had been instructed that staff at the home did not cut resident toenails. The resident also confirmed that they were not diabetic and did not have brittle or thickened toenails, or any issues with their feet or toenails. This information was confirmed by review of the resident's clinical health record.
In an interview, resident #021 stated that they had paid the home a sum of money monthly for an outside service to cut their toenails as they understood that staff at the home did not cut toenails. The resident also confirmed that they were not diabetic and did not have brittle or thickened toenails, or any issues with their feet or toenails. This information was confirmed by a review of the resident's clinical health record.
In an interview, registered staff #104 stated that residents' toenails were not cut by staff as it was a paid service from an outside contract service. Registered staff #106 stated that the registered staff should cut the residents' toenails. PSW #117 stated toenail cutting for residents was not done by staff as it was a paid service only. PSW #100 stated staff did not cut residents' toenails.
A review of policy #RCM05-02-06, titled "Nail Care – Toenails", effective December 2014, stated, "Each resident will receive preventative and basic foot care services including cutting of toenails, to ensure comfort and prevent infection" and "Direct care staff do not cut: thickened or brittle nails, nails of diabetic residents, residents who have contracted an outside service". The policy did not include direction for staff to cut non-diabetic, non-brittle, or non-thickened residents' toenails.
A review of the document titled "Foot Care Consent and Authorization" stated, "Basic foot care includes assessing the condition of the feet, nail trim and

cleanse….authorize Erin Mills Long Term Care to bill me the amount including applicable taxes per treatment and I agree to pay this monthly bill as full and appropriate payment for this Basic foot care
service".
A request was made for the home to provide an updated copy of the total number of residents who gave consent for the contracted service provider to cut their toenails. A review of the document titled "Foot Care Consent List" provided by the home revealed that 51 of 83 residents gave consent for the contracted service to cut their toenails.
In an interview, the DOC stated that on admission, residents were offered foot care service through the contracted provider to provide care every four to six weeks. If they wanted the service, they were expected to sign a consent form. They confirmed that not all of the residents who provided consent were diabetic or had thickened or brittle nails, and further confirmed that residents who were not diabetic or do not have thickened or brittle nails should not be expected to pay for the care, and should have their toe nails cut by the registered staff.
In an interview with the contracted service provider, the company owner confirmed that residents were billed an identified sum of money monthly for a foot care nurse from their company to provide "advanced", not "basic", foot care to consenting residents every four to six weeks.
In an interview, the Administrator stated that the home's expectation was that basic foot care should be performed by the registered staff, and if the resident was diabetic or had brittle nails, they should be referred to the physician who would cut their toenails unless they had paid for the contracted service. The Administrator confirmed that this direction was not included in the related policy. They stated that though the "Foot care Consent and Authorization" form stated "Basic Foot care service", the care provided to the residents was in fact "advanced" foot care. The Administrator stated that of the charges to the residents, a portion of the charges went to the home and a portion went to the contracted service each month and when combined, totaled the amount charged to the residents. During the course of the inspection, the Administrator provided a document titled "Erin Mills Lodge – Provision of toenail Care; 2016 Plan for improvement of Process for Toenail care provision" and also an updated "Foot Care Consent and Authorization" form.

The licensee charged for basic toenail care that they were required to provide to residents using funding that the licensee received from the Minister under section 90 of the Act.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

(591)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 2nd day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Natasha Jones

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