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
May 11, 2015	2015_323130_0004	H-001830-15	Resident Quality Inspection

Licensee/Titulaire de permis

GRACE VILLA LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

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

GRACE VILLA NURSING HOME
45 LOCKTON CRESCENT HAMILTON ON L8V 4V5

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

GILLIAN TRACEY (130), BERNADETTE SUSNIK (120), KELLY HAYES (583), ROSEANNE WESTERN (508)

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): February 18, 19, 20, 23, 24, 25, 27, March 2, 3, 4, 5, 6, 17, 2015

Please note: the following inspections were conducted concurrently with this RQI: H-001845-15, Follow-up to r. 72 (3) (a), H-000720-14, Follow-up to r. 15 (1), H-001927-15, Follow-up to r. 77 (2), Complaints: H-001266-14, H-001463-14 and Critical incidents: H-001271-14, H-001686-14, H-001891-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant DOC, Physician, Resident Assessment Instrument (RAI) Coordinator, Business Coordinator, Skin and Wound Care Coordinator, Social Worker, registered staff, personal support workers (PSW), Nutrition Manager, dietary staff, Manager of Recreation Services, Environmental Services Manager (ESM), maintenance staff, laundry staff, President of Residents' Council, residents and families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **17 WN(s)**
- **8 VPC(s)**
- **5 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 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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the right of an identified resident to participate fully in the development, implementation, review and revision of his or her plan of care, was fully respected and promoted.

A) According to the clinical record, multidisciplinary care conferences to review the resident's plan of care, were held for an identified resident on four identified dates in 2012, 2013 and 2014. The resident, Social Worker and minutes of those meetings confirmed the resident was not in attendance at those conferences. During this inspection the resident was oriented to person, place, time and was observed using their personal computer to access and update their facebook account. The resident stated during an interview with the Inspector on a specified date in 2015, that they would have

attended the conference had they been invited.

On a specified date in 2012, the resident signed an Advance Health Care Directive, indicating Level 4, Transfer to Acute Care Facility with Cardiopulmonary Resuscitation (CPR). On a specified date in 2014, the resident signed a Management of Worsening of Condition, which indicated Level 3, Transfer to Hospital with CPR. On a specified date in 2015, the resident's Substitute Decision Maker (SDM) signed a Management of Worsening of Condition, which indicated a Level 2, Transfer to Hospital without CPR. There was no recorded evidence found to indicate whether or not this change in directive had been discussed with the resident. Resident #500's right to participate fully in the development, implementation, review and revision of their plan of care, was not fully respected and promoted. (Inspector #130) [s. 3. (1) 11. i.]

2. The licensee failed to ensure that an identified resident's right to 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 secure unit and to obtain an independent opinion with regard to any of those matters, was fully respected and promoted.

A) An identified resident was admitted to the home in 2012. Admission placement records provided by Community Care Access Centre (CCAC), specifically the Home Care MDS (Minimum Data Set) (Hospital) record indicated that on a an identified date in 2012, prior to their admission, a Social Worker deemed the resident "not capable of making a shelter decision". A consultation report completed by a physician, in 2013, indicated the resident remained incapable of making care decisions, especially shelter. The home obtained signed Advanced Health Care Directives and Consents to Treatment from the resident at the time of their admission in 2012 and later in 2014. Since admission to the home, the resident had repeatedly sought information surrounding their admission and potential discharge. There was no documentation found in the resident's clinical record to indicate whether or not the resident had been advised of their right to contest the incapacity decision and to obtain an independent capacity assessment through the appeal process with the Consent and Capacity Board. The Social Worker confirmed the home had not assisted the resident with the appeal process application. (Inspector #130) [s. 3. (1) 11. iii.]

3. The licensee failed to ensure that an identified resident's right to receive visitors of his or her own choice was fully respected and promoted.

A) On an identified date in 2012, registered staff documented in progress notes that the "POA" had called the home to advise staff that the resident had not seen their children in a number of years and they just recently found out that the resident was in a nursing home and may try to contact them. The spouse believed that seeing their children would cause them to be more confused and agitated. The POA did not want the resident's children to know that they were in the home. The nurse informed the office staff of the POA's concerns so that if they answered the phone they would know not to tell anyone the resident was there. The POA also instructed that the resident could only be taken on LOA's (leave of absences) with the them. Office staff indicated they updated the profile to reflect these instructions. The POA requested that no information be shared with outsiders. The POA was advised by the home's staff that no information would be given to anyone inquiring about the resident and that they would be notified if anyone came to visit. On a specified date in 2012, registered staff recorded in progress notes that the resident's spouse had been in and left the names of identified individuals who were restricted from receiving any information about the resident or knowing their whereabouts. Staff were made aware of the POA's concern and an email was sent to administration staff. The Inspector reviewed the resident's business file with the Business Coordinator and confirmed that these instructions remained in effect. The Business Coordinator also verified that the POA documents provided by the resident's spouse at the time of admission, did not contain signatures or identify the date they were executed, which rendered them invalid. The Administrator and DOC confirmed the resident's spouse would be regarded as the Substitute Decision Maker (SDM) and not the POA. There was no recorded evidence found to indicate that the visitor restrictions in effect were ever discussed and or agreeable with the resident. (Inspector#130) [s. 3. (1) 14.]

Additional Required Actions:

CO # - 001, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 rights of residents, including resident #500, to participate fully in the development, implementation, review and revision of his or her plan of care, right to 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 secure unit and to obtain an independent opinion with regard to any of those matters and right to receive visitors of his or her own choice, is fully respected and promoted, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) Four identified residents were observed to be sleeping in beds on two dates in 2015 with one bed rail elevated or in use. A review of their plans of care did not identify any bed rail information, yet PSWs had elevated at least one rail. When several staff were

asked why the rails were being elevated, the responses varied from statements such as "to keep the resident from getting into bed, or getting out of bed on a particular side or to allow the resident to reposition themselves while in bed." Yet, the residents identified did not have any such instructions in their plan for staff to follow.

Further review of residents' plans of care revealed that some residents had bed rail use information in their plan of care and others did not and confirmation was made with the DOC that no formal assessment had been completed on any resident. According to prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and endorsed by Health Canada), residents would need to be evaluated while sleeping in bed over a period of time by an interdisciplinary team to determine if the bed rail was a safe alternative for the resident after trialling other options. (Inspector #120) [s. 15. (1) (a)]

2. The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment.

A) During the inspection on February 24, 25 and March 3, 2015, a tour of resident rooms revealed that a number of residents were sleeping in beds with one or more bed rails elevated or in use that did not pass one or more entrapment zones. The identified residents' beds were not modified in any way (gap fillers, bolsters, rail pads etc.) to mitigate the zone specific risk. According to records maintained by the DOC, 42 out of 186 beds were tested and failed one or more entrapment zones in July 2014. The records were also noted to be partially inaccurate, as some of the beds had been moved to other rooms without management awareness.

Residents in four identified beds were observed to be sleeping in bed with both or one of their ¾ length bed rails elevated with no modifications in place. The beds were all identified and confirmed to have failed one or more zones of entrapment in July 2014.

B) During a tour of the beds on February 24, 25 and March 3, 2015, unoccupied (resident not in bed) beds were observed in nine identified rooms to have at least one rail elevated without any mattress keepers (corner guards to prevent the mattress from sliding back and forth on the deck of the bed). Although some passed entrapment zone testing (completed with both rails elevated), a risk remained as the mattress was capable of shifting, creating a gap between the one bed rail and the mattress. The bed in another identified room was specifically observed to be ¼ of the way off the bed deck with a large

gap between the bed rail and mattress. The licensee did not address or identify this issue during their assessment of the beds. (Inspector #120) [s. 15. (1) (b)]

Additional Required Actions:

CO # - 002, 003 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. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee did not ensure that procedures were developed or implemented for cleaning of the home, specifically flooring and resident rooms.

A) The flooring material was observed with wear patterns and dark areas under beds and/or around the perimeter of the bedrooms in 318, 319, 321, 327, 305, 118, 106, 107, 108, 131, 131, 212 and 204. In bathing rooms located on the east side of the home on floors 1, 2 and 3, the gray non-slip tiled floors were black in appearance throughout the shower and tub areas. Corridor flooring material was also visually discoloured just outside the lounge on 2E and towards the stairwell on 2E and in the corridor and lounge on 3E. According to the ESM, the tub rooms and above noted bedrooms were all "buffed" once between August 10, 2014 and February 17, 2015, with room 204 being most recently done. However, when observed on February 24, 2015, the room perimeter and under Bed A was observed to be black. According to the ESM, the method used to clean the tiles in the bathing rooms was not having any effect on the visible outcome of the tiles

and alternatives were discussed. The ESM had an on-going schedule for floor buffing; however, the rooms and areas were not on a scheduled rotation. According to the home's various procedures regarding floor care dated September 2011, floors were to be either buffed, polished or stripped based on an established schedule or once a week or once per year, depending on the process. One procedure titled "floor polishing" identified that floors were to be polished once per week in resident rooms and on weekends, the activity room, dining rooms, corridors, lounges would be done. The procedure related to floor stripping offered a frequency of once per year for common areas, dining rooms and lounges, but did not identify the need to strip and re-wax resident rooms. No procedure had been developed to address the cleaning requirements of the tiled non-slip floors in 3 out of the 6 bathing rooms located on the east side, all of which were renovated within the last 3 years.

B) The licensee's resident room cleaning procedure titled "cleaning resident's rooms" specified that sills, radiators and furniture surfaces be done daily. Another separate procedure for resident ensuite washroom cleaning identified that they were to be cleaned daily. During the inspection on February 24, 2015 between the hours of 10:30am and and 4:30pm, many rooms were noted to have dusty radiators and sills (330, 328, 325, 322, 106, 103). These rooms continued to have dusty surfaces on a return visit on March 3, 2015. Every ensuite washroom checked on each floor had overly dusty vanity light covers; however, the procedure did not specify to clean the light cover and how often. No procedure was identified in the housekeeping binder describing what specific surfaces needed to be cleaned and how often in washrooms.

The licensee did not implement and/or develop policies related to the floor care program or cleaning of horizontal surfaces. (Inspector #120) [s. 87. (2) (a)]

Additional Required Actions:

CO # - 004 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. 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. (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. (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 :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A) The written plan of care for an identified resident indicated the resident required assistance for eating; however, the same plan indicated the resident required no set-up help or physical assistance from staff. The plan indicated the resident required assistance for the physical process for toileting; however, the same plan stated the resident toileted without assistance. The plan indicated the resident required assistance for transferring from one position to another; however, the same plan indicated the resident was independent with transfers. The ADOC was interviewed and confirmed the plan of care did not provide clear directions to staff providing care. (Inspector 130) [s. 6. (1) (c)]

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

A) The written plan of care for an identified resident indicated the resident required assistance with eating, toileting and transfers. The resident was observed transferring independently and stated they did not require staffs assistance with any activities of daily living (ADLs), except bathing. Front line staff were interviewed and confirmed the resident was independent with all ADLs. The written plan of care was not based on the needs of the resident. (Inspector #130) [s. 6. (2)]

3. The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

A) It was observed on an identified date in 2015 that an identified resident was sitting in a common area in their wheelchair with a safety device in place. A review of the current care plan, did not identify that the resident required a safety device. A review of the resident's clinical record indicated that the safety device had been ordered in 2011. In 2015, the registered staff had documented in the clinical record that the resident was no longer attempting to get up out of their chair and that they would often refuse the safety device. It was discussed with the resident's POA at that time, that the device be removed as it was no longer required. The POA agreed and verbal consent was received to remove it.

It was verified by staff that the wheelchair that the resident was observed sitting in on February 24, 2015, with the device in place belonged to another identified resident and it was also noted by the inspector to be labeled with the other resident's name.

An interview with the ADOC in 2015, confirmed that the safety device should not have been applied to the resident and that the care set out in the plan of care had not been provided as specified in their plan. (Inspector #508) [s. 6. (7)]

4. The licensee failed to ensure that when resident an identified resident was reassessed the plan of care was revised because care set out in the plan had not been effective.

A) An identified resident was identified as a moderate risk for falls after a post fall assessment in 2014. The resident's plan of care contained interventions to minimize the risk of falls. The resident had a second fall in later in 2014; however, there were no changes or additions to the interventions. The resident sustained a third fall later in

2014, and then again twelve days later. The resident was transferred to hospital and had a confirmed injury. The resident's plan of care for falls which included fall prevention interventions had not been revised until after the second fall in 2014.

It was confirmed by the ADOC that the resident's plan of care had not been revised when the plan was not effective until after the resident had three falls. (Inspector# 508) [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, 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, that care set out in the plan of care is provided to the resident as specified in the plan and to ensure that when a resident is reassessed the plan of care is revised when care set out in the plan has not been effective, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

in accordance with all applicable requirements under the Act.

A) A review of the "Skin and Wound Management Policy, Section S, dated January 2011", identified that the policy did not include the following requirements:

a) a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, ii) upon any return of the resident from hospital, iii) upon any return of the resident from an absence of greater that 24 hours; b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, iii) was assessed by a registered dietitian who was a member of the staff of the home and any changes made to the resident's plan of care relating to nutrition and hydration were implemented; iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The Administrator confirmed the policy was outdated and was not in compliance with the requirements in the Act. (Inspector #130) [s. 8. (1) (a),s. 8. (1) (b)]

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

A) An identified resident had reported that money was missing from their room after they withdrew the money from their trust account. The resident stated that they had taken the money out with the intention of purchasing items later that day. The resident put the money in an unlocked drawer in their room and when they went to get the money they discovered it was gone.

The resident reported the missing money to registered staff immediately. They indicated that staff looked for the missing money but it was never recovered.

A review of the home's policy, titled "Complaints section 2-05", of the Administration Manual indicated that all complaints, whether verbal, email, written or voice mail were to be documented on the Client Services Response Form and Response and Resolution Form for performance quality improvement initiatives.

This verbal complaint had been followed up with by staff; however, it had not been documented. It was confirmed by the DOC and the Administrator that this verbal complaint had not been documented as indicated in their policy. (Inspector #508) [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act and complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

A) An activation station was not available in the hair salon, 1st floor dining room, 1st floor activity room, small kitchen area (beside activity area), outdoor patio or any of the sitting areas (near nurse's stations) on floors 1-3. (Inspector #120) [s. 17. (1) (e)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home.

A) On an identified date in 2015, registered staff recorded that an identified resident had new impaired skin integrity to a specified area. According to the clinical record, the resident had not been assessed by the RD since 2014. The Skin and Wound Care Coordinator confirmed that the registered staff did not complete a referral to the RD. (Inspector #130) [s. 50. (2) (b) (iii)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #8: 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 were offered and available at each meal.

A) During a lunch observation on the third floor on February 18, 2015, eight residents chose the cottage cheese fruit plate which included strawberries. It was observed that the strawberries were not offered on the show plate and not provided to the residents. In an interview with the dietary aide it was shared that the strawberries came up from the kitchen after some of the residents had already been served. The planned muffin on the menu for the cottage cheese plate was a carrot muffin. Staff presented a show plate to the residents which contained a bran muffin and did not share that a carrot muffin was an available choice. It was observed that 10 residents were provided a bran muffin and not offered a choice of carrot muffin. In an interview with the Nutrition Manager it was confirmed strawberries were not available and offered and carrot muffins were not offered to all residents during the lunch meal on February 18, 2015. (Inspector #583) [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, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. As part of the organized program of maintenance under clause 15 (1) (c) of the Act, the licensee failed to ensure that procedures were in place for preventive maintenance specifically related to window condition.

A) The licensee's policy titled "Window Closures" identified the need to ensure that windows did not open more than five inches and information on an audit form completed by the ESM on a monthly basis identified that window handles closed properly and that hinges were intact and functioning. However, no information was available regarding window seals. During the inspection, when outdoor air temperatures were below -15C, cold air was felt blowing into various areas of the building via window frames and mullions. Although the windows that were tested were properly closed and latched, cold air was felt blowing into the room around the perimeter of the window frame (i.e. 107, 108, 3rd floor east lounge, 1st floor south lounge). Some rooms had duct tape affixed to the perimeter of the window to suppress the infiltration of air. Room 108 had drafty windows and the air temperature was measured with a hygrometer/thermometer on February 24, 2015 with a result of 20C. The fixed aluminum mullions in the chapel had visible gaps where the horizontal and vertical pieces joined, and strong air currents were felt blowing through the joints. As a result the air temperature in the chapel was 20C (instead of the required 22C) over a two-day period when measured.

The licensee did not manage the condition of the windows related to poor seals and air gaps. (Inspector #120) [s. 90. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are in place for preventive maintenance specifically related to window condition, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program related to cleaning and disinfection of communal equipment and the implementation of the program related to outbreak management.

A) Tub lift seats (underside) were identified by Inspectors #130 and #120 to be coated in a yellow substance (soap scum) on February 20, and again on February 24 and 25, 2015 in 1S, 1E, 2E and 3S tub rooms. Instructions for cleaning the tubs or lift seats were not posted in all tub rooms. According to the home's tub lift cleaning procedure, evidence based practices ("Cleaning, Disinfection and Sterilization of Medical Equipment/Devices, 2013" developed by the Provincial Infectious Diseases Advisory Committee) and the manufacturer's instructions for cleaning the tub lift seats, all sides were to be cleaned and disinfected between resident use.

B) On February 18, 2015 Inspector #508 observed two large nail clippers and nail clippings stored inside of an unlabeled drawer of a multi-drawer storage caddy located on the wall of the 2nd floor south tub room. The other drawers were labeled with resident's names, and according to a PSW, were supposed to contain a small nail clipper inside for each resident.

On February 20, 2015, Inspector #130 observed one large nail clipper inside of an unlabeled drawer of a similar caddy in the 1st floor south tub room. A PSW was interviewed at the time of the observation about the process of handling and cleaning communally shared nail clippers and they explained that they used alcohol wipes to wipe the surface of the clipper.

On February 25, 2015, Inspector #120 observed a large nail clipper and several packets of rubbing alcohol wipes in the same unlabeled drawer as noted by Inspector #130 above and smaller nail clippers were observed in other labeled drawers. A large nail clipper in an unlabeled drawer was also observed in the 3 East clean utility room.

Discussion held with the DOC revealed that the home's cleaning and disinfecting procedures for communal equipment did not include any instructions for cleaning and disinfecting nail care equipment between resident use. According to the above identified evidence based practice document, such articles would require immersion in a high level disinfectant after cleaning between resident use. The use of alcohol wipes would be acceptable only after cleaning and on clippers going back to the same dedicated resident.

C) Visibly used hair brushes (with hair strands wrapped around bristles) and a total of 20 unlabeled visibly used (semi solid surface rounded down and scratched) deodorant roll-ons were found in clean utility rooms amongst new supplies in 1S, 1E, 2E, 3S and 3E on February 25, 2015 and three unlabeled used combs and a toothbrush in the 2 South tub room on February 18, 2015. According to the DOC, staff were oriented and expected to store such items with the resident in their room and labeled accordingly. No specific policy was identified in the infection prevention and control manual regarding the consequences of such practices. Communal use of such products can lead to outbreaks of lice, scabies and fungal skin infections. (Inspector #120) [s. 229. (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 staff participate in the infection prevention and control program, specifically related to cleaning and disinfection of communal equipment and the implementation of the program related to outbreak management, to be implemented voluntarily.

WN #11: 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 license failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A) On a specific date in 2015 an identified resident shared with a staff member in the home that they had received rough care and had been verbally abused by another staff member of the home. A review of the Prevention, Elimination and Reporting of Abuse Policy and Procedure (7-16-01), Effective November 1, 2013, identified any alleged, suspected or witnessed abuse of any form required the home to initiate the investigation process immediately. The policy directed the home to use the abuse decision trees, provided by the Ministry of Health and Long-Term Care (MOHLTC). The long-term care home's documented investigation records for this resident for a specific time frame in 2015, were reviewed. It was identified that the home began their investigation on a specific date in 2015 and reported the alleged abuse to the Director ten days later. In an interview with the Administrator it was confirmed that as soon as reasonable grounds were suspected that abuse may have occurred related to the identified resident the licensee did not immediately report suspicion and information to the Director and the alleged incident that was reported by the resident was not immediately investigated as per the home's policy. (Inspector #583) [s. 20. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) An identified resident required assistance for personal hygiene which included assistance with cleaning their teeth. During an interview in stage one with the resident and the resident's family member, they had indicated to Inspector #130 that the oral care the resident was receiving was not adequate. The family member had indicated that during an off site dental appointment, the Dentist stated that the condition of the resident's mouth was "appalling".

During this inspection, the resident's mouth was observed by this Inspector on three separate occasions. The resident's teeth were coated with a thick white substance and debris was noted on their gums. During the assessment of the resident's mouth on the third date, a family member was present. The family member cleaned out the resident's mouth for a large amount of debris and thick mucous.

The family member had also indicated that they had requested for staff to clean the resident's teeth more than twice a day due to the condition of their mouth. During an interview with a PSW they indicated that they did not do additional oral care for this resident. The resident's plan of care did not indicate the frequency of oral care or that additional oral care had been required.

It was confirmed by the ADOC, that the plan of care was not based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene. (Inspector #508) [s. 26. (3) 12.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #500 was given an opportunity to participate fully in the annual care conferences.

A) According to the clinical record, multidisciplinary care conferences to review the resident's plan of care, were held annually for an identified resident from 2012-2014. The resident, Social Worker and minutes of those meetings confirmed the resident was not in attendance at those conferences. The resident stated during an interview with the Inspector on a specified date in 2015, that they would have attended the conference had they been invited. (Inspector #130) [s. 27. (1) (a)]

2. The licensee failed to ensure that a record was kept of the date, the participants and the results of the annual care conferences held for an identified resident.

A) The Social Worker confirmed that the care conference records for an identified resident did not include the names of all participants who attended the conference, nor was the Multidisciplinary Care Conference Tool used to record the minutes of the conference held in 2015, completed by all disciplines. (Inspector 130) [s. 27. (1) (c)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids. O. Reg. 79/10, s. 37 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident received the assistance they required to use personal aids.

A) During an interview on a specific date in 2015 with an identified resident, it was shared they could not find their glasses and were observed not wearing their glasses. On another date in 2015, the resident was observed watching television not wearing their glasses. The resident asked Inspector #583 to get their glasses from their room because they were unable to get them independently. The resident reported staff had not offered to provide assistance with their glasses. A review of the plan of care identified there were visually impaired and directed staff to ensure resident they wore their eyeglasses at all times and on daily basis. (Inspector #583) [s. 37. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. As part of the organized program of laundry services under clause 15 (1) (b) of the Act, the licensee failed to ensure that procedures were developed and implemented to ensure that residents' personal items and clothing were labeled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing.

A) On February 25, 2015, a tour of the laundry room revealed multiple bags of clothing waiting to be labeled with the resident's name. No forms were attached or in the bags, identifying the date that the clothing was submitted for labeling. According to the laundry clerk, the bags had been in the laundry room since February 20, 2015. The home's laundry handling procedure dated March 2006 titled "labeling" stated that the clothing would be labeled within 24 hours of receiving the clothing and that the clothing should be dropped off in the office. No information was included in the procedure as to what forms would be used, if any, to keep track of the submissions. The procedure also lacked information as to how the items would be labeled, by whom, where the label would be applied to ensure that items would be labeled in a dignified manner and whether staff needed to document what had been labeled. (Inspector #120) [s. 89. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's SDM was notified within 12 hours upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident.

A) The long-term care home's documented investigation records for an identified resident for a time period in 2015 were reviewed. The records identified that the registered staff notified the DOC on a specific date in 2015 to report that the identified resident alleged they had been physically and verbally abused by a staff member. A review of the progress notes identified that the resident's SDM was notified on a specific date in 2015 that the resident received rough treatment, an investigation took place and actions had been taken. A review of the "Prevention, Elimination and Reporting of Abuse Policy and Procedure (7-16-01), Effective November 1, 2013", identified the Administrator/Director of Nursing/delegate would ensure that the resident's SDM would be informed of allegations of resident abuse immediately. In an interview with the DOC on a specific date in 2015, it was confirmed that the resident's SDM was not notified within 12 hours of the licensee becoming aware of an alleged incident of abuse.(Inspector #583) [s. 97. (1) (b)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the conditions to which the licensee was subject as outlined in section 4.1 Schedule C of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health System Integration Act, 2006 was complied with.

A) The LSAA reads as follows: "The Health Service provider shall use the funding allocated for an envelope for the use set out in applicable policy". The Long-Term Care Homes Nursing and Personal (NPC) Envelope Section 1(b) reads, "direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene, services, administration of medication, and nursing care."

A) During the inspection on February 24, 25 and March 3, 2015, nursing staff (PSWs) were observed completing laundry duties (delivering personal laundry to resident rooms). PSWs verified that they spend approximately 75 minutes delivering personal laundry to residents during the day shift. A laundry aide confirmed that in previous years, laundry aides delivered the clothing to residents; however, the process had changed. The DOC confirmed that the PSWs were being paid from the NPC envelope. (Inspector #120) [s. 101. (4)]

Issued on this 25th day of May, 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) :	GILLIAN TRACEY (130), BERNADETTE SUSNIK (120), KELLY HAYES (583), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2015_323130_0004
Log No. / Registre no:	H-001830-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 11, 2015
Licensee / Titulaire de permis :	GRACE VILLA LIMITED 284 CENTRAL AVENUE, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	GRACE VILLA NURSING HOME 45 LOCKTON CRESCENT, HAMILTON, ON, L8V-4V5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Annette Prentall

To GRACE VILLA LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that the right of all residents, including resident #500 to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference are fully respected and promoted.

The home shall review with resident #500 the visitor restrictions put in place by their SDM to determine whether or not these restrictions are acceptable to them.

Grounds / Motifs :

1. The licensee failed to ensure that an identified resident's right to receive visitors of his or her own choice was fully respected and promoted.

A) On an identified date in 2012, registered staff documented in progress notes that the "POA" had called the home to advise staff that the resident had not seen their children in a number of years and they just recently found out that the resident was in a nursing home and may try to contact them. The spouse believed that seeing their children would cause them to be more confused and agitated. The POA did not want the resident's children to know that they were in the home. The nurse informed the office staff of the POA's concerns so that if they answered the phone they would know not to tell anyone the resident was there. The POA also instructed that the resident could only be taken on LOA's (leave of absences) with the them. Office staff indicated they updated the profile to reflect these instructions. The POA requested that no information be shared with outsiders. The POA was advised by the home's staff that no information would be given to anyone inquiring about the resident and that they would be notified if anyone came to visit. On a specified date in 2012, registered staff recorded in progress notes that the resident's spouse had been in and left the names of identified individuals who were restricted from receiving any information about the resident or knowing their whereabouts. Staff were made aware of the POA's concern and an email was sent to administration staff. The Inspector reviewed the resident's business file with the Business Coordinator and confirmed that these instructions remained in effect. The Business Coordinator also verified that the POA documents provided by the resident's spouse at the time of admission, did not contain signatures or identify the date they were executed, which rendered them invalid. The Administrator and DOC confirmed the resident's spouse would be regarded as the Substitute Decision Maker (SDM) and not the POA. There was no recorded evidence found to indicate that the visitor restrictions in effect were ever discussed and or agreeable with the resident. (Inspector#130) [s. 3. (1) 14.] (130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall complete the following:
1. Develop a bed rail use assessment program using information contained in the prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003 " (developed by the US Food and Drug Administration and endorsed by Health Canada.
2. Assess all residents by applying the bed rail use assessment program.
3. Include bed rail use instructions in the plan of care for all residents so that health care staff are aware of when to apply one or more bed rails where appropriate, the reason for applying the bed rail, which side, the size of the rail and how many rails.
4. Educate all staff on all shifts who would apply a bed rail for a resident with respect to the rail use assessment program and Health Canada's bed safety guidelines.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, that residents were assessed in accordance with prevailing practices, to minimize risk to the resident.

A number of residents were observed to be sleeping in beds on two identified dates in 2015 with one bed rail elevated or in use. A review of their health care record (plan of care, care plan etc) did not identify any bed rail information, yet personal care staff had elevated at least one rail. When several staff were asked why the rails were being elevated, the responses varied from statements such as "to keep the resident from getting into bed, or getting out of bed on a particular side or to allow the resident to reposition themselves while in bed". Yet, the residents identified did not have any such instructions in their plan for staff to follow.

Further review of residents' health care records revealed that some residents had bed rail use information in their plan of care and others did not and confirmation was made with the Director of Care that no formal assessment had been completed on any resident. According to prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and endorsed by Health Canada), residents would need to be evaluated while sleeping in bed over a period of time by an interdisciplinary team to determine if the bed rail was a safe alternative for the resident after trialling other options.
(120)

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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2014_214146_0009, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall complete the following:
1. If a resident has been determined to require a bed rail and is sleeping in a bed where it did not pass one or more entrapment zones, complete one of the following;
a. institute a gap reducing strategy for the specific zone of failure (as per guide below)
b. replace the bed with a bed that has passed zones 1-4 of entrapment
c. modify the bed in accordance with "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006" developed by US Food and Drug Administration and endorsed by Health Canada.
2. Ensure that mattresses are not able to slide from side to side on the deck of any bed by installing mattress keepers on all beds where bed rails are used for any reason or other method with an equal outcome.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, steps were taken to prevent resident entrapment.

A) During the inspection on February 24, 25 and March 3, 2015, a tour of resident rooms revealed that a number of residents were sleeping in beds with one or more bed rails elevated or in use that did not pass one or more entrapment zones. The identified residents' beds were not modified in any way (gap fillers, bolsters, rail pads etc.) to mitigate the zone specific risk. According to records maintained by the DOC, 42 out of 186 beds were tested and failed one or more entrapment zones in July 2014. The records were also noted to be partially inaccurate, as some of the beds had been moved to other rooms without management awareness.

Residents in four identified beds were observed to be sleeping in bed with both or one of their ¾ length bed rails elevated with no modifications in place. The beds were all identified and confirmed to have failed one or more zones of entrapment in July 2014.

B) During a tour of the beds on February 24, 25 and March 3, 2015, unoccupied (resident not in bed) beds were observed in nine identified rooms to have at least one rail elevated without any mattress keepers (corner guards to prevent the mattress from sliding back and forth on the deck of the bed). Although some passed entrapment zone testing (completed with both rails elevated), a risk remained as the mattress was capable of shifting, creating a gap between the one bed rail and the mattress. The bed in another identified room was specifically observed to be ¼ of the way off the bed deck with a large gap between the bed rail and mattress. The licensee did not address or identify this issue during their assessment of the beds. (Inspector #120) [s. 15. (1) (b)]
(120)

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(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;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee shall prepare and submit a plan that summarizes;
1. How the flooring in all resident rooms, tub rooms, corridors and common areas will be maintained in appearance (free of discolourations, black areas, perimeter build-up and worn foot traffic patterns) as per the home's floor care program standards and who will review and amend where necessary the floor care policies and procedures. At a minimum, the plan shall identify who will be responsible, a sustainability plan and a time frame of implementation so that floor care issues are rectified by July 31, 2015.
2. How the current housekeeping duties as outlined in the licensee's housekeeping procedure for room and bathroom cleaning will be implemented as per the home's specified frequencies and standards and who will review and amend the policies as necessary.
The plan shall be submitted to Bernadette.susnik@ontario.ca by May 31, 2015 and fully implemented by July 31, 2015.

Grounds / Motifs :

1. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee did not ensure that procedures were developed or implemented for cleaning of the home, specifically flooring and resident rooms.

A) The flooring material was observed with wear patterns and dark areas under beds and/or around the perimeter of the bedrooms in 318, 319, 321, 327, 305, 118, 106, 107, 108, 131, 131, 212 and 204. In bathing rooms located on the east side of the home on floors 1, 2 and 3, the gray non-slip tiled floors were black in appearance throughout the shower and tub areas. Corridor flooring material was also visually discoloured just outside the lounge on 2E and towards the stairwell on 2E and in the corridor and lounge on 3E. According to the ESM, the tub rooms and above noted bedrooms were all "buffed" once between August 10, 2014 and February 17, 2015, with room 204 being most recently done. However, when observed on February 24, 2015, the room perimeter and under Bed A was observed to be black. According to the ESM, the method used to clean the tiles in the bathing rooms was not having any effect on the visible outcome of the tiles and alternatives were discussed. The ESM had an on-going schedule for floor buffing however the rooms and areas were not on a scheduled rotation. According to the home's various procedures regarding floor care dated September 2011, floors were to be either buffed, polished or stripped based on an established schedule or once a week or once per year, depending on the process. One procedure titled "floor polishing" identified that floors were to be

polished once per week in resident rooms and on weekends, the activity room, dining rooms, corridors, lounges would be done. The procedure related to floor stripping offered a frequency of once per year for common areas, dining rooms and lounges, but did not identify the need to strip and re-wax resident rooms. No procedure had been developed to address the cleaning requirements of the tiled non-slip floors in 3 out of the 6 bathing rooms located on the east side, all of which were renovated within the last 3 years.

B) The licensee's resident room cleaning procedure titled "cleaning resident's rooms" specified that sills, radiators and furniture surfaces be done daily. Another separate procedure for resident ensuite washroom cleaning identified that they were to be cleaned daily. During the inspection on February 24, 2015 between the hours of 10:30 am and 4:30 pm, many rooms were noted to have dusty radiators and sills (330, 328, 325, 322, 106, 103). These rooms continued to have dusty surfaces on a return visit on March 3, 2015. Every ensuite washroom checked on each floor had overly dusty vanity light covers, however the procedure did not specify to clean the light cover and how often. No procedure was identified in the housekeeping binder describing what specific surfaces needed to be cleaned and how often in washrooms.

The licensee did not implement and/or develop policies related to the floor care program or cleaning of horizontal surfaces.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2015

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure resident #500 is given the right to 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 and to obtain an independent opinion with regard to any of those matters.

The licensee shall:

a) Inform the resident of their right to contest the incapacity decision and assist the resident to obtain an independent capacity assessment through the appeal process with the Consent and Capacity Board, if they wish to proceed with an appeal.
b) Educate all registered staff regarding Residents' Rights and consent and capacity.
c) Provide a written update to the inspector on the status of this resident by the compliance date for this order.

Grounds / Motifs :

1. The licensee failed to ensure that an identified resident's right to 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 secure unit and to obtain an independent opinion with regard to any of those matters, was fully respected and promoted.

A) An identified resident was admitted to the home in 2012. Admission placement records provided by Community Care Access Centre (CCAC), specifically the Home Care MDS (Minimum Data Set) (Hospital) record indicated that on a an identified date in 2012, prior to their admission, a Social Worker deemed the resident "not capable of making a shelter decision". A consultation report completed by a physician, in 2013, indicated the resident remained incapable of making care decisions, especially shelter. The home obtained signed Advanced Health Care Directives and Consents to Treatment from the resident at the time of their admission in 2012 and later in 2014. Since admission to the home, the resident had repeatedly sought information surrounding their admission and potential discharge. There was no documentation found in the resident's clinical record to indicate whether or not the resident had been advised of their right to contest the incapacity decision and to obtain an independent capacity assessment through the appeal process with the Consent and Capacity Board. The Social Worker confirmed the home had not assisted the resident with the appeal process application. (Inspector #130) [s. 3. (1) 11. iii.] (130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 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 11th day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : GILLIAN TRACEY

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