Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 24, 2015	2015_353589_0010	T-2316-15	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE ROUGE VALLEY
551 Conlins Road TORONTO ON M1B 5S1

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

JOANNE ZAHUR (589), AMANDA WILLIAMS (101), SOFIA DASILVA (567), SUSAN SEMEREDY (501)

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): April 20, 21, 22, 24, 27, 28, 29, 30, and May 1, 2015.

The following complaints were conducted concurrently with this inspection: T-1784 -14 and T-2181-15.
The following critical incidents were conducted concurrently with this inspection: T-793-13 and T-2042-15.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), dietary manager, registered dietitian (RD), program manager, social worker (SW), physiotherapist (PT), acting maintenance manager, registered staff, personal support worker(s) (PSW's), dietary aides, cooks, residents, substitute decision makers (SDM's), long term care (LTC) home's Regional Director, Central East Local Health Integration Network (CE-LHIN), President's of Residents' Council and Family Council.

During the course of the inspection, the inspector(s)conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, complaint and critical incident record logs, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **24 WN(s)**
- **9 VPC(s)**
- **3 CO(s)**
- **1 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 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 resident #4 was protected from physical abuse, specifically, the use of physical force by anyone other than a resident that causes

physical injury or pain.

Physical abuse as outlined in section 2.(1) of the Regulation (O. Reg. 79/10) includes "the use of physical force by anyone other than a resident", that causes physical injury or pain.

Observation on an identified date in 2015, revealed resident #4 being fed in an inappropriate manner in the dining room at lunch by two family members. One family member fed the resident using a large tablespoon while the resident appeared to be trying to move his/her head away. The other family member was sitting on the other side of the resident. The resident could not communicate.

Interviews with the director of care (DOC), registered dietitian (RD) and social worker (SW) revealed they are aware that the family feeds the resident in this inappropriate manner at lunch and dinner meals. The RD stated that the family has been feeding resident #4 in this manner since the resident's admission and that the staff do not feed the resident in this manner. The RD further stated he/she has provided education to the family but believe they are doing the right thing by using this manner of feeding to ensure that the resident eats. The DOC stated this was an ethical issue that have been trying to resolve and this manner of feeding may have caused sites of altered skin integrity of identified areas of the resident’s face. The SW stated that this feeding issue was not raised at the last care conference and has not been brought forth to their ethical committee or corporate representatives for an ethics review. The DOC, RD and SW confirmed that this was a form of abuse.

On an identified date in 2015, an inspector brought the above mentioned concern to the attention of the administrator. However, observations at lunch on an identified date in 2015 and at dinner on an nidentified date in 2015 revealed that the family’s altered manner of feeding resident #4 continued. During the dinner meal it was observed that the the family used the same feeding technique as previously observed on the above identified dates. During the dinner meal it was observed that the family member used a tablespoon to scrape resident #4's mouth to wipe away excess food after each mouthful.

Record review of the progress notes revealed registered staff members are aware and concerned about this and have communicated in the progress notes as follows:

•On an identified date in 2014, registered staff #128 documented he/she heard resident #4 coughing and choking on several occasions at suppertime and observed resident

being fed by a family member vigorously by squeezing an identified area of the resident's face resulting in his/her mouth to open and in the resident's head moving over. The family member also used an identified part of his/her upper extremity to force an identified area of the resident's face upwards.
•On an identified date in 2015, registered staff #110 documented he/she observed both family members holding down the resident's bilateral upper extremities, while one family member was forcing the resident's mouth open with the use of a spoon and the other was holding the resident's head. Registered staff #110 also documented observing altered skin integrity on identified areas of the resident's face and that an identified area of the face was swollen. Registered staff #110 documented that messages to inform the DOC, ADOC #119, SW, and the registered nurse supervisor were left.

Interviews with registered staff #128 and #110 revealed that this is an ongoing problem and have identified the inappropriate manner in which family feeds resident #4 as abuse and reported it to management. The above mentioned staff confirmed they are aware of mandatory reporting of abuse to the Ministry of Health and Long Term Care but both felt informing management was sufficient.

Review of the home's policy #OPER-02-02-04 titled "Resident Abuse by Persons Other Than Staff", revised November 2013, states that in Ontario, in addition to reporting any suspected or witnessed abuse to the administrator, DOC or designate, anyone who suspects or witnesses abuse that causes or may cause harm to a resident, is required by the LTCHA 2007 to contact the Ministry of Health and Long Term Care (Director). Interviews with the RD, SW, and registered staff #128 and #110 revealed that they considered the inappropriate manner in which resident #4 is fed by family members to be a form of abuse and revealed they have not contacted the Director even though they are aware of the legislative requirements.

Record review of the most recent written plan of care revealed that resident #4 is at high nutritional risk related to identified issues with resident #4's ability to eat. Interview with the RD revealed that the resident had been previously hospitalized for an identified medical condition. The plan of care did not include any direction to staff on what interventions to take should family members be observed feeding the resident in the above mentioned manner.

Observations on two identified dates in 2015, revealed PSW's #101 and #131 feeding resident #4 his/her breakfast tray while in bed. It was observed that when sufficient time is given, resident #4 was able to open his/ her mouth and swallow. Resident #4

consumed approximately 50 per cent of the meal and 75 per cent of the fluids. Interview with PSWs #101 and #131 revealed they have no difficulty or concern feeding resident #4 and this is the resident's usual intake.

Interview with the administrator confirmed that the home has not protected resident #4 from abuse related to the feeding technique of family members. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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 has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Observation on an identified date in 2015, revealed that resident #8 was in bed being attended to by registered staff #116 for an identified injury. Interview with registered staff #116 revealed that resident #8 sustained this injury during a transfer by PSW #126 using a mechanical lift. Registered staff #116 stated that he/she was asked by PSW #126 to assess the resident because he/she was injured. Registered staff #116 went to the resident's room and found resident #8 seated in the wheelchair with the sling placed around him/her and the mechanical lift positioned close by. The resident said, "she is trying to kill me." PSW #126 revealed to registered staff #116 that resident #8 had struck an identified area of their body on the lift. Registered staff #116 and PSW's #126 and #124 transferred the resident into bed and the registered staff attended to the wound. Later that morning, the physician recommended sending the resident to the hospital for further assessment.

Record review of the most recent written plan of care revealed that resident #8 required extensive assistance with two staff for transferring and that if resident was experiencing

pain and not able to weight bear then staff were to use an alternate identified mechanical lift. Interview with the PT confirmed that the above mentioned mechanical lift was not appropriate for resident #8 because he/she suffers from physical limitations. This has resulted in resident #8 experiencing difficulty holding the bar of the lift required for support during transfers. The PT stated that due to these limitations, the use of an alternate identified mechanical lift was recommended for all transfers. Interview with PSW #126 who had been transferring resident #8 revealed he/she had not reviewed the resident's kardex or plan of care prior to transferring.

PSW #126 further revealed he/she had only positioned the resident, had not actually performed the transfer and was waiting for the assistance of PSW #124. Interview with PSW #124 revealed he/she had not been called upon to assist with the transfer.

Review of the home’s policy #01-02 titled "Safe Lifting with Care Program - Mechanical Lifts", states that two trained staff are required at all times when a mechanical lift is used for resident transfers.

Interview with the administrator confirmed that PSW #126 did not use safe transferring and positioning devices or techniques when assisting resident #8. [s. 36.]

2. A review of an identified critical system inspection on an identified date revealed PSW #111 transferred resident #12 with a mechanical lift unassisted in which the resident sustained an injury to an identified lower extremity requiring a transfer to hospital.

A review of resident #12's most recent written plan of care revealed the use of a mechanical lift for all transfers with two staff present for the above mentioned resident is required.

An interview with PSW #111 revealed he/she had completed the transfer of resident #12 using a mechanical lift independently and without assistance.

Record review of the home’s policy #01-02 titled "Safe Lifting with Care Program - Mechanical Lifts", states that two trained staff are required at all times when a mechanical lift is used for resident transfers.

An interview with the DOC confirmed PSW #111 completed the transfer of resident #12 using a mechanical lift without assistance. [s. 36.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review, observations, and interviews with residents, staff and management confirmed that the home has been experiencing water leaks on an identified home area as a result of damage to the roof. Water leaks from the roof of the above mentioned home area were identified to be ongoing since an identified month in 2011. Two identified resident rooms were observed to be vacant as a result of extensive recurring leaks and confirmed to be vacant since an identified date in 2014. The two affected residents were moved to alternative rooms to ensure their safety.

Observation of resident rooms and common areas revealed water damage to several common areas and resident rooms on an identified home area. Brown water marks were observed on the ceiling, around light fixtures, and around the sprinkler system in hallways, near nursing stations and identified residents rooms (three identified home area hallways, multiple identified resident rooms, an identified lounge and nursing station, and an identified spa room). Interviews with residents #13, #14 and #15 revealed that during heavy rainfall water drips in their rooms. Housekeeping staff cleaned up water leaks and maintenance staff continued to patch the affected areas. However, concerns of potential slip hazards and resident safety during periods of time when housekeeping is unavailable and when decreased nursing staff are present on identified shifts was noted.

Interview with the maintenance supervisor revealed that repairs to the roof are expected to begin in June/July 2015.

Identified resident rooms were observed to have evidence of water leaks and/or cracked pieces of ceiling drywall (four identified resident rooms on an identified home area). Interview with resident #13 revealed that personal belongings and furniture had to be re-arranged within the room to protect his/her belongings and/or prevent water from dripping directly on them. [s. 15. (2) (c)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 104. Beds allowed under licence

Specifically failed to comply with the following:

s. 104. (2) Every licensee shall ensure that all the beds that are allowed under the licence are occupied or are available for occupation. 2007, c. 8, s. 104. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all beds that are allowed under the license are occupied or are available for occupation.

Observation on April 20, 2015, by inspector 101 revealed that two beds in two identified rooms were closed to resident occupancy.

Interviews with the director of care, and administrator confirmed that the above mentioned beds had been closed to occupancy since an identified date in 2014, as a result of recurring water leaking from the roof into both rooms causing damage and posing a risk to residents. At the time of this inspection on April 20, 2015, these two identified rooms had been closed to resident occupancy for a total of 146 days.

Interviews with the maintenance supervisor and administrator revealed that the entire roof of the home requires repair and the project has been divided into 10 phases with phase one to commence June or July 2015.

On April 27, 2015, the inspector provided the home's administrator with Appendix "A"- Beds in Abeyance application form, to be completed and submitted to the central east local health integration network (CE-LHIN)office.

On April 28, 2015, the administrator confirmed that the Beds in Abeyance application form had been completed by Extendicare corporate office and submitted.

On May 13, 2015, an off-site inquiry with an identified senior manager of placement with the central east community care access (CE-CCAC) revealed and confirmed that the administrator had verbally notified the CE-CCAC of the two beds that had been closed for occupancy and that the home was advised to notify the CE-LHIN.

On May 27, 2015, an off-site inquiry with an identified member of the CE-LHIN revealed that an email correspondence began on April 27, 2015, between the CE-LHIN and an identified regional director of the licensee regarding applying for beds in abeyance (BIA) related to the two identified rooms. The CE-LHIN confirmed that a BIA application was submitted to the Director on May 5, 2015. [s. 104. (2)]

Additional Required Actions:

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse of residents is complied with.

Review of the home's policy #OPER-02-02-04 titled "Resident Abuse by Persons Other Than Staff", revised November 2013, states that in Ontario, in addition to reporting any suspected or witnessed abuse to the administrator, DOC or designate, anyone who suspects or witnesses abuse that causes or may cause harm to a resident, is required by the LTCHA 2007 to contact the Ministry of Health and Long Term Care (Director).

Record review of progress notes and staff interviews revealed that resident #4 had been fed in an altered manner by her family members and this has been reported to the DOC by registered staff #110 on an identified date in 2015, and discussed at the home's morning meetings.

Interviews with the RD, social worker, and registered staff #110 revealed and confirmed that they considered the altered manner of feeding resident #4 by family members to be a form of abuse, but had not contacted the Director even though they are aware they should have. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy that promotes zero tolerance of abuse of residents is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated.

Record review of progress notes and staff interviews revealed that resident #4 was fed in an inappropriate manner by family members and it was reported to the DOC on an identified date in 2015, by registered staff #110.

Interview with the SW revealed he/she became aware of the manner in which resident #4 was fed approximately two to three months ago during a review of progress notes at a daily management meeting.

Interview with the administrator revealed he/she was aware resident #4 was fed in an inappropriate manner by family members and considered these actions a form of abuse. The administrator confirmed that the suspicion of abuse had not been investigated. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Interview with the RD revealed that the family had been feeding resident #4 in an inappropriate manner since admission to the home. Registered staff #128, SW and RD confirmed reporting their suspicion of abuse to their managers was sufficient, even though they are aware of mandatory reporting and have received training in this area.

Interviews with the administrator, DOC, SW, RD, and registered staff #110 confirmed that the manner in which resident #4 was fed by family members is a form of abuse however, none of the above mentioned staff reported their suspicion of abuse to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who had reasonable ground to suspect abuse of a resident by anyone that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Residents' Council receives a response in writing within 10 days of receiving advice related to concerns or recommendations.

Review of the Residents' Council meeting minutes revealed that issues brought forth in the February 20th, 2015 meeting were not responded to until April 9, 2015. These issues included:
-staff left a resident hooked up for several minutes in the new lift while the one staff member went to get another staff to assist,
-too many carts and machinery cluttering up the halls,
-when coming to wake up residents staff leave the bedroom door open, resident would like it closed when they are getting dressed,
-dining room is still noisy, so noisy that a resident cannot hear what his/her table mate is saying,
-some staff are still putting their fingers inside the water filled glasses,
-continue to experience a shortage of towels and face cloths and,
-laundry comes back to residents damp.

Interview with the program manager revealed that the staff assistant for the Residents' Council is an activity aide who did not process the concerns to the department manager's in a timely manner.

Interview with the administrator confirmed that these concerns should have been responded to within 10 days of the licensee having knowledge of the concerns and recommendations. [s. 57. (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 the Residents' Council receives a response in writing within 10 days of receiving advice related to concerns or recommendations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items are offered and available at each meal and snack.

Observation on April 20, 2015, during lunch in the Clarke House dining room revealed resident #21 was not offered a choice of dessert and was given pureed pears. Interview with PSW #124 revealed resident #21 was not offered the alternate choice of an ice cream sandwich because of an identified health condition. The resident was eventually offered a thickened ice cream dessert but had already finished the pureed pears.

Record review of the most recent written plan of care revealed that resident #21 is on an identified diet with altered fluid consistency. The PSW after being interviewed by the inspector, offered the resident sherbet. Review of the home's policy #DIET-04-01-02 titled "Diet Types, Textures and Fluid Consistencies", revised June 2013, indicates that when jello, ice cream or sherbet is on the menu, alternate desserts must be planned and provided to residents with altered fluid consistency orders.

Interview with the dietary manager confirmed that altered consistency of ice cream was available but the dietary aide did not put it out for the PSW's to provide to residents on altered fluid consistency diets.

Observation on April 24, 2015, during breakfast revealed in the Clarke House dining room that many residents were eating oatmeal. Record review of the planned menu indicated that oat bran cereal was to be offered. Interview with dietary aide #138 could not identify what hot cereal was being served. Interview with the dietary manager confirmed that oatmeal and cream of wheat were served because the delivery of oat bran did not arrive on time and was not available.

Observation on April 24, 2015, during the lunch meal in Cedar Ridge House and Clarke House dining rooms, residents on identified altered diets were not offered an altered portion of dessert. Interviews with PSWs present in the dining room revealed that usually a smaller portion of dessert is offered to residents on an identified altered diets.

Record review of the planned menu revealed residents on diabetic diets are to receive 80 millilitres (ml) of mandarin chiffon while those on a regular diet are to receive 125 ml.

Interview with the dietary manager revealed that a new dietary staff member did not prepare the diabetic portions as per the planned menu.

Observation on April 24, 2015, revealed during the lunch meal in Clarke House dining room, residents on a pureed diet were being served mashed potatoes.

Record review of the planned menu for April 24, 2015, revealed that pureed wheat bread was on the menu.

Interview with dietary aide #138 revealed that mashed potatoes and pureed bread are the same. Interview with the dietary manager revealed that many residents prefer mashed potatoes and are therefore served potatoes instead of bread. When asked who decides what the resident receives, the dietary manager revealed that the PSWs make the choice for the resident and it is not part of their written plan of care.

The dietary manager confirmed that pureed bread should be offered to residents when it is on the planned menu unless their written plan of care indicates a preference for mashed potatoes. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #10: 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).**

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

Observations on April 21, 2015, revealed PSW #106 standing while assisting seated residents, to drink at nourishment time in the Highland Creek common area.

Interview with PSW #106 revealed that he/she usually sits when feeding in the dining room however, was unaware why he/she should not be standing when assisting residents with fluids at nourishment time.

Observation on April 29, 2015, revealed PSW #131 standing while feeding resident #4 in bed. PSW #131 used a tablespoon to assist the resident with fluids and the clothing protector to wipe resident #4s mouth.

Interview with PSW #131 confirmed that standing, the use of a tablespoon and wiping resident #4's face with a clothing protector were not proper techniques to assist with eating.

Interview with the dietary manager and RD confirmed that staff assisting residents with eating should be positioned at resident's eye level, should use a teaspoon and should not use clothing protectors to wipe their mouths. [s. 73. (1) 10.]

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 proper techniques are used to assist resident with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff receive retraining annually related to the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections.

Record review of the home's education attendance and an interview with the DOC confirmed that 14 per cent of staff in 2014, did not receive annual retraining in the above mentioned areas. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff receive retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response has been made to the person who made the complaint.

Record review revealed that resident #8’s SDM made a complaint that was documented by the DOC on an identified date in 2014. According to the complaint record, the resident was frightened by the way PSW's had been treating him/her.

Record review of the complaint investigation form indicated that a response had not been made to the SDM.

Interview with the DOC confirmed that the investigation revealed this complaint was unfounded and that the SDM was not contacted about the investigation findings.

Interview with resident #8’s SDM revealed that he/she made a verbal complaint via the telephone to ADOC #120 on an identified date in 2014, concerned that his/her mother was not being toileted as requested and was being being left in the dining room long after breakfast. The SDM indicated that no one, including ADOC #120 had made contact with him/her about the complaints made.

Interview and record review of the complaint log revealed that ADOC #120 spoke with resident #8’s SDM on an identified date in 2014, regarding the resident being left in the dining room but did not recall the issue of toileting. ADOC #120 confirmed he/she did not respond to the SDM after having spoken to the PSW's regarding leaving residents in the dining room. [s. 101. (1) 3.]

2. The licensee has failed to ensure that the documented record of complaints received is reviewed and analyzed for trends, at least quarterly.

Record review and interview with the administrator revealed that the home had a documented record of complaints and data related to types of complaints however, there was no documentation related to an analysis of this complaint data.

Interview with the administrator confirmed that an analysis of complaints had not been conducted. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response has been made to the person who made the complaint and that the documented record of complaints received is reviewed and analyzed for trends, at least quarterly, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances of an emergency including the unplanned evacuation of residents.

On April 20, 2015, inspector #101 conducted an inspection related to a complaint of leaking water into resident rooms and common areas on the third floor. The complainant stated, there were water buckets everywhere to collect the water and expressed fear mold could result in resident and staff illness.

On April 20, 2015, observations revealed that two identified resident rooms were closed to occupancy.

Interview with the DOC and ES revealed that the above mentioned resident rooms had been closed to resident occupancy from an identified date in 2014. Interview with the administrator revealed that the two residents occupying the above mentioned rooms were transferred and the beds were subsequently closed to admissions. The administrator further revealed that the transfer of the two residents and the closure of the two identified beds was not an unplanned evacuation but rather a decision he/she had made related to recurring water leaks from the roof into these two identified rooms. The administrator confirmed that a critical system report was not submitted to the Director.

Interview with the LTC home's Regional Director confirmed that a flood had occurred on the above mentioned identified date in 2014, affecting the two identified resident rooms, resulting in an emergency evacuation of the residents occupying these two rooms. [s. 107. (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 the licensee inform the Director immediately, in as much detail as is possible in the circumstances, of the following incident in the home: an emergency including fire, unplanned evacuation or intake of evacuees, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity is fully respected and promoted.

On April 20, 2015, the inspector observed resident #23 lying in bed with an over bed table at the bedside with a lunch meal tray on it.

Interview with PSW #117 revealed the resident refused to sit in a chair or have the head of his/her bed raised to eat meals. PSW #117 then proceeded to raise the head of the bed without asking or telling the resident what he/she was doing. When questioned, PSW #117 confirmed that the above mentioned actions were disrespectful to the resident. [s. 3. (1) 1.]

WN #15: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there 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.

Observation on April 20, 2015, at lunch in the Clarke House dining room revealed resident #20 being served an identified sandwich with an identified salad.

Interview with PSW #124 revealed resident #20 was on a diet that required an altered meat texture. After a discussion with the dietary aide, it was revealed that the resident's diet texture had been changed. It was also revealed that there are two lists used by staff in the dining room and one list had not been updated to reflect resident #20's change in diet texture.

Interview with the dietary manager confirmed that the above mentioned diet requirements for resident #20 did not give clear direction to staff who provide direct care. [s. 6. (1) (c)]

2. Record review of resident #8's most recent written plan of care related to toileting needs indicated extensive assistance is required with one staff to provide weight bearing assistance with transfers, peri-care, changing incontinent product and adjusting clothes. The most recent written plan of care related to transferring indicates, resident #8 requires extensive assistance with two staff to provide weight bearing assistance from sitting to upright position.

Interview with the DOC confirmed that this plan of care does not set out clear directions to staff and others who provide direct care to the above mentioned resident. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences.

Interview with a member of resident #11's family revealed the resident was not provided consistent help with cleaning his/her oral dentition and is unable to independently care for them.

Record review of the most recent written plan of care indicated that the resident #11 was independent and was able to brush his/her oral dentition independently once toothpaste was applied to the toothbrush.

Interview with registered staff #133 and PSW #134 confirmed that the plan of care was not based on an assessment of the resident's needs and preferences. [s. 6. (2)]

4. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other 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.

Observations on April 28, 29, and 30, 2015, revealed resident #10 in an identified mobility aid.

Interview with registered staff #108 and PSW #118 indicated that the above mentioned mobility aid was not being used as a restrictive device to their knowledge but, for comfort as they were not made aware it was a restrictive device; even though the point of care (POC) documentation revealed hourly restrictive device monitoring documentation by the PSWs.

Interviews with the physiotherapist, ADOC #119 and administrator confirmed that the use of the identified mobility aid was to be used as a restrictive device, and that other measures to ensure the resident's safety had been assessed and evaluated as unsafe. In addition, the above mentioned staff confirmed that they did not collaborate with direct care staff that the altered mobility aid was actually a restrictive device. [s. 6. (4) (b)]

5. The licensee failed to ensure that the care set out in the plan of care is provided to the resident #4 as specified in the plan.

Observations on April 27 and 29, 2015, revealed that resident #4 was served a breakfast meal that did not contain an egg or protein component. Interviews with PSW's #135 and #131 who were assisting resident #4 revealed that beverages, hot cereal and fruit are what he/she normally eats at the breakfast meal.

Record review of resident #4's most recent written plan of care indicates that he/she is at high nutritional risk due to low serum albumin, is to receive a protein supplement three times a day and is not to have any meat at supper as per the wishes of the family. The plan of care does not indicate any restrictions at breakfast or dislike of egg.

Interview with the RD revealed he/she was unaware that resident #4 was not receiving a protein source at breakfast in accordance with the planned menu, and confirmed that the resident would not therefore, be meeting his/her daily protein requirements. The RD planned to redirect the staff to offer all menu items at breakfast which would include a protein source and thus would enable the resident to meet the daily protein requirements.

The RD confirmed that the staff were not following the care set out in the plan of care as specified. [s. 6. (7)]

6. The licensee has failed to ensure that the resident #12 is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.

A review of progress notes revealed that resident #12 had a history of urinary tract infections (UTIs) which resulted in incidences of increased confusion.

A review of resident #12's most recent written plan of care revealed that the above mentioned history of UTIs with increased incidence of confusion was not identified.

An interview with ADOC #120 confirmed resident #12 does have a history of UTIs, resulting in incidences of increased confusion and confirmed that the above mentioned should be in the resident's written plan of care. [s. 6. (10) (b)]

7. Observations conducted at breakfast, lunch and dinner revealed that resident #4 received total assistance with all meals. Record review of resident #4's most recent written plan of care revealed staff are to provide a lipped plate and a rubber grip spoon at all meals.

Interview with the dietary manager confirmed that this plan had not been updated since resident no longer required a lipped plate or rubber grip spoon at meals. [s. 6. (10) (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written staffing plan for the nursing and personal support services programs.

Interview with the administrator revealed that there is no written staffing plan for the nursing and personal support services programs. It was revealed that changes are made and implemented based on need and funding.

Record review of the home's document titled Sufficient Staffing Quality Protocol for 2014, confirmed that the item related to having a written staffing plan for nursing and personal support services programs was unmet. [s. 31. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids are prepared and served using methods which preserve appearance.

Observation on April 20, 2015, revealed that during the lunch meal in the Clarke House dining room, resident #22 had a glass of water of an altered consistency placed in front of him/her. The water appeared to have portions of an undissolved agent in it that had not been properly dispersed.

Interview with the dietary manager confirmed that the appearance of this fluid was not acceptable and was the result of a new staff member not following the proper technique to prepare this item. [s. 72. (3) (a)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, specifically the posting of copies of the inspection reports from the past two years for the long term care home.

Observations on April 21, 2015, revealed the following two inspection reports were not posted:
-#2014_235507_0018, 2014 resident quality inspection(RQI) and,
-#2014_108110_0006, complaint inspection.

An interview with the administrator confirmed the above mentioned reports were not posted.

Observation on April 22, 2015, revealed the above mentioned reports were posted in the home. [s. 79. (3)]

WN #19: 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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

Review of the home's internal ambulation cleaning schedule and procedures revealed the night staff are to clean ambulation equipment on the night prior to the resident's first shower or bath of the week.

Review of the shower and bath schedule binder revealed that resident #7's first shower day of the week was on an identified week day and that resident #7's wheelchair was scheduled to be cleaned on the previous night of this identified day.

Observations on Wednesday, April 29, 2015, revealed resident #7's wheelchair to be unclean with dry crusted food on the armrest.

Interview with registered staff #108 confirmed that the chair had not been washed the night prior to the resident's first shower of the week. [s. 87. (2) (b)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

On April 28, 29, and 30, 2015, observations revealed a broken towel bar in an identified resident room.

A review of the identified home area's maintenance log revealed that the broken towel bar had been reported broken on identified dates in February 2015, and March 2015, with no documentation that corrective action had taken place.

An interview with registered staff #108 and the acting maintenance manager confirmed that the towel bar had not been repaired.

Prior to the completion of this inspection the towel bar in the above mentioned resident room was repaired. [s. 90. (2) (d)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

Interview with the administrator revealed and confirmed that the home did not conduct an evaluation for 2014 in the above mentioned areas. [s. 99. (b)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
-that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class, RN(EC).

Observations on April 28, 29, and 30, 2015, revealed resident #10 seated in a mobility aid in an identified position.

Interview with the PT and ADOC #119 confirmed that the resident was assessed for the use of an identified mobility aid for the resident’s safety and the PT had recommended and implemented the use of the above mentioned mobility aid as a restrictive device.

Record review of resident #10's health record revealed a physician's order had not been obtained and that consent from the resident’s SDM had not been obtained for the use of the identified mobility aid as a restrictive device.

Interviews with registered staff #108, ADOC #119 and the administrator confirmed the home had not obtained a physician's order and consent from resident #10’s SDM for the use of the identified mobility aid as a restrictive device. [s. 110. (2) 1.]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure to keep a written record of the minimizing restraint program that includes the date of the annual evaluation and the date that the changes were implemented.

A review of the 2014 restraint program evaluation revealed that the date of the evaluation and the date when changes were implemented was not identified.

Interviews with ADOC #119 and the administrator confirmed that the home's annual evaluation of the restraint program for 2014, was not complete and that it did not include all the required legislative requirements. [s. 113. (e)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that training has been provided for all staff who apply physical devices or who monitor residents restrained by a physical device, including application of these physical devices, use of these physical devices, and potential dangers of these physical devices.

Interview with ADOC #119 and record review of education attendance for 2014, confirmed that 46.4 per cent of all staff did not complete the above mentioned restraint training. [s. 221. (1) 5.]

Issued on this 30th day of July, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE ZAHUR (589), AMANDA WILLIAMS (101), SOFIA DASILVA (567), SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2015_353589_0010
Log No. / Registre no:	T-2316-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 24, 2015
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE ROUGE VALLEY 551 Conlins Road, TORONTO, ON, M1B-5S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Terry Pilgrim-Deane

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

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 : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall stop anyone from force-feeding resident #4, to protect the resident from aspirating food, facial bruising and fear.

Grounds / Motifs :

1. 1. The licensee failed to ensure that resident #4 was protected from physical abuse, specifically, the use of physical force by anyone other than a resident that causes physical injury or pain.

Physical abuse as outlined in section 2.(1) of the Regulation (O. Reg. 79/10) includes "the use of physical force by anyone other than a resident", that causes physical injury or pain.

Observation on an identified date in 2015, revealed resident #4 being fed in an inappropriate manner in the dining room at lunch by two family members. One family member fed the resident using a large tablespoon while the resident appeared to be trying to move his/her head away. The other family member was sitting on the other side of the resident. The resident could not communicate.

Interviews with the director of care (DOC), registered dietitian (RD) and social worker (SW) revealed they are aware that the family feeds the resident in this inappropriate manner at lunch and dinner meals. The RD stated that the family has been feeding resident #4 in this manner since the resident's admission and that the staff do not feed the resident in this manner. The RD further stated he/she has provided education to the family but believe they are doing the right thing by using this manner of feeding to ensure that the resident eats. The DOC stated this was an ethical issue that have been trying to resolve and this manner of feeding may have caused sites of altered skin integrity of identified areas of

the resident's face. The SW stated that this feeding issue was not raised at the last care conference and has not been brought forth to their ethical committee or corporate representatives for an ethics review. The DOC, RD and SW confirmed that this was a form of abuse.

On an identified date in 2015, an inspector brought the above mentioned concern to the attention of the administrator. However, observations at lunch on an identified date in 2015 and at dinner on an nidentified date in 2015 revealed that the family's altered manner of feeding resident #4 continued. During the dinner meal it was observed that the the family used the same feeding technique as previously observed on the above identified dates. During the dinner meal it was observed that the family member used a tablespoon to scrape resident #4's mouth to wipe away excess food after each mouthful.

Record review of the progress notes revealed registered staff members are aware and concerned about this and have communicated in the progress notes as follows:

•On an identified date in 2014, registered staff #128 documented he/she heard resident #4 coughing and choking on several occasions at suppertime and observed resident being fed by a family member vigorously by squeezing an identified area of the resident's face resulting in his/her mouth to open and in the resident's head moving over. The family member also used an identified part of his/her upper extremity to force an identified area of the resident's face upwards.
•On an identified date in 2015, registered staff #110 documented he/she observed both family members holding down the resident's bilateral upper extremities, while one family member was forcing the resident's mouth open with the use of a spoon and the other was holding the resident's head. Registered staff #110 also documented observing altered skin integrity on identified areas of the resident's face and that an identified area of the face was swollen. Registered staff #110 documented that messages to inform the DOC, ADOC #119, SW, and the registered nurse supervisor were left.

Interviews with registered staff #128 and #110 revealed that this is an ongoing problem and have identified the inappropriate manner in which family feeds resident #4 as abuse and reported it to management. The above mentioned staff confirmed they are aware of mandatory reporting of abuse to the Ministry of Health and Long Term Care but both felt informing management was sufficient.

Review of the home's policy #OPER-02-02-04 titled "Resident Abuse by Persons Other Than Staff", revised November 2013, states that in Ontario, in addition to reporting any suspected or witnessed abuse to the administrator, DOC or designate, anyone who suspects or witnesses abuse that causes or may cause harm to a resident, is required by the LTCHA 2007 to contact the Ministry of Health and Long Term Care (Director). Interviews with the RD, SW, and registered staff #128 and #110 revealed that they considered the inappropriate manner in which resident #4 is fed by family members to be a form of abuse and revealed they have not contacted the Director even though they are aware of the legislative requirements.

Record review of the most recent written plan of care revealed that resident #4 is at high nutritional risk related to identified issues with resident #4's ability to eat. Interview with the RD revealed that the resident had been previously hospitalized for an identified medical condition. The plan of care did not include any direction to staff on what interventions to take should family members be observed feeding the resident in the above mentioned manner.

Observations on two identified dates in 2015, revealed PSW's #101 and #131 feeding resident #4 his/her breakfast tray while in bed. It was observed that when sufficient time is given, resident #4 was able to open his/ her mouth and swallow. Resident #4 consumed approximately 50 per cent of the meal and 75 per cent of the fluids. Interview with PSWs #101 and #131 revealed they have no difficulty or concern feeding resident #4 and this is the resident's usual intake.

Interview with the administrator confirmed that the home has not protected resident #4 from abuse related to the feeding technique of family members. [s. 19. (1)]
(501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 25, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 ensuring that staff use safe transferring and positioning devices and/or techniques as appropriate, when assisting residents with transfers and positioning.

The plan to achieve compliance shall include, but is not limited to the following:
-how all staff who provide direct care to residents that require the use of a mechanical lift will be trained and maintain his/her proficiency when using the equipment in accordance with manufacturers' instructions.
-the development, implementation and monitoring of a process to ensure that all staff who provide direct care to residents requiring the use of mechanical lifts:
• are aware of the home's policy for safe lifting,
• review the plans of care prior to use for each resident, and
• use safe techniques at all times when transferring residents.

The plan must be submitted by e-mail to Joanne.Zahur@ontario.ca on or before July 07, 2015.

Grounds / Motifs :

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

A review of an identified critical system inspection on an identified date revealed PSW #111 transferred resident #12 with a mechanical lift unassisted in which the resident sustained an injury to an identified lower extremity requiring a transfer to hospital.

A review of resident #12's most recent written plan of care revealed the use of a

mechanical lift for all transfers with two staff present for the above mentioned resident is required.

An interview with PSW #111 revealed he/she had completed the transfer of resident #12 using a mechanical lift independently and without assistance.

Record review of the home's policy #01-02 titled "Safe Lifting with Care Program - Mechanical Lifts", states that two trained staff are required at all times when a mechanical lift is used for resident transfers.

An interview with the DOC confirmed PSW #111 completed the transfer of resident #12 using a mechanical lift without assistance. [s. 36.]
(589)

2. Observation on an identified date in 2015, revealed that resident #8 was in bed being attended to by registered staff #116 for an identified injury. Interview with registered staff #116 revealed that resident #8 sustained this injury during a transfer by PSW #126 using a mechanical lift. Registered staff #116 stated that he/she was asked by PSW #126 to assess the resident because he/she was injured. Registered staff #116 went to the resident's room and found resident #8 seated in the wheelchair with the sling placed around him/her and the mechanical lift positioned close by. The resident said, "she is trying to kill me." PSW #126 revealed to registered staff #116 that resident #8 had struck an identified area of their body on the lift. Registered staff #116 and PSW's #126 and #124 transferred the resident into bed and the registered staff attended to the wound. Later that morning, the physician recommended sending the resident to the hospital for further assessment.

Record review of the most recent written plan of care revealed that resident #8 required extensive assistance with two staff for transferring and that if resident was experiencing pain and not able to weight bear then staff were to use an alternate identified mechanical lift. Interview with the PT confirmed that the above mentioned mechanical lift was not appropriate for resident #8 because he/she suffers from physical limitations. This has resulted in resident #8 experiencing difficulty holding the bar of the lift required for support during transfers. The PT stated that due to these limitations, the use of an alternate identified mechanical lift was recommended for all transfers. Interview with PSW #126 who had been transferring resident #8 revealed he/she had not reviewed the resident's kardex or plan of care prior to transferring.

PSW #126 further revealed he/she had only positioned the resident, had not actually performed the transfer and was waiting for the assistance of PSW #124. Interview with PSW #124 revealed he/she had not been called upon to assist with the transfer.

Review of the home's policy #01-02 titled "Safe Lifting with Care Program - Mechanical Lifts", states that two trained staff are required at all times when a mechanical lift is used for resident transfers.

Interview with the administrator confirmed that PSW #126 did not use safe transferring and positioning devices or techniques when assisting resident #8. [s. 36.]

2. A review of an identified critical system inspection on an identified date revealed PSW #111 transferred resident #12 with a mechanical lift unassisted in which the resident sustained an injury to an identified lower extremity requiring a transfer to hospital.

A review of resident #12's most recent written plan of care revealed the use of a mechanical lift for all transfers with two staff present for the above mentioned resident is required.

An interview with PSW #111 revealed he/she had completed the transfer of resident #12 using a mechanical lift independently and without assistance.

Record review of the home's policy #01-02 titled "Safe Lifting with Care Program - Mechanical Lifts", states that two trained staff are required at all times when a mechanical lift is used for resident transfers.

An interview with the DOC confirmed PSW #111 completed the transfer of resident #12 using a mechanical lift without assistance. [s. 36.]
(501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 21, 2015

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 : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure resident home areas are maintained in a safe condition and in a good state of repair.

The plan is to include immediate, short-term and long-term actions to ensure:
- leaks into resident home areas are identified and repaired to ensure resident safety,
- completion of any necessary mold remediation from ongoing moisture damage in the home including resident rooms and common areas, and
- safety checks and precautions are implemented related to light fixtures surrounded by and affected by leaks from the roof.

Please submit your plan to Joanne.Zahur@ontario.ca no later than July 07, 2015.

Grounds / Motifs :

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

Record review, observations, and interviews with residents, staff and management confirmed that the home has been experiencing water leaks on an identified home area as a result of damage to the roof. Water leaks from the roof of the above mentioned home area were identified to be ongoing since an identified month in 2011. Two identified resident rooms were observed to be

vacant as a result of extensive recurring leaks and confirmed to be vacant since an identified date in 2014. The two affected residents were moved to alternative rooms to ensure their safety.
(101)

2. Observation of resident rooms and common areas revealed water damage to several common areas and resident rooms on an identified home area. Brown water marks were observed on the ceiling, around light fixtures, and around the sprinkler system in hallways, near nursing stations and identified residents rooms (three identified home area hallways, multiple identified resident rooms, an identified lounge and nursing station, and an identified spa room). Interviews with residents #13, #14 and #15 revealed that during heavy rainfall water drips in their rooms. Housekeeping staff cleaned up water leaks and maintenance staff continued to patch the affected areas. However, concerns of potential slip hazards and resident safety during periods of time when housekeeping is unavailable and when decreased nursing staff are present on identified shifts was noted.

Interview with the maintenance supervisor revealed that repairs to the roof are expected to begin in June/July 2015.

Identified resident rooms were observed to have evidence of water leaks and/or cracked pieces of ceiling drywall (four identified resident rooms on an identified home area). Interview with resident #13 revealed that personal belongings and furniture had to be re-arranged within the room to protect his/her belongings and/or prevent water from dripping directly on them. [s. 15. (2) (c)] (101)

3.
(101)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 24th day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Zahur

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