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
Feb 5, 2015	2015_360111_0001	O-001410-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE TORONTO INC
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE SCARBOROUGH
3830 LAWRENCE AVENUE EAST SCARBOROUGH ON M1G 1R6

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

LYNDA BROWN (111), KARYN WOOD (601), MELANIE SARRAZIN (592), SUSAN DONNAN (531)

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): January 12-16 & 19-22, 2015

The following complaint and critical incident reports were also reviewed concurrently during this inspection: log# O-00335-13, O-002250-14, O-000269-13, O-001060-13, T-534-14 & T-234-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Residents, Families, Resident Council President, Family Council Chairperson, Maintenance/Support Services Manager, Registered Nurses (RN), Registered Practical Nurses(RPN), Personal Support Workers (PSW), Social Worker (SW), RAI-Coordinator, Physiotherapist (PT), Physiotherapy Assistants (PTA), Restorative Care Coordinator (RCC), and Maintenance worker.

The Inspector(s) also observed residents, toured the home, reviewed resident health records, reviewed the home's investigations, reviewed maintenance logs, observed dining service, reviewed water and fridge temperature logs,staffing schedules, continence supplies, and reviewed the following home's policies: pain management, falls prevention management, preventative maintenance, and medication/treatments.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **6 VPC(s)**
- **3 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. 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).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair.

Review of the home's policy "Maintenance Program" (MNTC-01-01-01) states the following:
-all homes shall have a maintenance program that includes routine, preventative and remedial maintenance.
-this policy establishes a requirement for a program to maintain the building and equipment in a condition that provides a safe, comfortable and pleasant environment for occupants.
-Under procedures:Manager/designate: develop a program to maintain the building and key equipment as described in the maintenance handbook, manage the program, and monitor that the program is being followed.
-The preventative maintenance program included (outlined in Appendix 3) "Building Checklists
Procedures" (1151-1408) for: resident area/service area/common area procedures (with respect to resident rooms, walls, ceilings, plumbing , bedside tables, dressers, over bed tables, closets, vanity, windows, washrooms, ceiling flooring, doors, and electrical) and included the forms to be used to document the checklist for each area.

On January 19, 2015 during an interview the Administrator indicated the home's maintenance policy, procedures and handbook confirmed that the home has policies and procedures for preventative maintenance.

The Environmental Services Manager was interviewed and confirmed he was the designated manager/lead for Maintenance and was not aware of policies or procedures for preventative maintenance pertaining to furnishings including floors, sinks, faucets, wall surfaces in resident areas as well as the required "Building Checklists Procedures" to be completed. [s.90.(1)(b)]

2. The licensee has failed to ensure that the hot water temperature in the various random resident rooms and tub/shower room is monitored once per shift.

Observation of the tub room (second floor west)on January 15, 2015 noted a hot water temperature gauge (on the electronic panel on the wall) for the walk in tub. The temperature gauge was detached from the panel and not working.

During interview with S#100, S#105, and S#112 confirmed that any identified maintenance concerns that require maintenance to replace/repair/provide are to be documented in the maintenance request log at each nurse's station.

During an interview with S#100,S#107 and S#113 confirmed that the hot water temperature is monitored by the registered staff and recorded in a book at the nurses station. Interview with S#111 confirmed that the registered staff are to record the hot water temperature at the beginning of each shift using the manual thermometer and document on the water temperature log that is located in a binder at the nurses station.

Interview with S#121 confirmed that he/she monitors the temperature from the source every morning in the basement and in the service areas and the registered staff are to monitor the hot water temperature in various resident rooms and tub rooms each shift and document.

On January 16, 2015 review of the water temperature log and maintenance log confirm that the thermometer was" not working" from January 11-16, 2015 and was not documented in the maintenance request log until January 15, 2015.
On January 19, 2015 interview with Administrator and review of the daily water temperature records confirm that the hot water was not monitored from January 11 - January 16, 2015.

Additional Required Actions:

CO # - 001, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident related to pain and a new medical diagnosis.

Review of the progress notes for Resident #16 (for a two month period) indicated:
-on a specified date and time the resident had a medical event. The physician was notified and ordered medications to manage the medical event and blood work to monitor

the new diagnosis. Later the same day, the resident was administered analgesic for new injury and pain to a specified area.
-on the second day, the resident was administered analgesic in the morning for continued pain and swelling to same area with movement.
-on the third day, the resident was given analgesic in the morning and at lunch for continued pain, redness, to the same location with movement and had good effect after the second dose.
-two days later, the physician assessed the resident in the morning and ordered an x-ray. The resident was not given any analgesic despite complaints of pain.
-the following day, the resident had a portable x-ray completed and following the x-ray, Diagnostic imaging contacted the home to report result of x-ray which was positive. The resident was then given analgesic and transferred to hospital.
-the resident returned from hospital 7 days later with mobilizing device and a new order for analgesic for pain as needed as well as a second analgesic for breakthrough pain. Later that evening, the resident was administered analgesic for visible pain.
-the following day the resident was assessed by Physiotherapy and provided new recommendations related to personal care and restricted movements to specified area.

Review of the physician orders for Resident #16 indicated on a specified date, the medication ordered for the medical event was increased due to blood work results. Two weeks later, the physician decreased the frequency of blood work to monitor the new diagnosis.

Review of quarterly RAI-MDS (completed after the incident) had no indication of resident having a medical event or new diagnosis, or any indication the resident sustained an injury to a specified area that quarter.

Review of the care plan for Resident #16 (post new diagnosis and new injury)indicated:
1) use of [medication] to prevent [new diagnosis]. Interventions included monitor for medication compliance and over-the-counter drug use, and monitor the effect of pharmacological interventions.
2)potential for complications/injury related to fracture [to specified area]. Interventions included: protect from injury, avoid sudden movements, jarring bumps when transferring or providing care, and to be nursed in bed.

The written plan of care did not provide clear direction related to new diagnosis, blood work,pain, pharmacological interventions or provision of care related to a medical event [s.6.(1)(c)](111).

2. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to Resident#11, Resident#16 & Resident#37 related to grooming.

Related to Resident #37:
-Observation of Resident #37 on two specified days indicated the resident's face was not shaved. -Interview of Resident#37 stated "only shaved 2x/week in the evenings on bath days by staff".
-Interview of the PSW #104 indicated the resident is only shaved on bath days (2x/week in the evenings) and staff must complete.
-Review of the written plan of care for Resident #37 had no indication of personal grooming needs, or that the resident required one staff assistance with shaving 2x/week on bath days.

Interview of RAI-Coordinator indicated that all resident's grooming needs(shaving) should have been indicated on each resident's care plan under "personal hygiene"(111).

Related to Resident #11:
-Observation of Resident #11 on two specified days noted the resident had excessive facial hairs covering the chin area.
-Interview with PSW #102 on the second day,indicated Resident #11 required total assistance of staff for personal hygiene/grooming care and the home’s expectation to provide shaving to resident's on their shower/bath days. PSW#102 indicated that a shower was provided to the resident the day before but PSW#102 did not shave the resident.
-The current plan of care for Resident #11 had no clear directions for shaving/grooming needs(592).

Related to Resident #16:
-Observation of Resident #16 on a specified date noted excessive facial hairs covering the chin. Two days later, the excessive facial hairs to chin were removed.
-Interview with PSW #107, indicated the resident is to be shaved on bath days (2x/week) and as needed.
-The current plan of care for Resident #16 had no clear direction indicated for shaving/grooming needs(592).

3. The licensee has failed to ensure that the plan of care set out clear directions to staff

and others who provide direct care to the resident related to continence care.

Interview of PSW #116 indicated Resident #12 is completely incontinent of bowels and wears an incontinence product. PSW#116 indicated the resident is occasionally incontinent of bladder and will ring for assistance of one staff to toilet or change the brief.

Review of the(current) care plan for Resident #12 indicated under Toilet use: "Physical limitations related to inability to bath self independently due to [diagnosis]" and "requires two staff extensive assistance to complete task". Interventions also included: Assist client with peri-care, adjust clothing and assist client out of washroom, assess and report pain to Registered Staff, one staff standing pivot to transfer client onto commode, put commode over toilet, and Provide assistance to wash.

The plan of care was not clear as to whether the resident was incontinent of bowels, wears an incontinent product or whether the resident required extensive assistance of one staff or two(111).

4. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident /SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

Review of the progress notes for Resident #16 indicated on a specified date, the resident sustained a medical event. A message was left for the SDM at that time regarding the resident's medical event. Later the same day, the resident developed swelling to a specified area and complained of pain with movement and the SDM was not notified. The resident's condition remained unchanged to the specified area for four days and there was no documented evidence the SDM was notified. On the fifth day, the resident was diagnosed with an injury requiring transfer to hospital for treatment and then the SDM was notified.

Therefore, the SDM was not notified for a five day period when the resident developed a new injury with pain until the resident was being transferred to hospital for treatment of the injury.[s. 6. (5)](111).

5. The licensee has failed to ensure that when the resident is reassessed, the plan of care was reviewed and revised because the care set out in the plan was not effective and that different approaches were considered in the revision of the plan of care related to falls.

Related to log# 002250:

A critical incident report was received on a specified date for an incident that caused injury to a resident for which the resident was taken to hospital and which further resulted in significant change in condition. The CIR indicated Resident #39 was a high risk for falls, and had cognitive impairment. The CIR indicated 11 days earlier, Resident #39 was witnessed by a staff member to suffer a fall. The resident sustained an injury and was transferred to hospital. The CIR indicated an alarming device was "already in progress prior to incident" but the resident was now put on half hour safety checks, offered a room change, has a hi-low bed kept in lowest position, has a fallout mattress at bedside, and provided 1:1 activities. The CIR also indicated the resident is to wear non-skid shoes, call bell within reach and reminders to use call-bell, and discussed use of another safety device to minimize injury if a fall re-occurs.

Review of the progress notes (from admission to present)for Resident #39 indicated:
-the resident sustained a total of 12 falls in one year.
-the resident sustained 8 falls in one month.
-7/8 of the falls occurred when the resident was attempting to self transfer and occurred on the afternoon shift.
-after the first, third and fourth fall, staff indicated "Care plan reviewed and no update required".
-after the second fall, the staff noted the resident had a change in continence related to medication changes. The Physician assessed the resident and indicated the resident "has symptomatic low BP" and changed medication. Staff also noted that language barrier and cognitive impairment,impeded ablility to understand instructions.
-Physiotherapy assessed the resident after each fall and indicated "Resident is advise to walk only with supervision using a walker, due to dementia resident might not follow instruction and might be at risk of fall when walking independently without supervision". No recommendations.
-after the fifth fall, the resident sustained an injury and a bed/chair alarming device was implemented.
-the second last fall resulted in further injury requiring transfer to hospital for treatment.Staff then implemented hi-low bed, fall mat, room change, monitoring every half hour, recommended family provide 1:1 care giver and recommended a protective device. Family requested use of restraint but was declined due to safety concerns.
-the last fall resulted in the resident being transferred to hospital again and returned from hospital with diagnosis of an infection and new order for antibiotic.

Review of the care plan for Resident #39 (two months after the falls & current) indicated for falls:
-(only listed five of the falls in the same month and one other fall 4 months later).
Interventions included:
- Check q 30 minutes for safety during periods where risk for falls is increased.
- Evaluate and supply adaptive/walking equipment (w/c and walker) as needed.
-Re-evaluate as needed for continued appropriateness.

The strategies identified in the written plan of care did not reflect the frequency of the falls, when the high risk for falls were occurring, and when the every half hour checks were to occur.
-the triggers identified (ie. change in continence needs or low BP)were not indicated in the written plan of care (ie. changed medication/low BP)
- The strategies of placing near nursing station for close monitoring, use of a bed alarm, 1:1 sitter, room change, hi-low bed in low position, fall out mattress and specified activities were not included in the written plan of care.
-most of the strategies identified on the CIR and in the progress notes to reduce or mitigate falls were not implemented until after the resident sustained multiple falls, sustained injuries, and did not relate to the location of the resident's actual falls.
Therefore, the licensee has failed to ensure that when the resident was reassessed, the plan of care was revised because the care set out in the plan was not effective and different approaches were considered in the revision of the plan to reduce the risk of injury related to falls. [s.6.(11)(b)].

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. 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 :

Under O.Reg.79/10, s.114 (2)The licensee of a long-term care home shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Review of the home's policy "Skin Treatments" (11-08) indicated only treatment creams or ointments for residents who have an order for self-administration may be left in the resident room; however when not in use the container must be stored in an area that is not accessible to or by others.

During the medication review, Resident #44 was interviewed and indicated treatment cream is being applied twice daily to specified areas. Resident #44 indicated the cream was at the bedside in the top drawer. Observation of the top drawer noted: two treatment creams. Review of the physician orders indicated there was no order for storage of treatment cream at resident's bedside.

2. Under O.Reg.79/10, s.136(1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of, (a)all expired drugs.

Review of the home's policy "Drug Destruction and Disposal" (5-4) indicated all medications which become surplus due to expiry, illegible labels, discontinuation, change in order, resident death or discharge, are destroyed and disposed of.

Observation of the Treatment Cart on the second floor (east)on January 16, 2105 noted 4 medications were expired on the cart.

Observation of the Treatment Cart on the second floor (west) on January 15, 2015 indicated one expired medication.

Observation of the medication stock room (located on the second floor in the Medical Storage Room) on January 15, 2015 noted two expired medications.

Interview with the DOC indicated she was responsible to check the stock cupboard for expired medication and stated that she must have missed the medication that was outdated.(601).

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's policy of skin treatments and drug destruction and disposal are complied with, to be implemented voluntarily.

WN #4: 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 comply with the LTCH Act 2007 whereby the home furnishing and equipment are maintained in a good state of repair.

During the course of the inspection inspectors observed the following:
Main entrance front lobby:
-love seat main entrance wooden legs chipped and disrepair
-wall between the two elevators multiple drywall plaster patches rough not finished or painted

Second floor west home area tub room(across from the west nurses desk):
-door entrances heavy scarring, large amounts of paint chipped exposing the corner bead
-left lower floor 10 inch split in flooring
-toilet off main tub entrance observed some rusting in the bottom of the toilet bowl
-toilet tank lid is off the tank and sitting on the floor

-large 2 inch silicone patch covering lower metal bead that separate the floor and wall ceramic tile in the first shower stall the entire strapping base is covered, second area shower stall the far wall is also covered ,
- third shower stall the beading is exposed and rusted bead
- two soiled cloth covered chairs stored in the corner of third shower stall legs chipped
-water temperature gauge on the electronic wall panel above the walk in tub has detached from the electronic panel and not in working order
-to right lower corner of the panel there is a 3x3 hole in the ceramic tile exposing a pipe.

Second floor dining room on the west home area:
-legs of metal type dining room tables heavily scarred and paint chipped exposing steel and pink paint
-elevator doors scuffed and paint chipped lower 12 inches of both doors
- dining room floor to ceiling support beam in the location of the call bell drywall scarred and the paint chipped along corners and a 6x6 center drywall patch damaged/ patched exposing green paint beneath

Second floor main home area(common lounge/kitchenette):
- back wall missing trim exposing chipped multiple paint and glue patch along the wall
- legs of the wing back chairs chipped /scarred
-lower sides of the counter in disrepair chipped worn and unclean and wood chipped
-sink in this are rusting along edge, counter top worn pattern to base, cupboards scarred and worn
-lower window side of wall scarred, heavily chipped along the entire wall
-entrance lower wall drywall exposed no paint (531)

Second floor resident rooms:
-M211:cover on toilet tank not fitting; areas uncovered sliding doors are sliding halfway in the bathroom avoiding them to open widely; rust present underneath the toilet sink with sharp edges(592).
-M215:Pipe fitting on the wall detached and hanging at the back of the toilet (592).
-W218:tiles beside the window have a sticky reddish glue type substance on them;someone has scrapped the area but it is well adhered dark scuff marks on tiles near this area; sink metal outlet drain corroded; bathroom floor brown discolored area on the right side by the sink(531).
-W225:left lower wall scarred, drywall plastered unfinished and not painted; flooring tiles scuffed black marks; drywall at the entrance to bathroom patched plaster rough not painted; black marks on flooring below sink; water stained bathroom tile; paint stripped

behind the sink; drywall underneath sink patched rough plaster no paint (531).
-W230: sink outlet drain in corroded and rusted; back drop of sink heavy scarring and paint chipped; sink slightly detached from the wall and leaning to left approximately 2 1/2 inches; scarring right lower wall in the bathroom wall; bathroom floor seams are detaching; wooden bathroom door heavily scarred and chipped(531).
-W231:sink metal outlet drain finish corroded beginning to rust; drywall corner beside dresser drawers scarred paint chipped exposing corner bead (531).
-M232:Sink in the washroom has rusted base support observed underneath and the metal on the wheels on bedside table is covered with rust(592).
-M238:top cover of the toilet tank not fitting, leaving two top corners uncovered(592).
-M237:Bathroom sink caulking cracked between the wall and the sink, sink not sealed flush, around .5 cm detached(592).
-M239:right wall above the bed with numerous drywall patches not sanded or painted; left wall bottom 24 inches with multiple drywall patches unfinished and not painted; drywall patches have scarred areas; rust around bottom of the toilet bowl; bathroom door frame left lower corner heavily scarred wood chipped and damaged; lower corner of the bathroom door has a golf ball size hole wood cracked and chipped; green tape across the floor seam covering seam where flooring from hall and room join, tape is torn and worn; 24 x 1/2 inch strip of flooring tile missing right hand corner at entrance area; entrance door trim damaged/torn and not adhered to frame; wallpaper in left upper corner at the entrance missing and peeling(531).
-M240:wallpaper border torn; scuff marks on wall behind the sink; rust at the base of the toilet bowl; sink metal outlet drain scarred and rust forming on the left side(531).

First floor Resident rooms:
-N116:small chips in flooring tile in entrance; rust ring around the base of the toilet; bathroom tapes corroded and rusted; steel sink post corroded and rusted(531).
-N113:stained calcified areas in the toilet bowl; paint peeling along lower left bathroom wall; left interior bottom corner bathroom door damaged plaster missing exposing corner bead; exterior lower 3 feet of wooden bathroom door is heavily scarred and chipped; gap in ceiling tile above clothes closet, back tile ill-fitting(531).
-S102: bathroom sink the drain is rusted; floor tiles underneath the resident clothes cupboard lifted slightly; right lower bathroom wall scarred and chipped(531).
-N119:calcified sand coloured stain in toilet bowl; rust around base of toilet bowl;bathroom floor right upper edge coming apart along top where it joins the wall edge; flooring in the lower left corner of the door frame broken and peeling; rusting along the toilet bowl; exterior bathroom door frame drywall patches unfinished, unpainted and soiled; left lower wall heavily scarred; both lower corners of the clothes closet door frame

scarred paint chipped and soiled; bottom strapping edge of closet door detached and hanging; tile floor chipped scuffed and worn; stained ceiling tile on the left side of the ceiling at entrance (531).
-N122:left back tile soiled/stained with water; lower right exterior bathroom door frame plastic edging split along corner and scarred (531)

First level kitchenette/lounge:
-sink faucet fixture was cracked and a welding bead applied to the entire base which in turn has also cracked surrounding the base
-constant water drip from the tap
-counter top worn, chipped and a layer of silicone seal surrounding edges that is shriveled discoloured along the top outer edge
-lower cupboards are worn wooden chipped drawers
-upper cupboards wood surrounding door handles finish worn exposing bare wood
-ceiling intercom speaker far center ill-fitting protruding slightly, ceiling tile right next to intercom is also ill-fitting

First floor Shower/ Tub room :
- whitish brown scaled water stained area surrounding both shower drains

Second floor east home area:
Common tub/shower area:
-left lower wall in the first shower area silicone over seam peeling off cracked and drywall in the corner of this area had a 2 inch silicone patch applied which is cracked rough, peeling and hanging loosely posing a risk of injury.
-floor seam along the corner of the shower discolored whitish brown scale build up
-lower foot of the door and door frame scarred and paint chipped exposing metal
-first corner of the left lower section of ceramic tile broken piece missing and a sharp edge that protrudes from the wall posing risk for injury.
-corner piece ceramic tile broken missing inside left lower corner by the entrance (531)

On January 16, 2015 review of daily maintenance request log to confirm that identified areas that require maintenance was not identified and interview of S#100, S#107, S#113, S#112& S#111 indicated that areas that require maintenance is to be logged in the maintenance request log.

Interview with Environmental Services Manager(ESM) confirmed that identified items of concern/repair are to be logged in the maintenance request log book that is reviewed by

the maintenance staff daily and items are replaced/repaired by the maintenance staff. The ESM was not aware of the preventive maintenance policy/schedule (appendix 3-building checklists for preventative maintenance[section 1151-1166] which includes resident rooms, walls, plumbing and furnishings) or documentation of managing disrepair in resident areas.

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 furnishings and equipment are maintained in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Findings/Faits saillants :

1. Related to log #002250-14:

The licensee has failed to ensure that the program provides for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Review of the "Falls Prevention and Management Program" (RESI-10-02-01) (revised April 2013) indicated that "residents who are assessed as at risk for falls will have an interdisciplinary approach to fall risk minimization. This includes but is not limited to : falls history, gait and balance assessment, vision assessment, continence, medication review.

Establish a flagging system to clearly identify to all staff the residents that are at high risk for falls (ie. falling star, falling leaf, color coded arm bracelets)". This policy does not identify strategies to be used to prevent or mitigate falls.

Interview of S#101, S#118, S#119 indicated the home uses a falling leaf flagging system on the resident's name plates outside their doors to identify residents who are at high risk for falls. S#101 indicated it was the Falls Prevention Committee (which included the PT, Restorative Care Coordinator, and DOC) who update the flagging system for residents at risk for falls.

Interview of Physiotherapist(PT) indicated he/she completes an assessment of residents who have fallen when he/she receives a referral (either verbal or electronically) from nursing, then completes this assessment and provides recommendations on progress notes electronically. PT indicated "only updates care plans for residents that receives physiotherapy" and does not attend any Falls Prevention Committee.

Interview of the Restorative Care Coordinator(RCC) indicated he/she tracks all the falls and provides a monthly statistics report (which includes:which residents have fallen, how often, where they have fallen and percentage of falls per shift). The RCC indicated meets with the DOC at morning report to discuss residents who have fallen the previous 24 hrs and attends the quarterly Interdisciplinary Professional Advisory Committee (IPAC) meetings to review the falls statistics. The RCC indicated he/she meets weekly with PT to discuss which of the residents that have fallen would benefit from restorative care program. The RCC indicated the home does not have a "Falls Prevention Committee" and there was no flagging system currently in place. The RCC indicated there are falling leaf symbols in place but were there prior to RCC position and is no longer maintained due to concern regarding confidentiality. The RCC was not aware of the homes policy on falls prevention program requiring a flagging system. The RCC indicated that the Registered Nursing staff are responsible for updating the resident's care plans after they have fallen.

Interview of DOC indicated the home no longer has a Falls Prevention Committee but meets with PT and the RCC where they review the falls and discuss at IPAC meetings.

Review of the IPAC meeting meetings (Jan/14, April 14/14, July 28/14 & Oct.29/14) indicated each meeting reviewed the previous three months falls statistics. Resident #39's multiple falls were not reviewed/discussed until four months later and indicated "one resident who was a frequent faller was moved closer to the nursing station, fall out

mattress, bed and chair alarm provided and urgent IDTC held with family. The discussion did not indicate which resident this was or when the interventions were actually implemented.

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 the home's falls prevention and management program at a minimum, provides strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Review of progress notes for Resident #16 indicated:
- on a specified date, the resident had a medical event. Later that day, the resident had "noted swelling" to a specified area, "was screaming" when moved and regular analgesic was given.
- the following day, the resident was given analgesic for continued pain with movement to specified area with good effect.
-the following day, the resident was given analgesic "for pain" to the specified area. The

resident was given analgesic again at noon as “still with pain" with movement to specified area and was effective.
-there was no documentation regarding the resident's pain level the following day.
-two days later, the physician assessed the resident and indicated “has pain/swelling" to specified area and ordered an x-ray. There was no indication the resident was given any analgesic on this day.
-the following day the x-ray was completed and the result of the x-ray were received later that day. Analgesic was then given and the resident was transferred to hospital for treatment.
-7 days later, the resident returned from the hospital with a mobilizing device in place and an order for narcotic analgesic (1-2 tabs every 4 hours) as needed for pain. The resident was given narcotic analgesic (2 tabs)for pain “since resident was noted moaning”.
-the following day, there was no documentation regarding the resident being assessed for pain or any analgesic given.
-the following day, the resident was given 1 tab of narcotic analgesic for comfort as resident "displayed slight grimacing" with movement to specified area. Later that evening, a "Pain Flow Note" (pain assessment)indicated "grimaces during care" to specified area and narcotic analgesic given with good effect.
-three days later, a second "Pain Flow Note" was completed indicating pain severity (6/10), grimaces when providing care, pain in specified location, and narcotic analgesic given with good effect.
-approximately two weeks later, a PAINAD assessment was completed and scored(mild pain).

Review of Resident #16 electronic Medication Administration Records (E-MARS) for a two month period indicated prior to the fall incident, the resident had an order for regular analgesic every 4 hours as needed but was not administered (indicating it was a new pain). There was a new order for narcotic analgesic (1-2 tabs every 4 hrs PRN) upon readmission from hospital (which was administered). There was also the regular analgesic for breakthrough pain but was not administered after return from hospital.

Review of the homes policy "Pain Management" (RESI-10-03-01) (revised March 2014) stated the indicators for completing a pain assessment are when the resident:
-states they have new pain 4/10 (or as assessed by the PAINAD).
-taking an increased dose and or frequency of pain-related medication.
-taking new pain-related medication for greater than 72 hours.
-distress as observed through facial grimacing, guarding, rubbing or holding an area of the body.

The registered staff will complete a pain assessment using the Pain Assessment in Advanced Dementia Scale (PAINAD) tool for the cognitively impaired resident when a resident has experienced pain, or when the structured progress notes (pain)/or "Pain Flow Record" identifies patterns to PRN analgesic usage. Determine if the effect of the intervention meets the resident's goal for pain management and if pain intervention requires adjustment or if breakthrough medication is required.

There was no documented evidence of a pain assessment completed when the resident developed new pain to a specified area (post the medical event) and had ongoing pain until transfer to hospital five days later. The pain assessment tool was not completed until the resident returned from hospital 7 days later. The pain assessment indicated "distressing pain"(level 4) but the remainder of the assessment was incomplete. A "Pain Flow record" was not completed until two days after return from hospital and again 4 days later. The PAINAD assessment tool was not completed until approximately two weeks after return from hospital, after the resident's pain had subsided.

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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #7: 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).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

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

Findings/Faits saillants :

1. Related to log #000534-14:

The licensee has failed to inform the Director immediately, in as much detail as is possible in the circumstances of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

A Critical Incident Report was submitted to the Director on a specified date indicating the home was declared in an outbreak by Public Health four days earlier.

Interview of the Director of Care, indicated that she called the after-hours CIATT line on the day the home was declared in outbreak but had no documented evidence of this and did not document this on the CIR. Inspector contacted CIATT and CIATT had no documented record of an after-hours call received regarding this outbreak.

Therefore, there was no documented evidence the home immediately notified the Director of the circumstances of an outbreak of a communicable disease. [s. 107. (1)]

2. Related to log#000269-13:

The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

A Critical incident report was received by the Director on a specified date indicating nine days earlier, Resident #41 suffered a fall. The resident sustained an injury, was transferred to hospital, and required surgical intervention.

Interview with the DOC indicated the Director was not notified until the CIR was submitted.(531)

3.During the RQI, a census record review for Resident #16 was completed and indicated the resident had been hospitalized in the last 12 months.

Review of the progress notes for Resident #16 indicated on a specified date, the resident had sustained a medical event in the morning. Later that evening, the resident developed swelling and pain with ROM to a specified area. Four days later, the physician assessed the resident and ordered an x-ray to rule out fracture. The following day, an x-ray was completed in the home and a call was received by the diagnostic imaging indicating the resident had sustained a fracture to the specified area. The resident was then transferred

to hospital for treatment.

A Critical Incident Report was received for Resident #16, 10 days after the resident was transferred to hospital.

Interview of the DOC indicated the DOC was not able to provide evidence of contacting the Director prior to submitting the CIR. Therefore,there was no documented evidence that the Director was notified within one business day of the occurrence until 10 days later when the CIR was received(111).

4.Related to log# O-002250-14:

A Critical incident report was received for Resident #39 by the Director on a specified date for an incident that causes injury to a resident for which the resident was taken to hospital and which resulted in significant change in condition. The CIR indicated 12 days earlier, Resident #39 sustained a fall and was transferred to hospital for an injury to a specified area for assessment.

Interview of the DOC indicated she could not recall if she contacted the Director and had no documented evidence of contacting the Director prior to submitting the CIR which was received 12 days later.

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 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): an outbreak of a reportable disease or communicable disease, and an injury in respect of which a person is taken to hospital,, to be implemented voluntarily.

WN #8: 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 :

The licensee has failed to ensure that drugs are stored in an area or a medication cart, that complies with the manufacturer's instructions for the storage of the drugs.

On January 16, 2014 at 12:44 observation of the medication room (on the 2nd floor east nursing station) had a fridge that contained the following medications:
-Novolin GE 40/60 (4 boxes); Novolin ge 30/70 (4 boxes); Humalog 100 units (2 boxes); Humalog Mix 25 (3 boxes); Lantus insulin 100U/ml (10 boxes); Acetaminophen suppositories 650mg (3 boxes); Acetaminophen 325mg (1 box); Dimenhydrinate 50mg (1 box); Novolin GE Toronto (8 boxes); Eprex epoetin alfa 2, 000IU/0.5ml (1 box); Eprex 4,000UI (1 box); Risperdal injectable 50mg/vial (4 boxes); Novolin ge NPH (1 box); Novo Rapid insulin 100 U/ml (6 boxes); NovoMIx 30 (6 boxes); Levemir 100 units/ml (1 box).
-the manufacturer's directions for the above medications indicated the medications should be stored between 2-10 degrees celcius.
-review of the fridge temperature log book (from November 2014 to January 19, 2015) indicated: November 2014 had temperatures recorded outside the required 2 to 10 degrees celcius 17 times(November 2(x2),7(x2),8,10(x2),11(x2),18,19,20(x2),26,27,28& 29, 2014). The temperature log also dad documented the fridge "was not working properly")on November, 25, 2014.
-the temperature log book for December 2014 indicated that the fridge temperatures were out of range 13 times (December 6,11,13,18(x2),20),21(x2),23,25,26,29,30, 2014).
-the temperature log book from January 1-20, 2015 indicated that the fridge temperatures were out of range 13 times (January 2,3,4(x2),5,7,9,10,15,16,18,19 & 20, 2015).

-On January 19, 2015 (at 12:32) the thermometer displayed a temperature of 10.9 degrees celcius.

On January 16, 2015 at 10:38 observation of the medication room (on the 2nd floor west nursing station) had a fridge that contained the following medications:
-Injectable Respirdal 50mg/vial (4 boxes); Eprex epoetin alfa 4,000IU (1 box); Eprex epoetin alfa (1 box); Lantus Insulin 100U/ml (3 box); Humalog Mix 25 100U/ml (2 boxes); Novo Rapid 100U/ml (5 boxes); Novo Rapid 30 100U/ml (3 boxes); Novelin Ge Toronto 100IU/ml (2 boxes); Novolin ge 30/70 (1 box); Levemir 100U/ml (1 box); Acetaminophen 650mg Suppositories (4 boxe); Acetaminophen 325mg Supp (1 box); Lorazepam INJ 4mg/ml (1 bottle).
-the manufacturer's directions for the above medications indicated they should be stored between 2-10 degrees celcius.
-Review of the temperature log book from November 2014 to January 21, 2015 indicated: There was one day recorded outside the required temperature on January 15, 2015.
-On January 16, 2015(at 10:38) the thermometer displayed a temperature reading of 13.9 degrees celcius. [s. 129. (1) (a)]

2. The licensee failed to ensure that 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.

On January 16, 2015 at 1:45 the inspector observed 1 one vial of Lorazepam located in the nursing station medication room fridge (on second floor west)which is locked. There is no lock on the fridge. There was also 1 vial of Lorazepam in the medication room fridge on the second floor(east). This fridge is located in the medication room (which is locked) but there is no lock on the fridge. The DOC was also notified. The DOC indicated she was aware that Lorazepam was a controlled substance and stated "she was not sure how they were going to lock the fridge?".
-The Lorazepam that was on 2nd floor medication room(west),remained in the fridge from January 19, 2015 to January 21, 2015 when the DOC removed the Lorazepam.
-The Lorazepam in the 2nd floor (east) fridge was removed immediately. The DOC indicated the Lorazepam was disposed of as a narcotic. [s. 129. (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 drugs are stored in an area or a medication cart, that complies with manufacturer's instructions for the storage of the drugs and controlled substances are stored in a separated, double locked area or stored in a separate locked area withing the locked medication cart,, to be implemented voluntarily.

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:
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 :

The licensee failed to ensure that the resident's 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 tat Act.

On a specified date, observation of a medication administration indicated RPN #105 was observed placing discarded medication packages in the garbage dispenser on the medication cart without removing or denaturing the residents personal health information.

Interview of RPN#105 indicated does not remove personal health information and the medication strip packages are sent out with the regular garbage.

Interview of RPN #106 & #130 indicated empty medication strip packages are to be soaked in water to remove all of the resident identifying information and then thrown in the regular garbage.

WN #10: 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 :

The licensee has failed to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

During resident observations conducted during the Resident Quality Inspection (RQI), Inspector #592 observed Resident #11 on two specified days with excessive facial hairs covering the chin.

The current plan of care for Resident#11 indicated the resident required extensive assistance with personal hygiene (including shaving).

Interview with PSW #102, indicated that Resident#11 was totally dependent on staff for personal hygiene (including shaving)and indicated that the home's expectation was to provide shaving to residents on their shower/bath days. PSW#102 indicated that Resident #11 was showered by PSW#102 the day before (as per bath scheduling) but did not shave the resident.

Interview with RN#101, indicated that residents are shaved depending of their preferences but shower/bath time remains the best time. Indicated that PSW's are responsible to ensure that their assigned residents are being shaved and if they can't perform the task, the charge nurse should be notified. RN#101 indicated no awareness that Resident#11 was not shaved during the shower the day before.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

The licensee has failed to comply with O.Reg 79/10, s.92(2)(b)(c) where by the designated lead lacks the knowledge of evidence based practices relating to maintenance or a minimum of two years experience in a managerial or supervisory capacity in maintenance.

During an interview with Environmental Services Manager (ESM) confirmed he/she has been employed as the home's designated housekeeping, laundry and maintenance lead for the past eight months. ESM confirmed that he/she had a post secondary diploma, but prior to current designation, was employed in the capacity of a laundry/housekeeping aide. The ESM indicated he/she had no prior knowledge of evidence-based practices, or prevailing practices relating to maintenance and had no experience in a managerial or supervisory capacity.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

On January 15, 2015, observation of the treatment cart on 2nd floor(west) indicated two treatment creams were found for Resident #44.

Review of the physician orders for Resident #44 indicated the treatment creams were to be discontinued 8 days prior.

Review of the Treatment Administration Record (TAR)for Resident #44 for January 2015 indicated the treatment creams were discontinued on the required date as ordered.

Interview of PSW#125 indicated he/she applied both treatment creams to Resident #44 for six days after the treatment creams were discontinued.

Therefore, 2 treatment creams for Resident #44 that were to be discontinued on a specified date, were still available on the treatment cart and being applied by the PSW's for six days after they were discontinued.

2.Observation of the treatment cart on the second floor (west), noted a treatment cream was found for Resident #46.

Review of Physician orders for Resident #46 indicated the treatment cream was re-ordered on a specified day of the specified month and to be continued for a second month for two more weeks.

Review of the TAR for Resident #46 for two specified months indicated the treatment cream was applied until the 8th day of the first month and then was discontinued. The re-ordered treatment cream was not transcribed (or administered) after being re-ordered but was still available in the treatment cart.

Interview of PSW #100 & RPN #105 indicated that Resident #46 had a skin condition previously but had not been applying the treatment cream for approximately one month. RPN #105 confirmed that there were no current treatments for Resident #46 for the current month (despite having an order from the physician).

3. The licensee failed to ensure that a member of the registered nursing staff, permits a staff member who is not otherwise permitted to administer a drug to a resident, to administer a topical only if:
(a)The staff member has been trained by a member of the registered nursing staff in the

administration of topicals
(b)The member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical, and
(c)The staff member who administers the topical does so under the supervision of the member of the registered nursing staff.

Review of the home's policy "Skin Rashes" (03-10) indicated:
•Registered staff are to demonstrate to care staff how the cream is to be applied, including how to correctly remove the cream from the container, how much of the cream to apply, where to apply it and how to properly apply the cream or ointment.
•Care staff must demonstrate back to the Registered Staff the application process. Note: the demonstration by Registered Staff and the return demonstration must occur at different times and documentation of the demonstration with return demonstration must be completed in the resident record.
•Once this is completed , the care staff may continue to apply the cream as ordered to the area of the rash. Care staff will document the application of the treatment on the Treatment Administration Record. For homes on e-MAR or e-TAR system, Registered Staff are responsible for printing a TAR sheet monthly for care staff to initial.
•Each shift the treatment is required the care staff is to obtain the cream/ointment from the Registered Staff, apply it to the affected area and then return the cream or ointment to the Registered Staff.
•Registered staff is responsible for documenting on the Treatment Administration Record (paper or electronic) that the cream or ointment was given to the care staff for application.

On a specified date, interview of Resident #44 indicated the treatment cream is applied twice a day to a specified area and is applied by the PSW's.

Interview with RPN #105 indicated Resident #44 has treatment cream that was ordered. RPN#105 indicated he/she usually applies the treatment, but sometimes the PSW will apply with supervision.
Interview of RPN #106 indicated the RPN usually applies the treatment cream or supervises the PSW to apply a treatment cream.

Interviews by Inspector #592:
-PSW#126 & #128 indicated the home's process for the application of the cream is that the cream is given to PSW's at the morning report in order to have them applied the prescribed cream to residents. Once the prescribed cream is applied, PSW are to give

back the cream and nurse in charge of their unit signs for them.
-PSW#127 indicated the PSW's are not to apply creams on unit but RPN#105 does. PSW#127 also indicated received training to apply treatment creams but does not apply them.
-RPN#115 indicated the RPN is responsible to give the prescribed cream ordered by the physician to the PSW in the morning and the PSW's have to return the creams to the RPN to be locked in treatment cart. RPN#115 indicated the RPN is responsible to record the administration of the cream on the treatment record in the TARS once they are returned.

Interview with Director of Care indicated they had no documented evidence to indicate the delegation of application of treatment creams for any of the PSW's or documentation of return demonstration of application of treatment creams as per the home's policy. The DOC stated "some PSW's have been trained and are applying the treatment cream, but there is no record".

Issued on this 13th day of February, 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) :	LYNDA BROWN (111), KARYN WOOD (601), MELANIE SARRAZIN (592), SUSAN DONNAN (531)
Inspection No. / No de l'inspection :	2015_360111_0001
Log No. / Registre no:	O-001410-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 5, 2015
Licensee / Titulaire de permis :	EXTENDICARE TORONTO INC 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE SCARBOROUGH 3830 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1G-1R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pinky Virdi

To EXTENDICARE TORONTO 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. 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,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a corrective action plan which includes who will be responsible for each action and date of completion for the following:
-that maintenance services in the home, ensure that the building, including interior and exterior areas, and its operational systems are maintained in good repair; by completing repairs to identified areas indicated under WN #4, and
-the designated maintenance manager/lead is retrained on the home's schedules, and procedures for routine, preventative and remedial maintenance.
-a process is put in place to ensure that the routine, preventative and remedial maintenance is completed as per the homes policy.

This plan is to be submitted to LTC Inspector, Lynda Brown via email to lynda.brown2@ontario.ca by March 16, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair.

Review of the home's policy "Maintenance Program" (MNTC-01-01-01) states the following:
-all homes shall have a maintenance program that includes routine, preventative and remedial maintenance.
-this policy establishes a requirement for a program to maintain the building and equipment in a condition that provides a safe, comfortable and pleasant environment for occupants.
-Under procedures:Manager/designate: develop a program to maintain the building and key equipment as described in the maintenance handbook, manage the program, and monitor that the program is being followed.
-The preventative maintenance program included (outlined in Appendix 3) "Building Checklists
Procedures" (1151-1408) for: resident area/service area/common area procedures (with respect to resident rooms, walls, ceilings, plumbing , bedside tables, dressers, over bed tables, closets, vanity, windows, washrooms, ceiling flooring, doors, and electrical) and included the forms to be used to document the checklist for each area.

On January 19, 2015 during an interview the Administrator indicated the home's maintenance policy, procedures and handbook confirmed that the home has policies and procedures for preventative maintenance.

The Environmental Services Manager was interviewed and confirmed he was the designated manager/lead for Maintenance and was not aware of policies or procedures for preventative maintenance pertaining to furnishings including floors, sinks, faucets, wall surfaces in resident areas as well as the required "Building Checklists Procedures" to be completed [s.90.(1)(b)]. (531)

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, s. 6 (1)(c), by ensuring that:
-Resident #16 is reassessed (and any other resident currently experiencing pain), to ensure each resident's pain is managed effectively.
-after reassessment of Resident#16, (and any other residents currently experiencing pain), review and revise the written plan of care to ensure the plan sets out clear directions to staff and others who provide direct care to those residents related to pain.
-review and revise the plan of care for Resident #16 (and any other residents with new diagnoses) to ensure the written plan of care sets out clear directions to staff and others who provide direct care to those residents related to new diagnosis.
-all Reg.nursing staff is to receive re-training regarding: the requirement to ensure that any resident experiencing pain, is reassessed, and receives effective pain management as per the homes policy; and the plan of care is reviewed and revised to ensure clear direction is provided to staff and others who provide care to the resident related to pain and new diagnoses.

This plan is to be submitted to LTC Inspector, Lynda Brown via email to Lynda.Brown2@ontario.ca on or before February 16, 2015. The plan shall identify who will be responsible for each of the corrective action listed.

The licensee shall prepare, implement and submit a corrective action plan which includes who will be responsible for each action and date of completion for the following: 1)

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident related to pain and a new medical diagnosis.

Review of the progress notes for Resident #16 (for a two month period) indicated:
-on a specified date and time the resident had a medical event. The physician was notified and ordered medications to manage the medical event and blood work to monitor the new diagnosis. Later the same day, the resident was administered analgesic for new injury and pain to a specified area.

-on the second day, the resident was administered analgesic in the morning for continued pain and swelling to same area with movement.
-on the third day, the resident was given analgesic in the morning and at lunch for continued pain, redness, to the same location with movement and had good effect after the second dose.
-two days later, the physician assessed the resident in the morning and ordered an x-ray. The resident was not given any analgesic despite complaints of pain.
-the following day, the resident had a portable x-ray completed and following the x-ray, Diagnostic imaging contacted the home to report result of x-ray which was positive. The resident was then given analgesic and transferred to hospital.
-the resident returned from hospital 7 days later with mobilizing device and a new order for analgesic for pain as needed as well as a second analgesic for breakthrough pain. Later that evening, the resident was administered analgesic for visible pain.
-the following day the resident was assessed by Physiotherapy and provided new recommendations related to personal care and restricted movements to specified area.

Review of the physician orders for Resident #16 indicated on a specified date, the medication ordered for the medical event was increased due to blood work results. Two weeks later, the physician decreased the frequency of blood work to monitor the new diagnosis.

Review of quarterly RAI-MDS (completed after the incident) had no indication of resident having a medical event or new diagnosis, or any indication the resident sustained an injury to a specified area that quarter.

Review of the care plan for Resident #16 (post new diagnosis and new injury) indicated:
1) use of [medication] to prevent [new diagnosis]. Interventions included monitor for medication compliance and over-the-counter drug use, and monitor the effect of pharmacological interventions.
2)potential for complications/injury related to fracture [to specified area]. Interventions included: protect from injury, avoid sudden movements, jarring bumps when transferring or providing care, and to be nursed in bed.

The written plan of care did not provide clear direction related to new diagnosis, blood work,pain, pharmacological interventions or provision of care related to a medical event[s.6.(1)(c)](111). (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall ensure the water temperatures are monitored in random locations where residents have access to hot water at least once per shift and that appropriate action is taken when the devices used to monitor the temperatures, are not in working condition.

Grounds / Motifs :

1. The licensee has failed to ensure that the hot water temperature in the various random resident rooms and tub/shower room is monitored once per shift.

Observation of the tub room (second floor west)on January 15, 2015 noted a hot water temperature gauge (on the electronic panel on the wall) for the walk in tub. The temperature gauge was detached from the panel and not working.

During interview with S#100, S#105, and S#112 confirmed that any identified maintenance concerns that require maintenance to replace/repair/provide are to be documented in the maintenance request log at each nurse's station.

During an interview with S#100,S#107 and S#113 confirmed that the hot water temperature is monitored by the registered staff and recorded in a book at the nurses station. Interview with S#111 confirmed that the registered staff are to record the hot water temperature at the beginning of each shift using the manual thermometer and document on the water temperature log that is located in a binder at the nurses station.

Interview with S#121 confirmed that he/she monitors the temperature from the source every morning in the basement and in the service areas and the registered staff are to monitor the hot water temperature in various resident rooms and tub rooms each shift and document.

On January 16, 2015 review of the water temperature log and maintenance log confirm that the thermometer was" not working" from January 11-16, 2015 and was not documented in the maintenance request log until January 15, 2015. On January 19, 2015 interview with Administrator and review of the daily water temperature records confirm that the hot water was not monitored from January 11 -January 16, 2015. (531)

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 : Feb 19, 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 5th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

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