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

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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
Apr 27, 2015	2015_312503_0008	H-002170-15	Resident Quality Inspection

Licensee/Titulaire de permis

UNGER NURSING HOMES LIMITED
312 Queenston Street St. Catharines ON L2P 2X4

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

HAMPTON TERRACE CARE CENTRE
75 PLAINS ROAD WEST BURLINGTON ON L7T 1E8

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

LAURA BROWN-HUESKEN (503), LALEH NEWELL (147), MELODY GRAY (123), THERESA MCMILLAN (526)

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): March 24, 25, 26, 27, 30, 31, April 1, 2, 7, 8, 9, 10, 16, 2015.

The following complaint and critical incident inspections were completed: H-001399-14, H-001718-14, H-001811-15, H-001908-15, and H-002011-15.

During the course of the inspection, the inspector(s) spoke with Acting Administrator, Director of Care (DOC), Dietary Manager, Resident Assessment Instrument Minimum Data Set (RAI_MDS) Coordinator, Quality Improvement (QI) Lead, Social Service Worker, Maintenance, Housekeeping Coordinator, Registered Nursing staff, Personal Support Workers (PSW), Administrative Assistant, Cooks, Dietary Aides, Housekeeping staff, family members and residents.

During the course of the inspection, the inspector(s): toured the home, observed provision of care, meal preparation and meal service, reviewed clinical health records, policies and procedures, maintenance and housekeeping schedules and logs, meeting minutes, and staff files.

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
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **28 WN(s)**
- **15 VPC(s)**
- **9 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

The bed for resident #100 was observed by the Long-Term Care (LTC) Inspector to have one half rail and one assist rail up. Interviews with PSW and Nursing staff revealed that the rails are PASDs and are used to assist the resident with bed mobility. The resident's

plan of care included one half rail but did not include the use of the assist rail. An interview with the home's DOC confirmed that the assist rail was being used as a PASD and was not included in the resident's plan of care. [s. 33. (3)]

2. Not all of the following were satisfied prior to including the use of a PASD to assist in routine activities of daily living: alternatives to the use of the PASD considered, the use of the PASD was reasonable given the resident's condition, consent had been obtained and the device was approved.

Resident #100 used one half rail and one assist rail when in bed as a PASD to assist with bed mobility. Review of the resident's health records and interview with the DOC indicated that there was no documented evidence to support that an assessment identifying other alternatives were tried prior to the use of the bed rails. Interview with the DOC and Registered Practical Nurse (RPN) also confirmed that an approval of the PASD by an appropriate person, as defined in the legislation, was not obtained, nor was there a consent documented from the resident or their substitute decision maker for the use. [s. 33. (4)]

3. Resident #105 used one half rail and one assist rail when in bed as a PASD to assist with bed mobility. Review of the resident's health records and interview with the DOC indicated that there was no documented evidence to support that an assessment identifying other alternatives were tried prior to the use of the bed rails. Interview with the DOC further confirmed that an approval of the PASD by an appropriate person, as defined in the legislation, was not obtained, nor was there a consent documented from the resident or their substitute decision maker for the use. [s. 33. (4)]

4. Resident #108 used two bed rails when in bed and a tilted wheelchair as a PASD to assist with bed mobility and positioning. Review of the resident's health records and interview with the registered staff indicated that the bed rails are used as PASDs for bed mobility and transfers and the tilt wheelchair is to ensure proper posture while in wheelchair. However, there was no documented evidence to support that an assessment identifying other alternatives were tried prior to the use of the bed rails or the tilted wheelchair. Interview with the DOC and review of the resident's clinical records confirmed that an approval of the PASD by an appropriate person, as defined in the legislation, was not obtained, nor was there a consent documented from the resident or their substitute decision maker for the use. [s. 33. (4)]

Additional Required Actions:

CO # - 001 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 when a PASD is used to assist a resident with a routine activity of living the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the persons who received training under s. 76 (2) 9., regarding infection prevention and control (IPAC), received retraining annually in accordance with r. 219 (1).

Review of the home's infection prevention and control training documents indicated that 76 of 146 (52.1%) staff completed Part 1 and 74 of 146 (50.7%) staff completed Part 2 of the home's IPAC training modules during 2014. The DOC confirmed this and stated that all staff should have completed this training annually. [s. 76. (4)]

2. The licensee failed to ensure that all staff that provide direct care to residents receive, as a condition of continuing to have contact with residents, training on how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the Act and regulations, annually in accordance with r. 221 (2).

Review of the home's restraints and PASDs training documents indicated that 41 of 114 (36%) direct care staff completed the home's training module in 2014. The DOC confirmed this and stated that all direct care staff should have completed this training annually. [s. 76. (7) 4.]

3. The licensee failed to ensure that the direct care staff received retraining annually in falls prevention and management in accordance with r. 221 (1) 1.

Review of the home's falls prevention and management training documents indicated that 73 of 113 (64.6%) direct care staff completed the home's training module in 2014. The DOC confirmed this and stated that all direct care staff should have completed this training annually. [s. 76. (7) 6.]

Additional Required Actions:

CO # - 002, 009 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. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that clearly indicated, when activated, where the signal was coming from.

Interview with PSW staff indicated that normally, when the home's resident-staff communication and response system was triggered at a call station, a light above the doorway to that room/call station would activate and a sound would activate in the hallway of the respective care area. Staff confirmed that they did not carry paging devices to alert them if a station had been triggered. If the sound did not activate, the staff would not be aware that a call station had been triggered, unless they were in clear view of the light that was activated above the respective room. PSWs stated that they relied on the alarm sounding in the hallway in addition to the light above a room for them to identify that the system had been triggered and from where.

A) During the initial tour of the home on March 24, 2015 at approximately 0940 hours, the resident-staff communication and response system was triggered in the Ivy home area activity room. A small light directly above the room was activated, but there was no sound associated with the triggered system. Approximately five minutes later, a Registered Practical Nurse (RPN) and PSW told the Long Term Care Homes (LTC)

Inspector that they were not aware that the response system had been triggered. The RPN and PSW confirmed that the system, when triggered from the Ivy home area activity room, did not clearly indicate where the signal was coming from.

Between March 26, and April 10, the Acting Administrator confirmed that the resident-staff communication and response system in the Ivy Lane activity room did not clearly indicate, when activated, where the signal was coming from.

B) On March 26, 2015, two PSW staff informed the LTC Inspector that the resident-staff communication and response system was not making any sound on Rose Arbour Lane at approximately 0700 hours when most residents were still in bed. They stated that they confirmed that no stations on Rose Arbour Lane triggered the system to activate an alarm sound. Unless they were in clear view of the activated light above a resident's room, the system did not clearly indicate where the signal was coming from.

C) On March 26, 2015, between 1145 and 1215 hours, the resident-staff communication and response system on Rose Arbour Lane was noted to be sounding the emergency alarm signal. All residents were in the dining room at the time. Two PSW staff confirmed that they did not know where the sound or signal was coming from and stated that this problem had occurred the day before. They confirmed that there were no lights above doors that were activated. They stated the current emergency alarm signal/sound would not end when cancelled at any call station, and maintenance staff had advised them to stop the alarm sound by hitting the speaker that emanated the sound with a broom.

D) On March 26, 2015 between 1330 and 1350 hours, resident-staff communication and response system on Rose Arbour Lane was observed to be sounding the emergency alarm signal. Two PSW staff confirmed that they did not know where the sound/signal was coming from and that no lights were activated above doorways. They stated that the signal would alarm in this way if a call bell station was triggered, and the alarm would not stop even if cancelled at the triggered station. Because the signal was fast and continuous, the staff confirmed that unless they were in the hall to view the activated light above the door where a station was triggered, they could not tell if a station had been triggered.

During interview at 1350 hours on March 26, 2015, the Acting Administrator confirmed that resident-staff communication and response system on Rose Arbour Lane did not clearly indicate, when activated, where the signal was coming from.

E) On April 9, 2015, the resident-staff communication and response system on Lilac Lane was observed to have an alarm sounding continuously and could not be turned off when the alarm was cancelled at the call station that triggered the system. PSW and RPN staff confirmed that if they were not in clear view of the lights above resident rooms, they would not be aware that a signal had been triggered or where it was coming from.

F) On April 16, 2015, the resident-staff communication and response system on Rose Arbour Lane was observed to have an alarm sounding continuously that began spontaneously without being triggered. There were no lights activated above residents' rooms. Staff stated that they could not disable the alarm sound and that the system did not clearly indicate, when activated, where the signal was coming from. [s. 17. (1) (f)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

Record review revealed that resident #113 had a fall on an identified date, which resulted in multiple fractures. The resident's written plan of care, initiated on an identified date prior to the fall, directed staff to provide the resident with the assistance of two staff for transferring on and off of the toilet. Review of the clinical record and interview with PSW and RPN revealed that the resident was being assisted by one PSW for transfer onto a commode for toileting at the time of the fall. Interview with the DOC confirmed that the resident should have been assisted by two staff and that resident had been transferred in an unsafe manner. [s. 36.]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

The home's Continence Care policy for "Continence Care and Bowel Management Program" Number ND-C-04-01-01 effective as of August 2104 directed staff to complete the "Continence Care Assessment-Bowel and Bladder" when there was a significant change in a resident's continence care needs.

1. Resident #103's RAI MDS assessments completed on three identified dates, indicated that the resident was continent of bowel during the 14 day assessment period. Review of the resident's health record indicated that the resident had been incontinent of bowel six times in an identified month; eight times in a second identified month; and 14 times in a third identified month. The review of resident #103's health record also revealed no assessment of bowel continence had been conducted that included identification of causal factors, patterns, type of incontinence and potential to restore function with

specific interventions, using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required. The RAI Coordinator and DOC confirmed that a continence assessment had not been conducted according to the home's policy for resident #103. [s. 51. (2) (a)]

2. Resident #101's RAI MDS assessments completed on two identified dates, indicated that the resident was frequently incontinent of urine and usually continent of bowel during the 14 day observation period. The RAI MDS assessment completed on an identified date indicated that the resident was incontinent of urine and incontinent of bowel. During interviews, PSW and RPN staff confirmed that the resident had wet through the brief during night and daytimes. Review of the resident's health record revealed that, when they had a significant change in continence and care needs, the resident had not had a bowel or bladder continence assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was a clinically appropriate continence assessment instrument. The RAI Coordinator confirmed that a continence assessment had not been conducted when the resident's continence worsened or according to the home's policy for resident #101. [s. 51. (2) (a)]

3. Review of resident #100's Minimum Data Set Resident Assessment Instrument (MDS RAI) indicated that the resident was first coded as being incontinent of bladder on an identified date. Interviews with PSW and Nursing staff revealed that the resident had experienced a decline in bladder continence since admission and confirmed that the resident was incontinent of bladder. A review of the resident's clinical record did not locate an assessment of the incontinence including identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. An interview with the home's DOC confirmed that an assessment of the resident's incontinence had not been completed. [s. 51. (2) (a)]

Additional Required Actions:

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented for cleaning the home. Throughout the course of this inspection resident bathrooms, tub and shower rooms were observed to be unclean.

According to the Acting Administrator, the home's housekeeping services were provided through the use of a contracted service provider. The Environmental Coordinator was the service provider's representative in the home. On April 7, 2015, the home's Environmental Coordinator confirmed that cleaning procedures were not implemented in the following home areas:

i) Tub and shower rooms for Rose Arbour, Ivy, Primrose and Lilac Lanes: floors soiled with dirt on floor surface and ground in dirt on the floors, particularly on the laminate located beneath the tubs and along the floor/base board juncture. Soiled brown/yellow matter located around the base of toilets.

ii) Resident bathrooms noted to have yellow/brown soiling matter located around the base of toilets and between tiles surrounding toilets in the following rooms: Rose Arbour Lane rooms 100, 103, 107 and 114; Ivy Lane room 206; Primrose Lane rooms 403, 405, 413, 416; and Lilac Lane rooms 301, 304, 305.

Concerns about the cleanliness of the home had been raised during the Family Council meeting dated January 21, 2015. According to the minutes for that meeting, "Cleaning staff to be reviewed due to poor quality of work".
The home's Cleaning Guidelines policy "Resident Areas Cleaning" number ES-04-02-01 effective as of December 2014 directed staff to damp mop tub room floor with disinfectant/detergent solution daily. The home's Cleaning Guidelines policy "Washroom Cleaning" number ES-04-02-02 effective as of December 2014 directed staff, on a daily basis, to clean toilets including cleaning exterior of bowl and area around base of fixtures using disinfecting solution.

The Environmental Coordinator confirmed that cleaning procedures of the areas identified should have been implemented on a daily basis, according to the home's policy. [s. 87. (2) (a)]

2. The licensee failed to ensure that procedures were implemented for addressing incidents of lingering offensive odours.

Throughout this inspection, the following rooms were noted to have a urine odour: Rose Arbour Lane rooms 100, 103, 107, 114; Primrose Lane rooms 401, 410, 413, 416; Lilac Lane room 305; and Ivy Lane shower room and room 206.

The home's Cleaning Guidelines policy for "Washroom Cleaning" number ES-04-02-02 effective as of December 2014, indicated that odours usually resulted from the following sources: Soil rings under toilet and urinal rims, spattered urine on floors, particularly those which are improperly sealed; heavy encrustations of crystals in urinals; improperly cleaned grooves and crevices; and dry traps in floor drains. The following rooms were observed to have evidence of potential sources of odours, such as improperly cleaned grooves and crevices, and urine splatter and/or brown/yellow staining on and between tiles in disrepair: Rose Arbour Lane rooms 100, 103, 107 and 114; Primrose Lane rooms 413, and 415; Lilac Lane room 305; and Ivy Lane room 206.

During interview, the home's housekeeping staff and the Environmental Coordinator stated that when residents were incontinent, urine would lodge between caulking and the base of the toilet, and also would seep between separating floor tiles that surrounded the toilets. The Environmental Coordinator confirmed that housekeeping staff should have scrubbed around the base of toilets and on/between tiles to remove urine and debris from these areas. In addition, they indicated that PSW staff were to use the spills bucket equipped with disinfectant located on each Lane area to clean up spills that occurred

after the room was cleaned. During interview, PSW staff stated that when a resident was incontinent on a floor, they would wipe up the spill with a paper towel and water.

The Environmental Coordinator confirmed that odours were lingering and that procedures were not implemented to eliminate persistent odours. [s. 87. (2) (d)]

Additional Required Actions:

CO # - 006 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 procedures are implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there were schedules and procedures in place for preventive maintenance.

Maintenance services in the home were being managed by the Acting Administrator and the Maintenance Coordinator. According to the Maintenance Coordinator and the home's maintenance policies, no specific procedure was in place to guide preventive maintenance or designated staff in their role in conducting preventive maintenance related to the condition of the resident bathrooms, tub and shower rooms.

During the inspection, the following areas of disrepair in the home were observed and discussed with the Maintenance Coordinator, some of which he was aware of and others

that he was not.

A) Tub and shower rooms:
i) Ivy Lane shower room: Laminate flooring coming away from floor at edge of shower; caulking between baseboard and wall appeared blackened and coming away at the edge of floor.
ii) Primrose Lane Shower room: Laminate flooring coming away from floor at left edge of shower.
iii) Rose Arbour Lane tub room: warped and separating base board to the left of the tub with peeling paint; discoloured caulking; laminate flooring in tub room separating.
iv) Rose Arbour Lane shower room: chunks of dry wall and paint out of walls; floor tiles leading into tub room cracked; laminate flooring in tub room separating.
v) Lilac Lane shower room: uneven and bulging grout between floor and wall tiles; cracked tiles around floor drain; rough and broken tiles leading into shower room at doorway; grout around toilet coming away and stained yellow.

B) Resident bathrooms:
i) Ivy Lane room 206: cracked and separating floor tiles and degrading caulking around base of toilet
ii) Rose Arbour rooms 100 and 107: cracked and separating floor tiles around base of toilet
iii) Primrose Lane rooms 403, 405, 413, and 416: stained, cracked caulking and tiles at base of toilet; tiles coming away from baseboard in room 416
iv) Lilac Lane room 300: 40 centimetre by 40 centimetre area in the bathroom ceiling where drywall was buckled, separating, and ripped with old water marking around the area
v) Lilac Lane rooms 301, 304, and 305: cracked and stained tiles and caulking around the base of toilet

Review of maintenance records and interview with the Maintenance Coordinator in the home indicated that monthly audits had been completed but there was no indication which rooms had been audited, or the process to use when areas of disrepair were identified. The Maintenance Coordinator and Acting Administrator could not provide documentation to confirm that the preventative maintenance checklist and procedures were followed and completion of work regularly documented, as indicated in the monthly audit. No documented evidence was provided that indicated that preventive maintenance schedules and procedures regarding resident bathrooms, tub and shower rooms were in place in the home. [s. 90. (1) (b)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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 the Infection Prevention and Control program was evaluated and updated at least annually in accordance with evidence based practices.

Review of the home's program evaluation documentation revealed that there had not been an evaluation of the home's Infection Prevention and Control Program in 2014. This was confirmed by the DOC who stated that there had been a high turnover of administrative staffing which had resulted in the 2014 program evaluations not being completed. The home was not able to provide documentation that confirmed when the most recent evaluation of the home's infection prevention and control program. [s. 229. (2) (d)]

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

Throughout this inspection, on numerous occasions and different times of the day, all inspectors observed uncovered clean linen carts and clean resident laundry carts located in the hallways. The home's Infection Control policy "Handling Infected Linen" number ES-05—06-01, effective as of December, 2014, directed staff to ensure that clean linen should be stored in a covered area. PSW staff confirmed that the clean linen should be covered when stored in the carts in the hallways, according to the home's policy. [s. 229. (4)]

3. During noon medication administration observation on April 2, 2015, the Registered Practical Nurse (RPN) was observed to not be performing hand hygiene between administration of medication to several different residents in their rooms and in the dining room. [s. 229. (4)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) The document the home referred to as resident #101's "care plan" last reviewed on an identified date, indicated that the resident liked to get up at a specified time. Interview with three PSW staff confirmed that the resident did not like to get up at the specified time and needed encouragement. During an interview, the resident stated that they didn't like to get up early and often preferred to stay in bed well into the morning. The resident also stated that a PSW staff member came into their room early and took the

covers off, insisting that they get up. Interview with a staff member working at that time indicated that the PSW was new and did not know that the resident didn't like to get up early. Registered and non registered staff confirmed that the plan of care did not set out clear directions to direct care staff regarding resident #101's preference for getting up in the morning.

B) The document the home referred to as resident #110's "care plan" last reviewed on an identified date, indicated that there was no particular time that the resident wished to get up in the morning. During an interview, the resident stated that some staff get the resident up before their preferred time. During interview PSW staff stated that the resident wished to get up no earlier than an identified time. Registered and non registered staff confirmed that the plan of care did not set out clear directions to direct care staff regarding resident #110's preference for getting up in the morning. [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

A) Resident #103's RAI MDS assessment completed on an identified date indicated that the resident was continent of bowel during the 14 day assessment period. The document the home referred to as the "care plan" last reviewed on an identified date, indicated that resident #103 was continent of bowels. Review of the resident's PSW point of care documentation reporting system indicated that the resident was incontinent of bowel on two occasions during 14 days prior to the assessment. The resident had been incontinent of bowels 12 times in an identified time period prior to the assessment. Interview with resident and PSW staff confirmed that the resident was known to be incontinent of bowels. The RAI Coordinator and DOC confirmed that the assessments of resident #103's bowels were not collaborated.

B) Resident #101's RAI MDS assessments completed on two identified dates, indicated that the resident was frequently incontinent of urine during the 14 day observation period. The RAI MDS assessment completed on an identified date indicated that the resident was incontinent and that there had been no change urinary continence. The RAI Coordinator confirmed that the continence assessments were not consistent with or complemented each other. [s. 6. (4) (a)]

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

During interview on an identified date, the resident #201's Power of Attorney (POA) expressed concern about the home's management of the resident's bowels and constipation. Health record review indicated that the resident had a bowel related health condition, that they had a history of constipation and that they were receiving several treatments to prevent constipation. The resident's plan of care also included the administration of medications when the resident had not had a bowel movement within two and three days. Review of the resident's electronic medical record (eMAR) and the point of care (POC) PSW charting indicated that resident #201 had not received treatments to prevent constipation on seven occasions when they had not had a bowel movement within two days, and on three occasions when they had not had a bowel movement within an identified time period. During interview, a Registered Nurse (RN) confirmed that care had not been provided to resident #201 as specified in their plan of care. [s. 6. (7)]

4. The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

The document the home referred to as resident #110's "care plan" last reviewed on on an identified date, directed staff to do the following regarding bathing the resident:

- Resident prefers tub bath but offer choice of tub bath or shower. Resident receives tub bath twice weekly
- One person to provide some physical assist;
- Two persons to provide physical assist using an identified lift for specified transfers.

During interview, resident #110 stated that they were being bathed in the shower and not according to their preference in the tub. During interview, PSWs who worked regularly with resident #110 indicated that the resident had requested that they have a bath instead of a shower, but that staff were concerned if the identified lift and tub would accommodate the resident's needs. Review of the resident's health record indicated that the resident had been assessed by the physiotherapist (PT) for transferring on an identified date. During an interview, the physiotherapy assistant (PTA) confirmed that the resident had not been assessed since that time and that mobility had changed since then. PSW staff, RPN staff and the PTA confirmed that resident #110 had not been assessed when their care needs regarding bathing had changed. [s. 6. (10) (b)]

5. Review of resident #100's Minimum Data Set Resident Assessment Instrument (MDS RAI) from admission on an identified date revealed that the resident required limited assistance for the self-performance of the activity of daily living of dressing. The most current MDS RAI, from an identified date, revealed that the resident required extensive assistance for the self-performance of the activity of daily living of dressing. Interviews with PSW and Nursing staff confirmed that the resident had experienced a decline and required additional assistance for dressing. The resident's plan of care indicated that the resident required only cueing from staff for dressing. An interview with the home's DOC confirmed that the resident had experienced a decline in self-performance of the activity of daily living of dressing and that the plan of care had not been revised to reflect the increased assistance needs. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- the plan of care set out clear directions to staff and others who provided direct care to the resident,
- staff and others involved in different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,
- the care set out in the plan of care is provided to the resident as specified in the plan,
- residents are reassessed and the plan of care reviewed and revised when the resident's care needs changed, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident of the home is Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

The LTC inspector observed resident #108 on an identified date at an identified time to be in a wheelchair, tilted at 35 degrees and to have a seat belt applied. Interview with the registered staff and review of the resident's clinical records confirmed that the resident was not to be restrained by the use of a physical device such as a seat belt. Review of the resident's plan of care indicated the resident was to be tilted at 10 degrees for proper positioning, however on the identified date the resident was observed to be tilted at 35 degrees while in their wheelchair. [s. 30. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no resident of the home is Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The document the home referred to as resident #110's "care plan" last reviewed on an identified date, indicated that the resident preferred to have a bath, was bathed twice weekly, and two persons were to provide physical assist using an identified lift for specified transfers.

During interview, the resident confirmed that they preferred to have a bath but staff had told the resident that because of weight bearing status, they could not put the resident in the bath; so they would give the resident a shower instead. Interview with the two PSWs who bathe resident #110 confirmed that the resident preferred to have a bath and indicated that some staff were unable to manage transferring the resident to the tub chair; they would shower them instead. One PSW indicated that, that due to change in the resident's status, staff were not sure if the tub sling would safely transfer the resident. PSW staff confirmed that the resident had not been assessed for safe transferring for bathing in the tub. The PSW staff confirmed that the resident was bathed using the shower and not according to their preference to have a tub bath. [s. 33. (1)]

2. Interview with resident #107 and review of the resident's plan of care indicated that the resident's method of choice for bathing had been determined by the resident to be a tub bath twice a week. However, review of the resident's clinical records and interview with the resident confirmed that the staff have been providing showers to the resident which was not the method of her choosing. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #12: 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. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Record review revealed that resident #100 had a fall on an identified date, which resulted in an injury. The resident complained of a specified symptom and was sent to hospital for further assessment. The home's "Fall Prevention and Management Program", policy #ND-F-03-01-01 effective September 2014, directed staff to complete the Fall Risk Assessment when a resident experienced a fall resulting in serious injuries. The Fall Risk Assessment was not completed following the identified fall. Interview with the DOC confirmed that the home's Fall Risk Assessment is the home's clinically appropriate assessment instrument and should have been completed after the identified fall due to the injury the resident sustained. [s. 49. (2)]

2. Record review revealed that resident #113 had a fall on an identified date, which resulted in multiple fractures. The home's "Fall Prevention and Management Program", policy #ND-F-03-01-01 effective September 2014, directed staff to complete the Fall Risk Assessment when a resident experienced a fall resulting in serious injuries. The Fall Risk Assessment was not completed following the identified fall. Interview with the DOC confirmed that the home's Fall Risk Assessment is the home's clinically appropriate assessment instrument and should have been completed after the identified fall due to the injury the resident sustained. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #13: 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 did not ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

The home's Nursing Documentation policy "Skin and Wound Program" number ND-S-05-01-01 directed registered staff to complete a skin and wound assessment anytime

alteration in skin integrity is identified.

Resident #104 fell in the home on an identified date. Progress notes indicated that the resident sustained specified injuries. On an identified date, the resident was observed to have bruising on an identified area of the body. Review of the resident's health record indicated that the resident had been assessed for one specified injury but not for the other specified injury including altered skin integrity using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. During interview, an RN confirmed this and indicated that all of resident #104's alteration in skin integrity should have been assessed using the home's instrument designed for this purpose and according to the home's policy. [s. 50. (2) (b) (i)]

2. Resident #108 was observed on three identified dates to have altered skin integrity on an identified area of the body. Interview with the registered staff confirmed that the resident is active in bed and on occasion sustains altered skin integrity as a result of the activity.

Review of the home's Skin and Wound policy – Skin/Wound Assessment Record – Policy No. ND-S-05-04-01 – Effective date – May 2014, states that a skin assessment Record will be completed by the registered staff in Point Click Care (PCC) on each resident at any time there is an alteration in skin integrity.

Review of the resident's clinical and electronic records confirmed that there was no evidence to support when resident #108 exhibited an altered skin integrity the resident had received a skin assessment by a member of the registered staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

3. The licensee failed to ensure that a resident who exhibited altered skin integrity was assessed by a registered dietitian.

Review of resident #104's health record indicated that they fell on an identified date, and sustained two areas of altered skin integrity. The home's Nursing Documentation policy "Skin and Wound Care" number ND-S-05—01-01 effective as of May 2014 stated that "The Home will ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are receiving…Assessment by the Registered Dietitian, ensuring that any changes made to the resident's plan of care relating to nutrition and hydration are effectively communicated and implemented".

Review of progress notes indicated that the last time the resident had been assessed by the dietitian was on an identified date. The dietitian progress note on that day stated "needs ++ encouragement to come to the dining room for meals". The document the home referred to as the "care plan" completed on an identified date, indicated that the resident was at moderate nutritional risk.
During interview, a PSW confirmed that the resident had sustained altered skin integrity as the result of the fall. During interview, an RN stated that staff in the home did not refer residents for dietary assessment for alteration of skin and wound unless the wound was not healing well. They confirmed that resident #104 had not been assessed by a registered dietitian when they sustained altered skin integrity on an identified date. [s. 50. (2) (b) (iii)]

4. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During interview on an identified date, resident #200's Power of Attorney (POA) told the Long Term Care (LTC) Inspector that they were concerned that staff did not know how to properly care for the resident's altered skin integrity, particularly at the beginning of an identified month. Review of progress notes from a specified date also indicated that the POA was upset that the resident had developed new areas of altered skin integrity.

Review of resident #200's health record indicated that they were at risk for altered skin integrity. The UNGER HOMES Weekly Skin/Wound Treatment Assessment completed on an identified date indicated they had five areas of altered skin integrity, two of which were pressure ulcers. The home's electronic treatment administration record (eTAR) directed staff to conduct weekly skin assessments for these areas of altered skin integrity. The assessment was signed off a total of 12 times in a three and a half month time period; however, no weekly skin assessments were found in the progress notes or the UNGER HOMES Weekly Skin/Wound Treatment Assessment form. Review of the health record regarding the areas noted on an identified date, indicated that an initial assessment had been completed, but no further weekly assessments were found.

The home's Nursing Documentation policy for "Skin and Wound Care Program" number ND--05-01-01 effective as of May, 2014, indicated the following: "Skin/Wound Assessment by a registered staff to be completed anytime alteration in skin integrity is identified" and "The home shall ensure that resident's exhibiting altered skin integrity,

including skin breakdown, pressure ulcers, skin tears, or wounds are receiving Weekly Skin/Wound Treatment Assessment by a Registered Staff".

During interview with the LTC Inspector on an identified date, the Continuous Quality Improvement (CQI) staff person stated that it was the home's policy that staff conduct weekly skin assessments using the UNGER HOMES Weekly Skin/Wound Treatment Assessment form. They confirmed that weekly skin assessments had not been completed for resident #200, some of the resident's wounds had healed, and their plan of care had not been updated to reflect the change. They stated that the resident's plan of care would have been updated had the assessments been completed. The CQI staff person confirmed that staff did not conduct weekly skin assessments for resident #200 using the appropriate assessment tool. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure
i) that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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;
iii) that a resident who exhibited altered skin integrity was assessed by a registered dietitian; and
iv) that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible, (b) strategies are developed and implemented to respond to these behaviours, where possible, and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Resident #400 was admitted to the home on an identified date. The admission package included a Behaviour Assessment Form from Hamilton Niagara Haldimand Brant Community Care Access Center which indicated the resident had displayed specified responsive behaviours. During the first 20 days the resident resided in the home progress notes indicated that the resident was observed to exhibit responsive behaviours. A review of the resident's clinical record, including the plan of care effective during the identified time period, did not include an assessment of the behaviours, their triggers, strategies for response to the behaviours and actions to respond to the resident's needs related to responsive behaviours. Interview with the home's DOC confirmed that the resident was demonstrating responsive behaviours prior to admission and during the initial period after admission to the home. The DOC further confirmed that the these behaviours were not assessed and strategies identified and implemented to respond to the needs of the resident. [s. 53. (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, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible, (b) strategies are developed and implemented to respond to these behaviours, where possible, and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 57. Integrating restorative care into programs
Every licensee of a long-term care home shall ensure that,
(a) restorative care approaches are integrated into the care that is provided to all residents; and
(b) the restorative care approaches are co-ordinated to ensure that each resident is able to maintain or improve his or her functional and cognitive capacities in all aspects of daily living, to the extent of his or her abilities. O. Reg. 79/10, s. 57.

Findings/Faits saillants :

1. The licensee failed to ensure that restorative care approaches were integrated into the care that was provided to all residents so that the resident was able to maintain or improve their functional and cognitive capacities in all aspects of daily living, to the extent of their abilities.

Resident #103's RAI MDS assessments completed on two identified dates indicated that the resident was continent of bowel during the 14 day assessment period. Review of the resident's health record indicated that the resident had been incontinent of bowel six times in an identified month; eight times in a subsequent month; and 14 times in the next month. The document the home referred to as resident #103's "care plan" completed on an identified date, indicated that the resident was "able to verbalize and call for assistance when need for toileting arise. However, [they] can become impatient and

attempt to self transfer. Ensure that call bell is attended to immediately".

During interview, the resident stated that they felt very embarrassed when they were incontinent of feces into their brief; they stated that this happened when they "didn't get to the bathroom in time", that they would have to wait for staff to assist them, and when staff arrived they would not always address the resident's concerns to get to the toilet immediately. During interview, the resident's POA told the inspector that staff were not always available to assist the resident with their toileting. The POA also stated that the resident complained to them that night shift staff had told the resident to have a bowel movement in their brief because there wasn't enough staff to toilet them, and that this further embarrassed the resident. The POA reported that when they approached the RN about the resident's complaint, the RN suggested that the resident have a bowel movement in their brief. The care plan completed on an identified date, directed staff to "offer resident bed pan at night…if problem with obtaining immediate assistance from another staff member".

During interview, PSW staff confirmed that they could not always assist resident #103 immediately if staff were assisting another resident, and that resident #103 was occasionally incontinent of feces into their brief. Review of the home's Professional Advisory Committee meeting minutes stated "The restorative aspect of continence care is unattainable as more staffing is needed to achieve this". The DOC confirmed that the home's restorative program was short staffed at and that restorative approaches were not being provided in the home at present.

The RAI Coordinator confirmed that resident #103 would benefit from a toileting schedule. Interview with the DOC indicated that resident #103 did not have restorative care approaches integrated into continence care and would have benefited from this approach to improve their functional continence capacities. [s. 57. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that restorative care approaches are integrated into the care that is provided to all residents so that the resident is able to maintain or improve their functional and cognitive capacities in all aspects of daily living, to the extent of their abilities, to be implemented voluntarily.

WN #16: 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 shall ensure that the planned menu items are offered and available at each meal and snack.

During the preparation of the lunch meal and the lunch meal service on April 9, 2015 the Long-Term Care (LTC) Inspector observed the following:
i) The residents in the Ivy and Primrose Lane Dining room were not provided crackers with their soup. The therapeutic spreadsheet directed staff to provide four crackers with the regular texture soup.
ii) The residents requiring a puree texture diet were served puree texture whole wheat bread with both meal options, pasta primavera and sliced turkey sandwich. The therapeutic spreadsheet directed staff to prepare and serve a pureed toasted garlic bread to be served with the pasta primavera.

Interview with the home's Nutrition Manager confirmed that the crackers and puree toasted garlic toast should have been offered and available as part of the home's planned menu. [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 the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system provides for standardized recipes and production sheets for all menus.

Preparation of the lunch meal on April 9, 2015, was observed by the Long Term Care (LTC) Inspector. An interview with the cook indicated that the recipe binder located in the kitchen contained the standardized recipes for the daily menu and was consulted by the cooks and dietary aides in the meal preparation. The following recipes were not located in the binder:
- Sliced turkey on rye, regular texture
- Romaine and onion salad, minced and puree texture
- Diced pears, minced and puree texture
- Crème caramel, regular texture

Interview with the home's Nutrition Manager confirmed that the standardized recipes for the noted items were not available. [s. 72. (2) (c)]

2. The licensee failed to ensure that the all menu items are prepared according to the planned menu.

Preparation of the lunch meal on April 9, 2015, was observed by the LTC Inspector. The menu directed staff to prepare Italian Mix Vegetables which includes a mixture of zucchini, green beans, lima beans, red peppers, cauliflower and carrots. The cook revealed that the pre-prepared Italian mix was unavailable and that the Montego mix, containing broccoli, cauliflower, carrots and yellow carrots, were prepared as a replacement. An interview with the home's Nutrition Manager confirmed that the Italian mix vegetables were not prepared as per the home's planned menu. [s. 72. (2) (d)]

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 food production system provides for standardized recipes and production sheets for all menus, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that measures were in place to prevent the transmission of infection.

Resident #100 was admitted to the home on an identified date. Review of their health record indicated that they tested positive for a specified infection on an identified date. Review of the electronic medication administration record (eMAR) indicated that the resident had received treatment for a different identified infection during two identified time periods. The original physician order sheet from an identified date, stated that the resident has specified symptoms related to an identified infection. During interviews on identified dates, PSW and RPN staff and the "Infection Control Person" (ICP) in the home stated that they were not aware that the resident had a history of the specified infection.

The home's "Specific Infections" policy number IC-08-07-01 effective as of October 2014 directed staff to do the following:

- Notify the resident's attending physician immediately.
- Initiate isolation and barrier precautions for the resident.
- Inform Director of Care.
- Immediately screen the resident's roommates and residents in the rooms in the immediate vicinity of the affected resident's room.
- Screening includes swabbing (nares bilaterally, axilla, bilateral groins, rectum).
- Begin treatment as ordered by the attending physician, in consultation with the local Public Health Department.
- Follow-up screens with colonized residents and negative unit/floor residents, weekly.
- Once a negative culture is obtained, conduct weekly screens until three (3) consecutive specimens have been obtained at least one week apart. Precautions can be removed at

this time. Once the resident stage negative, after three (3) consecutive screens, continue screening monthly for four (4) months. Reinstate precautions at this time if a positive screen is obtained.
- Document intervention on individual resident care plan, 24 hour unit report and progress notes.

The home's policy related to residents who test positive for the specified infection, Number IC-08-07-02 effective on October 2014, directed staff to do the following:

- Place sign on the resident's door advising all persons to check in at the nursing station before entering the room
- Staff should wear gloves when providing direct personal care or cleaning the environment.
- Document the use of all barriers in the care plan

The home did not ensure that measures were in place to prevent the transmission of infection according to their policy in the following manner:

i) Contact precautions: Review of the document the home referred to as resident #100's "care plan" completed on identified dates did not indicate that the resident had the identified infection and/or required contact precautions. The ICP could not confirm that barrier precautions such as the use of gloves had been implemented following being found to have the infection. During observation on identified dates, resident #100's door did not have precaution signs posted and personal protective equipment was not readily available. During interview, PSW staff confirmed that they were not using contact precautions when providing direct care to resident #100.

ii) Screening of resident: The ICP confirmed that resident #100 had a follow up test completed on an identified date, which indicated probable contamination and should have been repeated. The ICP stated that the home had not repeated the test or screened the resident according to the home's policy using swabbing of nares bilaterally, axilla, bilateral groins, and rectum. They also confirmed that the resident was not screened weekly until a negative status was found for three consecutive weeks. The ICP could not confirm whether the resident had the infection at the time of this inspection.

iii) Screening of resident's living in the same room or rooms adjacent to resident #100: The IPC could not confirm that the home had screened residents living in the same room as resident #100 or residents living in rooms adjacent to them.

iv) Documentation: Review of resident #100's health record indicated that there was no documentation in the "care plans" or progress notes that included the identified infection, interventions or precautions to be taken to prevent the transmission of infection.

On an identified date, the resident's room was observed not to have any indication that contact precautions were to be used when providing direct care to resident #100. During interview, the ICP confirmed that the home was assuming that the resident still had the infection and staff should be using contact precautions when working with them. The ICP confirmed that the home had not ensured that measures were in place to prevent the transmission of infection. [s. 86. (2) (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 measures are in place to prevent the transmission of infection, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

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

On March 23, 2015 at approximately 1015 hours, the LTC inspector observed resident care area storage room doors to be unlocked making hazardous substances accessible to residents. The following doors were unlocked:

i) Ivy Lane laundry room which contained hydrogen peroxide. The Programs Manager confirmed that the toxic substance should not have been accessible to residents and discarded it.

ii) Rose Lane servery door leading to a cabinet containing Clorox cleaner with a "Toxic" Workplace Hazardous Materials Information System (WHMIS) symbol on the container.

iii) Primrose Lane shower room containing "Inox" virox cleaning solution hanging from the shower curtain bar.

iv) On April 1 and 7, 2015, the "Janitor" closet on Primrose lane was unlocked and contained an unlabeled container with yellow liquid inside and a large partially full bottle of window cleaner. The Environmental Coordinator could not identify the type of liquid in the unlabeled bottle and confirmed that the door should have been locked.

The home's Cleaning Products policy "Storage of Cleaning Supplies" number ES-04-04-04 effective as of December 2014 directed staff to do the following: "If cleaning agent is transferred from one container to another, new container must be relabeled to indicate contents", "Entry to storage is limited to Supervisor and authorized personnel" and "Supplies stored on the units and elsewhere must be kept in locked closets".

The Environmental Coordinator confirmed that hazardous substances should be properly labeled and inaccessible to residents at all times. [s. 91.]

Additional Required Actions:

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

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

A) During interview on an identified date, the Power of Attorney (POA) for resident #200 told the Long Term Care Homes (LTC) Inspector that in an identified month, the staff who cared for the residents living on a specified home area had been rotated off of the unit. The POA stated that the "new" staff were not familiar with the care needs of resident #200, particularly regarding skin integrity management. Review of progress notes indicated that the POA had complained to staff on an identified date, that the resident developed altered skin integrity on an identified area of the body. The POA told the Inspector that they complained to the DOC in an identified month, about staffing changes/levels and the impact on the resident's care. According to the POA, they were told by the DOC that they could move the resident to another home if they were not happy with the care. The DOC at that time has since left the home. The issue was not resolved until the POA sought the assistance from a RN who changed the plan of care.

During interview on an identified date, the RN involved, and the current DOC, confirmed that they intervened to change the skin integrity plan of care for resident #200. When asked for the documented record regarding the home's response to the POA's complaints, the DOC stated that they could not find it. The DOC confirmed that the home should have retained a documented record for verbal complaints not resolved within 24 hours according to legislative requirements.

B) During interview on an identified date, the POA for resident #103 told the LTC Inspector that resident #103's care needs were not being met and felt that this was due to staffing levels. The POA stated that they complained to the DOC for the past six months regarding resident #103's bowel management and their concerns about staffing levels in the home. Specifically, the resident was having frequent bowel movements and had become incontinent of bowel during the past three months. In addition, within the past three months, the POA complained to the DOC that the resident had reported to the POA that they were told by night staff to have a bowel movement in their brief because there was weren't enough staff to take the resident to the toilet. According to the POA, the DOC did not follow up with them at that time.

During an interview on an identified date, the current DOC stated that they were not aware of the complaints to the former DOC. The DOC stated that they could not find any documented report of the complaints made by resident #103's POA.

During interview, the Acting Administrator confirmed that they could not provide evidence that the home kept documented records of complaints. The also stated that the home should keep documented reports of complaints in the home according to legislative

requirements. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with,
i. fires,
ii. community disasters,
iii. violent outbursts,
iv. bomb threats,
v. medical emergencies,
vi. chemical spills,
vii. situations involving a missing resident, and
viii. loss of one or more essential services. O. Reg. 79/10, s. 230 (4).

Findings/Faits saillants :

1. The licensee did not ensure that emergency plans are provided for viii) loss of one or more essential services including loss of the home's resident-staff communication and response system.

Between March 24 and March 27, 2015, inspectors observed the home's resident-staff communication and response system to be in disrepair, which was confirmed through interviews with PSWs, Maintenance staff and the home's Acting Administrator. When asked about the home's emergency plans in the event that the resident-staff communication and response system was lost, the Acting Administrator stated that the home's emergency plan did not include a policy or contingencies for the resident-staff communication and response system as an essential service if the service was lost. [s. 230. (4) 1. viii.]

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 ensure that emergency plans are provided for viii) loss of one or more essential services including loss of the home's resident-staff communication and response system., to be implemented voluntarily.

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy in the home that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's "Resident Abuse" policy number RC-01-03-01 effective as of September 3, 2014 included the definition of neglect as follows: "failure to provide a resident with treatment, care, services or assistance required for health, safety or well-being of one or more residents. Examples may include but are not limited to: intentionally or unintentionally ignoring the needs of a resident such as unkept appearance, untreated medical problems, malnourishment, or dehydration". The policy directed the person witnessing or having knowledge of the abuse to "notify the Charge Nurse/Supervisor immediately"; the policy directed the Administrator to "notify the MOHLTC - Action Line".

During interviews on identified dates, a staff member reported to LTC Inspectors that they observed the following during the lunch meal service on an identified date:

- a PSW was feeding two residents who required assistance;
- before the residents had finished their meal, the PSW stopped feeding and left them to talk with a co-worker for approximately five minutes;
- the PSW returned to the two residents and said something similar to: "I guess you're finished";
- the PSW was observed to discard the food remaining on the plates without attempting to continue to feed the residents.

According to investigative notes provided to the LTC Inspectors on an identified date and during interviews with LTC Inspectors on an identified date, the Acting Administrator stated that the staff person reported the incident described above on an identified date. The Administrator confirmed that neglect was suspected, the home began an investigation, and the staff person was suspended until the investigation was complete.

The staff person confirmed that they reported their concerns of resident neglect on an identified date, for an incident that occurred on an identified date. The Acting Administrator stated that the home had not notified the Ministry of Health and Long Term Care (MOHLTC) Action Line when a suspected abuse/neglect had occurred according to the home's policy. The Acting Administrator confirmed that the home's "Resident Abuse" policy was not complied with. [s. 20. (1)]

WN #23: 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:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident's Continence, including bladder and bowel elimination.

Review of the Minimum Data Set Resident Assessment Instrument (MDS RAI) for resident #107 for the three identified quarters indicated the resident had been assessed as having a decline in urinary incontinence. However, there had been no documented evidence that strategies and intervention had been assessed and put in place and the most current plan of care did not include at a minimum, an interdisciplinary assessment with respect to the resident #107's bladder and bowel elimination. [s. 26. (3) 8.]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record of the evaluation of the Falls Prevention and Management Program is kept, including the names of persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

During the inspection, the home's DOC was unable to locate a written record of the annual evaluation of the Falls Prevention and Management Program for 2014 and revealed that the evaluation had not been completed for 2015. The DOC was unable to verify whether the evaluation had been complete in 2014. [s. 30. (1) 4.]

WN #25: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Review of minutes for six Family Council meetings that occurred between April 14, 2014 and February 8, 2015 indicated that the Family Council had raised concerns and recommendations with the home's administration. For example, minutes provided by the President of the Family Council for the meeting held on January 21, 2015 indicated that discussions with the Administrator included the following:
-"limitation of changes (rotation) of staff. This creates confusion to residents"
-"Necessity to increase staff"
-"Cleaning staff to be reviewed due to poor quality of work"

The minutes for the Council meeting held on October 22, 2014 indicated that the following issues were raised with the DOC who was in attendance:
-"Cutting of staff hours"
-"Claim of management staff increasing from 3 to 6"
-"Settlement of contract"
-"Salaries to be assisted in increase by Unger Homes"
-"Are budget surpluses retrieved by Ministry"
-"Is budget flexible or locked into lines"
-"Is there an overseeing of Unger Homes profit"
-"A noticeable decline in staff morale"
-"Was staff aware of possible cutbacks before salary settlement"
-"What steps have been taken re: violence issue of 3 years ago"

Review of the Family Council Binder provided did not include written responses to these concerns. The DOC at that time was not working in the home at the time of this inspection. During interview, the President of the Family Council confirmed that issues were raised during the meetings with home staff in attendance. The President stated that

they were not aware of the home's obligation to respond to the council in writing within 10 days and did not recall receiving anything in writing. The President stated that on occasion, they would follow up verbally with the Administrator and then discuss the Administrator's response with the Family Council during the following meeting.

During an interview, the current Acting Administrator in the role since March 13, 2015, stated that they were not aware of any issues or recommendations that had been raised by the Family Council and that they had not received minutes from these meetings. They stated that they were not able to provide documentation of the home's written responses to the Family Council for meetings held between April 14, 2014 and February 8, 2015. The Acting Administrator confirmed that the home should provide a written response to Family Council concerns or recommendations within 10 days of becoming aware of these concerns. [s. 60. (2)]

WN #26: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the results of the satisfaction survey were made available to the Family Council in order to seek advice of the Council about the survey.

Review of minutes for six Family Council meetings that occurred between April 14, 2014 and February 8, 2015, did not indicate that the home had made the results of the satisfaction survey available to the Family Council in order to seek advice. During an interview, the President of the Family Council stated that they could not recall having the results discussed during the Council meetings. The Acting Administrator confirmed that the home was unable to provide evidence to indicate that the satisfaction survey results had been made available to the Family Council to seek advice of the Council on the survey's results. [s. 85. (4) (a)]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of persons who participated in the evaluation, and the date that the changes were implemented is promptly prepared.

During the inspection, the home's DOC was unable to locate a written record of the annual evaluation of the home's policy to minimize restraining of residents for 2014 and revealed that the evaluation had not been completed for 2015. The DOC was unable to verify whether the evaluation had been completed in 2014. [s. 113. (e)]

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has 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 April 7, 2015, five 1mg vials of morphine were observed in an unlocked emergency medication box stored with other medications in a locked cupboard in the medication room. Interview with the registered staff and the DOC confirmed that the home's practice is to keep the morphine vials in the emergency box for resident needs, which is counted by the registered staff on every shift. The home did not ensure that the controlled substances were stored in a separate, double-locked stationary cupboard in the locked area. [s. 129. (1) (b)]

Issued on this 11th 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) :	LAURA BROWN-HUESKEN (503), LALEH NEWELL (147), MELODY GRAY (123), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2015_312503_0008
Log No. / Registre no:	H-002170-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 27, 2015
Licensee / Titulaire de permis :	UNGER NURSING HOMES LIMITED 312 Queenston Street, St. Catharines, ON, L2P-2X4
LTC Home / Foyer de SLD :	HAMPTON TERRACE CARE CENTRE 75 PLAINS ROAD WEST, BURLINGTON, ON, L7T-1E8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Donna Spasic

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:

1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
   i. a physician,
   ii. a registered nurse,
   iii. a registered practical nurse,
   iv. a member of the College of Occupational Therapists of Ontario,
   v. a member of the College of Physiotherapists of Ontario, or
   vi. any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that:
The use of all PASDs to assist residents with routine activity of daily living satisfy the following:
1. Alternatives to the use of the PASD is considered
2. the use of the PASD was reasonable given the resident's condition
3. had been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
4. the device was approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.

The plan to be submitted by May 29, 2015 via Email to Laleh.Newell@ontario.ca.

Grounds / Motifs :

1. Not all of the following were satisfied prior to including the use of a PASD to assist in routine activities of daily living: alternatives to the use of the PASD considered, the use of the PASD was reasonable given the resident's condition, consent had been obtained and the device was approved.

Resident #108 used two bedrails when in bed and a tilted wheelchair as a PASD to assist with bed mobility and positioning. Review of the resident's health records and interview with the registered staff indicated that the bedrails are used as PASDs for bed mobility and transfers and the tilt wheelchair is to ensure proper posture while in wheelchair. However, there was no documented evidence to support that an assessment identifying other alternatives were tried prior to the use of the bed rails or the tilted wheelchair. Interview with the DOC and review of the resident's clinical records confirmed that an approval of the PASD by an appropriate person, as defined in the legislation, was not obtained, nor was there a consent documented from the resident or their substitute decision maker for the use. (147)

2. Resident #105 used one half rail and one assist rail when in bed as a PASD to assist with bed mobility. Review of the resident's health records and interview with the DOC indicated that there was no documented evidence to support that an assessment identifying other alternatives were tried prior to the use of the bed rails. Interview with the DOC further confirmed that an approval of the PASD by an appropriate person, as defined in the legislation, was not obtained, nor was there a consent documented from the resident or their substitute decision maker for the use. (503)

3. Resident #100 used one half rail and one assist rail when in bed as a PASD to assist with bed mobility. Review of the resident's health records and interview with the DOC indicated that there was no documented evidence to support that an assessment identifying other alternatives were tried prior to the use of the bed rails. Interview with the DOC and Registered Practical Nurse (RPN) also confirmed that an approval of the PASD by an appropriate person, as defined in the legislation, was not obtained, nor was there a consent documented from the resident or their substitute decision maker for the use. (503)

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 : Jun 26, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

The licensee shall ensure all staff that that provide direct care to residents receive, as a condition of continuing to have contact with residents:
A) training on how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the Act and regulations, annually in accordance with r. 221 (2),
B) annual retraining in falls prevention and management in accordance with r. 221 (1) 1.

Grounds / Motifs :

1. The licensee failed to ensure that all staff that provide direct care to residents receive, as a condition of continuing to have contact with residents, training on how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the Act and regulations, annually in accordance with r. 221 (2).

Review of the home's restraints and PASDs training documents indicated that 41 of 114 (36%) direct care staff completed the home's training module in 2014. The DOC confirmed this and stated that all direct care staff should have completed this training annually.
(503)

2. The licensee failed to ensure that the direct care staff received retraining annually in falls prevention and management in accordance with r. 221 (1) 1.

Review of the home's falls prevention and management training documents indicated that 73 of 113 (64.6%) direct care staff completed the home's training module in 2014. The DOC confirmed this and stated that all direct care staff should have completed this training annually. (503)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(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).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to include how the home will achieve the following:
1. Demonstrate that the home's resident-staff communication and response system is reliable and consistently functional.

2. Develop policies and procedures, regarding but not limited to, maintenance and repair of the system, frequency and content of audits, and who is responsible for conducting audits, ensuring repairs have been completed and that the system is functional.

3 Conduct scheduled and as needed audits on the resident-staff communication and response system and maintain records of the audits that include the person responsible, the frequency of audits, the status of the system at each call station and each paging device and whether repairs are needed.

4. The home shall, in a timely manner, repair or replace components of the system that are in disrepair and prepare written documentation of the status of repair and when the repair has been completed.

5. Prepare and implement policies regarding contingencies for potential failure of the resident-staff communication and response system as an essential service.

The plan to be submitted by May 29, 2015 via Email to Theresa.McMillan@Ontario.ca.

Grounds / Motifs :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that clearly indicated, when activated, where the signal was coming from.

Interview with PSW staff indicated that normally, when the home's resident-staff communication and response system was triggered at a call station, a light above the doorway to that room/call station would activate and a sound would activate in the hallway of the respective care area. Staff confirmed that they did not carry paging devices to alert them if a station had been triggered. If the sound did not activate, the staff would not be aware that a call station had been triggered, unless they were in clear view of the light that was activated above the respective room. PSWs stated that they relied on the alarm sounding in the

hallway in addition to the light above a room for them to identify that the system had been triggered and from where.

A) During the initial tour of the home on March 24, 2015 at approximately 0940 hours, the resident-staff communication and response system was triggered in the Ivy home area activity room. A small light directly above the room was activated, but there was no sound associated with the triggered system. Approximately five minutes later, a Registered Practical Nurse (RPN) and PSW told the Long Term Care Homes (LTC) Inspector that they were not aware that the response system had been triggered. The RPN and PSW confirmed that the system, when triggered from the Ivy home area activity room, did not clearly indicate where the signal was coming from.

Between March 26, and April 10, the Acting Administrator confirmed that the resident-staff communication and response system in the Ivy Lane activity room did not clearly indicate, when activated, where the signal was coming from.

B) On March 26, 2015, two PSW staff informed the LTC Inspector that the resident-staff communication and response system was not making any sound on Rose Arbour Lane at approximately 0700 hours when most residents were still in bed. They stated that they confirmed that no stations on Rose Arbour Lane triggered the system to activate an alarm sound. Unless they were in clear view of the activated light above a resident's room, the system did not clearly indicate where the signal was coming from.

C) On March 26, 2015, between 1145 and 1215 hours, the resident-staff communication and response system on Rose Arbour Lane was noted to be sounding the emergency alarm signal. All residents were in the dining room at the time. Two PSW staff confirmed that they did not know where the sound or signal was coming from and stated that this problem had occurred the day before. They confirmed that there were no lights above doors that were activated. They stated the current emergency alarm signal/sound would not end when cancelled at any call station, and maintenance staff had advised them to stop the alarm sound by hitting the speaker that emanated the sound with a broom.

D) On March 26, 2015 between 1330 and 1350 hours, resident-staff communication and response system on Rose Arbour Lane was observed to be sounding the emergency alarm signal. Two PSW staff confirmed that they did

not know where the sound/signal was coming from and that no lights were activated above doorways. They stated that the signal would alarm in this way if a call bell station was triggered, and the alarm would not stop even if cancelled at the triggered station. Because the signal was fast and continuous, the staff confirmed that unless they were in the hall to view the activated light above the door where a station was triggered, they could not tell if a station had been triggered.

During interview at 1350 hours on March 26, 2015, the Acting Administrator confirmed that resident-staff communication and response system on Rose Arbour Lane did not clearly indicate, when activated, where the signal was coming from.

E) On April 9, 2015, the resident-staff communication and response system on Lilac Lane was observed to have an alarm sounding continuously and could not be turned off when the alarm was cancelled at the call station that triggered the system. PSW and RPN staff confirmed that if they were not in clear view of the lights above resident rooms, they would not be aware that a signal had been triggered or where it was coming from.

F) On April 16, 2015, the resident-staff communication and response system on Rose Arbour Lane was observed to have an alarm sounding continuously that began spontaneously without being triggered. There were no lights activated above residents' rooms. Staff stated that they could not disable the alarm sound and that the system did not clearly indicate, when activated, where the signal was coming from. (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that:
1. All staff use safe transferring and positioning devices or techniques when assisting residents.
The plan to be submitted by May 29, 2015 via Email to Laura.Brown-Huesken@ontario.ca

Grounds / Motifs :

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

Record review revealed that resident #113 had a fall on an identified date, which resulted in multiple fractures. The resident's written plan of care, initiated on an identified date prior to the fall, directed staff to provide the resident with the assistance of two staff for transferring on and off of the toilet. Review of the clinical record and interview with PSW and RPN revealed that the resident was being assisted by one PSW for transfer onto a commode for toileting at the time of the fall. Interview with the DOC confirmed that the resident should have been assisted by two staff and that resident had been transferred in an unsafe manner. (503)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to include how the home will achieve the following:
1) Ensure that all residents who are incontinent receive an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and are conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require
2) Training for staff on the home's policy for "Continence Care and Bowel Management Program"
3) Procedures and schedules for auditing compliance for completion of the assessments.

The plan to be submitted by May 29, 2015 via Email to Laura.Brown-Huesken@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure that a resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

Review of resident #100's Minimum Data Set Resident Assessment Instrument (MDS RAI) indicated that the resident was first coded as being incontinent of bladder on an identified date. Interviews with PSW and Nursing staff revealed that the resident had experienced a decline in bladder continence since admission and confirmed that the resident was incontinent of bladder. A review of the resident's clinical record did not locate an assessment of the incontinence including identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. An interview with the home's DOC confirmed that an assessment of the resident's incontinence had not been completed.
(503)

2. Resident #101's RAI MDS assessments completed on two identified dates, indicated that the resident was frequently incontinent of urine and usually continent of bowel during the 14 day observation period. The RAI MDS

assessment completed on an identified date indicated that the resident was incontinent of urine and incontinent of bowel. During interviews, PSW and RPN staff confirmed that the resident had wet through the brief during night and daytimes. Review of the resident's health record revealed that, when they had a significant change in continence and care needs, the resident had not had a bowel or bladder continence assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was a clinically appropriate continence assessment instrument. The RAI Coordinator confirmed that a continence assessment had not been conducted when the resident's continence worsened or according to the home's policy for resident #101 (526)

3. The home's Continence Care policy for "Continence Care and Bowel Management Program" Number ND-C-04-01-01 effective as of August 2104 directed staff to complete the "Continence Care Assessment-Bowel and Bladder" when there was a significant change in a resident's continence care needs.

Resident #103's RAI MDS assessments completed on three identified dates, indicated that the resident was continent of bowel during the 14 day assessment period. Review of the resident's health record indicated that the resident had been incontinent of bowel six times in an identified month; eight times in a second identified month; and 14 times in a third identified month. The review of resident #103's health record also revealed no assessment of bowel continence had been conducted that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required. The RAI Coordinator and DOC confirmed that a continence assessment had not been conducted according to the home's policy for resident #103 (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2015

Order # / Ordre no : 006

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, submit and implement a plan to ensure that (a) housekeeping services in the home are available seven days per week; (b) procedures are in place and implemented for cleaning the home including resident washrooms, shower rooms and tub rooms according to the home's policies "Resident Areas Cleaning" number ES-04-02-01 and "Washroom Cleaning" number ES-04-02-02.

The plan shall summarize the home's strategies for achieving the following:

1. Review and revise housekeeping policies to ensure that they accurately reflect implementation of the home's Environmental Services Programme.

2. Implement the procedures so that resident washrooms, tub rooms and shower rooms are cleaned according to the home's policy.

3. Audit housekeeping services monthly. Clearly indicate and document audited issues, which rooms were audited, outcomes of the audit, remedial actions taken as the result of the audit, if any.

4. Evaluate housekeeping services at least annually according to legislative requirements.

The plan to be submitted by May 29, 2015 via Email to Theresa.McMillan@Ontario.ca.

Grounds / Motifs :

1. Non Compliance was previously issued as a VPC on August 18, 2014.

The licensee failed to ensure that procedures were implemented for cleaning the home. Throughout the course of this inspection resident bathrooms, tub and shower rooms were observed to be unclean.

According to the Acting Administrator, the home's housekeeping services were provided through the use of a contracted service provider. The Environmental Coordinator was the service provider's representative in the home. On April 7, 2015, the home's Environmental Coordinator confirmed that cleaning procedures were not implemented in the following home areas:

i) Tub and shower rooms for Rose Arbour, Ivy, Primrose and Lilac Lanes: floors soiled with dirt on floor surface and ground in dirt on the floors, particularly on the laminate located beneath the tubs and along the floor/base board juncture. Soiled brown/yellow matter located around the base of toilets.

ii) Resident bathrooms noted to have yellow/brown soiling matter located around the base of toilets and between tiles surrounding toilets in the following rooms: Rose Arbour Lane rooms 100, 103, 107 and 114; Ivy Lane room 206; Primrose Lane rooms 403, 405, 413, 416; and Lilac Lane rooms 301, 304, 305.

Concerns about the cleanliness of the home had been raised during the Family Council meeting dated January 21, 2015. According to the minutes for that meeting, "Cleaning staff to be reviewed due to poor quality of work".
The home's Cleaning Guidelines policy "Resident Areas Cleaning" number ES-04-02-01 effective as of December 2014 directed staff to damp mop tub room floor with disinfectant/detergent solution daily. The home's Cleaning Guidelines policy "Washroom Cleaning" number ES-04-02-02 effective as of December 2014 directed staff, on a daily basis, to clean toilets including cleaning exterior of bowl and area around base of fixtures using disinfecting solution.

The Environmental Coordinator confirmed that cleaning procedures of the areas identified should have been implemented on a daily basis, according to the home's policy. (526)

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 007

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 plan to ensure that (a) maintenance services in the home are available 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 preventive maintenance. The plan shall summarize the following:

1) Procedures for preventive maintenance including schedules and documentation for completion of preventive maintenance in the home.

2) Preparation of a preventive maintenance schedule that includes flooring, tiling, toilets, grout/caulking, baseboards, and ceilings, in resident, washrooms shower rooms and tub rooms.

3) Maintain and repair areas of disrepair in resident washrooms, shower rooms and tub rooms.

4) Procedures for monitoring how the preventive and remedial maintenance program will be monitored to ensure that resident rooms, washrooms and tub rooms are maintained as per policy ESM04-01-09.

The plan to be submitted by May 29, 2015 via Email to Theresa.McMillan@Ontario.ca.

Grounds / Motifs :

1. Non Compliance was previously issued as a VPC on August 18, 2014.

The licensee failed to ensure that there were schedules and procedures in place for preventive maintenance.

Maintenance services in the home were being managed by the Acting Administrator and the Maintenance Coordinator. According to the Maintenance Coordinator and the home's maintenance policies, no specific procedure was in place to guide preventive maintenance or designated staff in their role in conducting preventive maintenance related to the condition of the resident bathrooms, tub and shower rooms.

During the inspection, the following areas of disrepair in the home were observed and discussed with the Maintenance Coordinator, some of which he was aware of and others that he was not.

A) Tub and shower rooms:
i) Ivy Lane shower room: Laminate flooring coming away from floor at edge of shower; caulking between baseboard and wall appeared blackened and coming away at the edge of floor.
ii) Primrose Lane Shower room: Laminate flooring coming away from floor at left edge of shower.
iii) Rose Arbour Lane tub room: warped and separating base board to the left of the tub with peeling paint; discoloured caulking; laminate flooring in tub room separating.
iv) Rose Arbour Lane shower room: chunks of dry wall and paint out of walls; floor tiles leading into tub room cracked; laminate flooring in tub room separating.
v) Lilac Lane shower room: uneven and bulging grout between floor and wall tiles; cracked tiles around floor drain; rough and broken tiles leading into shower room at doorway; grout around toilet coming away and stained yellow.

B) Resident bathrooms:
i) Ivy Lane room 206: cracked and separating floor tiles and degrading caulking around base of toilet
ii) Rose Arbour rooms 100 and 107: cracked and separating floor tiles around base of toilet
iii) Primrose Lane rooms 403, 405, 413, and 416: stained, cracked caulking and tiles at base of toilet; tiles coming away from baseboard in room 416
iv) Lilac Lane room 300: 40 centimetre by 40 centimetre area in the bathroom ceiling where drywall was buckled, separating, and ripped with old water marking around the area
v) Lilac Lane rooms 301, 304, and 305: cracked and stained tiles and caulking around the base of toilet

Review of maintenance records and interview with the Maintenance Coordinator in the home indicated that monthly audits had been completed but there was no indication which rooms had been audited, or the process to use when areas of disrepair were identified. The Maintenance Coordinator and Acting Administrator could not provide documentation to confirm that the preventative maintenance checklist and procedures were followed and completion of work regularly documented, as indicated in the monthly audit. No documented evidence was provided that indicated that preventive maintenance schedules and procedures regarding resident bathrooms, tub and shower rooms were in place in the home.

(526)

This order must be complied with by /
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Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that:
All staff participate in implementation of infection prevention and control program by ensuring
1. All clean linen and clean resident laundry carts are stored according to home's policy and procedure
2. All Registered staff are to practice in proper hand hygiene during medication administration to residents.
The plan to be submitted by May 29, 2015 via Email to Laleh.Newell@ontario.ca.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participate in the implementation of the program.

During noon medication administration observation on April 2, 2015, the Registered Practical Nurse (RPN) was observed to not be performing hand hygiene between administration of medication to several different residents in their rooms and in the dining room. (147)

2. Throughout this inspection, on numerous occasions and different times of the day, all inspectors observed uncovered clean linen carts and clean resident laundry carts located in the hallways. The home's Infection Control policy "Handling Infected Linen" number ES-05—06-01, effective as of December, 2014, directed staff to ensure that clean linen should be stored in a covered area. PSW staff confirmed that the clean linen should be covered when stored in the carts in the hallways, according to the home's policy.

(526)

This order must be complied with by /
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Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 009

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all the persons who received training under s. 76 (2) 9., regarding infection prevention and control (IPAC), receive retraining annually in accordance with r. 219 (1).

Grounds / Motifs :

1. The licensee failed to ensure that the persons who received training under s. 76 (2) 9., regarding infection prevention and control (IPAC), received retraining annually in accordance with r. 219 (1).

Review of the home's infection prevention and control training documents indicated that 76 of 146 (52.1%) staff completed Part 1 and 74 of 146 (50.7%) staff completed Part 2 of the home's IPAC training modules during 2014. The DOC confirmed this and stated that all staff should have completed this training annually. (526)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 26, 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
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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 27th day of April, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Laura Brown-Huesken

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