Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 26, 2016	2016_344586_0002(A1)	002269-16	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

JESSICA PALADINO (586), BERNADETTE SUSNIK (120), CATHIE ROBITAILLE (536), GILLIAN TRACEY (130), THERESA MCMILLAN (526), YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 28, 29, February 2, 3, 4, 5, 8, 9, 10, 11 and 12, 2016.

The following complaint, critical incident and follow-up inspections were

completed:

FOLLOW-UP
009991-15 - PASD's
009992-15 - PASD training
009993-15 - communication and response system
009994-15 - safe transferring
009997-15 - continence
010000-15 - housekeeping
010001-15 - maintenance
010002-15 - infection prevention and control
002270-16 - bed rails
002271-16 - hourly safety checks
010003-15 - infection prevention and control training

CRITICAL INCIDENT
029614-15 - abuse
003613-15 - abuse

COMPLAINT
027216-15 - staffing levels
003655-16 - plan of care

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Managing Director, Accounting Manager, Administrative Assistant, Programs Manager, Dietary Manager (DM), Housekeeping Supervisor, Resident Assessment Instrument Minimum Data Set (RAI-MDS) Co-ordinator, Behavioural Support Ontario (BSO) Manager and worker, Physiotherapist (PT), Social Service Worker, Quality Improvement (QI) Co-ordinator, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), maintenance staff, activity staff, dietary staff, residents and families.

During the course of the inspection, the inspector(s) toured the home, including tub/shower areas, dining rooms, resident rooms, soiled utility rooms and common sitting areas, measured illumination levels, reviewed bed system audits and resident bed rail use assessments, reviewed clinical health records, policies and procedures, meeting minutes and staff files, and observed the provision of care,

medication pass, meal preparation and meal service.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **21 WN(s)**
- **10 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2015_240506_0012	120
O.Reg 79/10 s. 17. (1)	CO #003	2015_312503_0008	120
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2015_240506_0012	536
O.Reg 79/10 s. 229. (4)	CO #008	2015_312503_0008	120
LTCHA, 2007 S.O. 2007, c.8 s. 33. (4)	CO #001	2015_312503_0008	169
O.Reg 79/10 s. 36.	CO #004	2015_312503_0008	169
O.Reg 79/10 s. 51. (2)	CO #005	2015_312503_0008	536
LTCHA, 2007 S.O. 2007, c.8 s. 76. (4)	CO #009	2015_312503_0008	120 169
LTCHA, 2007 S.O. 2007, c.8 s. 76. (7)	CO #002	2015_312503_0008	120 169
O.Reg 79/10 s. 87. (2)	CO #006	2015_312503_0008	120
O.Reg 79/10 s. 90. (1)	CO #007	2015_312503_0008	120

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

Resident #048 was admitted to the home in 2014. Since admission, the resident had exhibited aggression. Interviews and progress notes confirmed that on four occasions in 2014 and 2015, the resident demonstrated responsive behaviours towards a staff member and three other residents.

Over a 46-day period in 2015, the resident had 29 incidences of aggression toward co-residents. On an occasion in 2015, resident #048 demonstrated responsive behaviours towards a family member of another resident while visiting the home.

The home's policy "Responsive Behavior – Resident Approaches" (policy number ND-R-03-01-01, last revised September 2015) stated, "in situations where the aggressive or violent behaviour poses a risk to others in the Home, the Home will arrange one-to-one staffing until the situation is diffused and the risk minimized". Interview with registered staff #002 on February 11, 2016, confirmed the resident potentially put other residents at risk. Progress notes revealed on several occasions, staff could not locate the resident and would find them in other residents' rooms.

Interview with the DOC confirmed one-to-one staffing was only implemented for up to 72 hours after certain instances of aggression. After the incident on the identified date in October 2015, one-to-one staffing was implemented for 72 hours, and a progress note stated there had been no issues with the resident over the weekend with the availability of a one on one staff member to keep them occupied. The DOC confirmed ongoing one-to-one supervision should have been in place for the resident until their aggression was managed. They confirmed interventions and strategies were not put into place to assist residents and staff who were at risk of harm or were harmed as a result of resident #048's responsive behaviours. [s. 55. (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (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 has failed to ensure that the resident, the resident's substitute decision-maker (SDM), if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The Power of Attorney (POA) for resident #900 provided information regarding the needs and preferences of the resident and posted it in the resident's room to assist front line staff who provided care. This information included a request that the POA be contacted at any time when the resident was confused or upset. The DOC confirmed this information was not included in the resident's plan of care. This non compliance was issued as a result of Complaint #003655-16. [s. 6. (5)]

2. The licensee has failed to ensure that resident #047 was provided the care set out in their plan of care.

On February 2, 2016, resident #047 was observed sitting on the toilet in the tub room. The resident was attached to a specific type of lift and was asleep on the toilet. The resident was alone in the tub room and was not being supervised. The plan of care directed staff to use the identified type of lift for toileting and to have one staff remain with the resident at all times while on the toilet. Interview with PSW's #010 and #011 confirmed the resident was left alone. Both PSW's stated that due to the extensive number of residents that required a full mechanical lift, they were unable to stay with residents when they were on the toilet and were not able to provide the care according to the plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A) Resident #048 had a history of wandering and aggression. On an identified date in 2015, resident #048 was discovered in resident #049's room demonstrating responsive behaviours towards the resident. Interview with the DOC and registered staff #001 confirmed that due to the incident, a specific intervention was put into place to alert staff of the resident's whereabouts. Review of the resident's documented plan of care after the incident revealed it did not include the use of this intervention. This was confirmed by the DOC.(586)

B) A review of residents #030 and #019 plans of care stated that the residents wore a specific type of brief provided by their family. The SDM's for the residents, when contacted, stated the home now provided the incontinence product for the resident and had done for quite some time. The DOC confirmed that the plan of care was not revised when care needs changed. [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 every resident's plan of care is reviewed and revised when their care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

An order was previously issued following an inspection (2015-240507-0012) conducted on May 26, 2015, regarding the lack of clinical bed safety assessments for residents using bed rails. The licensee was required to use a prevailing practice document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes and Home Settings, April 2003" to develop their assessment questionnaire and decision tree when they reviewed residents who used one or more bed rails.

During this inspection, the clinical assessment for residents #008, #019, #023, #030 and #050 were reviewed with the QI Co-ordinator to determine if assessments were completed in accordance with the prevailing guidelines. According to the QI Co-ordinator, who completed the clinical bed safety assessments, the form used to evaluate residents since the last inspection was not evaluated to determine if it met all of the recommendations in the prevailing practice document.

The assessment form was tilted "Personal Assistance Safety Devices Assessment" which included a variety of recommended questions related to the resident's bed mobility, cognition, history of falls and self- transferring ability. The questionnaire did not include an evaluation of the resident's sleeping patterns and habits, underlying medical conditions, behavioural symptoms (aggression, banging of the rail, attempts to crawl over the rail) or medication use that may have impacted their ability to use the bed rail(s) safely. Once the questions were answered with either a "yes" or a "no", no guidance was provided to the assessor with respect to whether the resident was at high or low risk of injury related to bed rail use. The assessment included an option for the assessor to check a box titled "safety" as one of the reasons a resident or Power of Attorney could choose for use of one or more rails. The term was not defined and it was unclear what issues could be considered unsafe. The assessment process ended if the resident or POA chose to use a rail, without any further alternatives documented.

Although the assessments were completed for each resident and the benefits listed for use of the bed rail (independence, mobility, transfers), the assessment did not include a more comprehensive evaluation of potential resident safety risks associated with the bed rails if selected by either the resident or POA or if a rail was suggested for use by the assessor. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident is assessed in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

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

Findings/Faits saillants :

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

The home was built prior to 2009 and the section of the lighting table titled "All other homes" was applied. Lighting levels were measured using a hand held analogue light meter and a digital light meter which was held at a standard 30 inches above and parallel to the floor (as per The Illuminating Engineering Society of North America). Areas that did not meet the minimum requirements included resident washrooms and shower rooms with faulty lights.

A) Resident washrooms were equipped with a fluorescent tube bulb behind an opaque lens and mounted on the wall above the vanity. The illumination level was 300-400 lux at the vanity but dropped to 175- 90 lux at the toilet, depending on the room layout. A minimum required level of 215.28 lux is required throughout the room (excluding along walls and corners).

B) The shower rooms and some toilet areas in tub rooms were equipped with pot lights with an opaque lens that did not provide reliable and consistent lighting for staff and residents.

Two out of three lights were burnt out in the Rose Arbour shower room and the pot light over the shower area was flickering between February 3 and 5, 2016. The lux was 20 at the doorway, 20-25 at the toilet and zero at the hand sink. According to maintenance logs, staff reported that the various pot lights in this room were flickering or burnt out on September 8, November 8 and December 24, 2015 and replaced within 24 hours.

The shower in the Primrose Hill home area had one pot light burnt out which created a lux of under 200 near the sink and toilet. Staff reported in the maintenance logs that various pot lights were burnt out in this room on November 24, 2015 and flickering on September 11, November 8 and December 3, 2015 and replaced within 24 hours.

A minimum of 215. 28 lux is required in the room at the vanity, sink, toilet and shower at all times when in use. [s. 18.]

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 lighting requirements set out in the lighting table were maintained, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure all residents were protected from abuse by anyone.

The licensee has failed to ensure procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

Resident #048 was admitted to the home in 2014. Since admission, the resident had exhibited aggression. Interviews and progress notes confirmed that on four occasions in 2014 and 2015, the resident demonstrated responsive behaviours towards a staff member and three other residents.

Over a 46-day period in 2015, the resident had 29 incidences of aggression toward co-residents. On another occasion in 2015, resident #048 demonstrated responsive behaviours towards a family member of another resident while visiting the home.

Interview with the DOC and Administrator confirmed all residents were not protected from abuse by resident #048. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all residents are protected from abuse by anyone, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate action was taken in response to every incident of abuse.

Resident #009 alleged they were the victim of financial abuse to the inspectors. The BSO, who was a staff member of the home, was part of the resident's care team. The clinical notes indicated the resident had shared their concerns with the BSO; however, the allegation was not investigated and appropriate action taken, according to the policy of the home. This was confirmed by the BSO and the DOC. [s. 23. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure appropriate action is taken in response to every incident of abuse, to be implemented voluntarily.

WN #7: 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #014's responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns, including wandering.

On an identified date in 2015, resident #014 entered resident #051's room and demonstrated responsive behaviours towards resident #051. This was witnessed by resident #015. Interview with resident #015, activity staff #007, and the DOC, and observation of resident #014 throughout the RQI, confirmed that the resident would wander into other residents' rooms. Interview with the BSO, DOC and activity staff #007 confirmed resident #014 exhibited responsive behaviours directed toward other residents. The DOC confirmed the resident wandered into other residents' rooms, along with their behaviours, which put the resident and other residents at risk for altercations. Review of the resident's documented plan of care did not include the identification of wandering and did not include any interventions for staff. This was confirmed by the DOC. [s. 26. (3) 5.]

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 every resident's responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure resident #043 was offered the planned menu items at each meal.

During lunch meal service at 1200 hours, on January 28, 2016, residents were offered bean soup prior to their entrée as per the planned menu. Resident #043's documented plan of care indicated they required total assistance with feeding. A staff member was available to assist resident #043 at 1240 hours; however, only fed the resident their entrée. The resident was not offered and did not receive soup. Interview with the DM and RD confirmed every resident should have been offered soup. [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 planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure resident #041 was given sufficient time to eat at their own pace.

During lunch meal service on January 28, 2016, resident #041 was observed eating their dessert at 1315 hours, when PSW #001 told the resident they could "not stay here forever", and told the resident to take their cup of coffee with them, then proceeded to wheel the resident out of the dining room. The resident still had half of their dessert left to eat and did not get to finish their dessert. Interview with the DM and RD confirmed no resident should be rushed and should be given the opportunity to finish their meal. [s. 73. (1) 7.]

2. The licensee has failed to ensure residents #044 and #046, who required assistance with eating, were assisted using safe positioning techniques.

During lunch meal service on January 28, 2016, PSW #001 was observed feeding resident #044 their soup while standing up. The PSW was later observed feeding resident #046 their sandwich standing up. Review of the home's policy "Table Service Policy" (policy number DM-05-02-01, last revised March 3, 2014) and interview with the DM and RD confirmed staff must be seated while feeding residents for safety reasons as it put them at increased risk for choking. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure every resident is given sufficient time to eat at their own pace, and to ensure residents who require assistance with eating are assisted using safe positioning techniques, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee has failed to ensure that procedures were fully developed or implemented for cleaning and disinfection of resident care equipment, such as tub lift chairs, wash basins and bed pans using at a minimum, a low level disinfectant in accordance with evidence-based practices.

According to a document titled "Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices, 2013", non-critical devices such as bed pans and wash basins are to be cleaned and disinfected with a low level disinfectant after each use (unless the device is not used by any other person whereby cleaning is sufficient).

Communal equipment is to be cleaned and disinfected between each use. Communal equipment and bed pans and wash basins act as vehicles for the transmission of organisms, from one body area to another (in the case when wash basins used for bed baths) and from staff hands to other surfaces when not adequately cleaned and disinfected when necessary.

According to the home's policy for cleaning bed pans and basins (policy number IC-03-06-21), the wash basins were required to be collected weekly for cleaning by 7-11 shift and bed bans be cleaned each and every time they were removed from a resident and stored in the tub room. Basins were to be collected on the 3-11 shift on the designated night and left in the dirty utility room to be cleaned by the 11-7 shift. The 11-7 shift was to disinfect them and return to resident room. The above noted procedure was not developed in full, taking into consideration some much needed details on when to clean versus disinfect the articles, how to clean the articles before disinfecting (if necessary) where (in the soiled utility sink, dishwasher, resident washroom) and with what products. The policy did not identify how to store the cleaned items after cleaned and disinfected to prevent contamination.

During a tour of the four soiled utility rooms in the home beginning on February 3, 2016, no detergent for the dishwashers, brushes, disinfectant or any cleaning instructions were available in the rooms. Two of the soiled utility rooms had a domestic dishwasher (Primrose Hill and Ivy). The sink in the Ivy Lane soiled utility room was monitored and had a bed pan and basin in it for 3 days. The two dishwashers were not used over a 3 day period as items inside found in both (linen bags and a piece of wrapping) remained in the machines.

Resident washrooms (#100, #111, #115, #106, #415) were observed to have wash basins stored on the floor over a three day period. Room #106 had a dusty unclean bed pan stored inside of a commode pot on the floor as well. Room #410 had a very dirty yellow bed pan on the grab bar above the toilet tank for 3 days. A basin stored in a vanity cabinet in room #114 was not clean in appearance and had a glove in it for 3 days. The Infection Control Designate (ICD) was not familiar with the process conducted on the 7-11 shift and inquired with staff on that shift. The ICD reported that there was no schedule as to when the basins were collected and cleaned. Staff reported to her that the soiled utility rooms were not used, specifically the dishwashers. The ICD was not certain how the staff cleaned the articles between use on the various shifts until further investigated. Based on the observations noted above, the existing procedures were not implemented. [s. 87. (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 procedures are fully developed or implemented for cleaning and disinfection of resident care equipment, such as tub lift chairs, wash basins and bed pans using at a minimum, a low level disinfectant in accordance with evidence-based practices, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that lap belts were applied by staff in accordance with any manufacturers instructions.

Manufacturer's instructions (Rexall) for lap belts used in the home instructed staff to ensure the lap belt was tightened around the residents' hips until snug.

On January 28, 2016, between 1130 and 1200 hours, the following residents were observed to have loose fitting lap belts:

i. Resident #043 was observed sitting in a tilt wheelchair with a loose fitting lap belt that was applied approximately 12 centimetres (cm) from the resident's torso. Staff person #002 was notified. The staff stated that they liked to apply the lap belt loosely as it was more comfortable for the resident. The staff person walked away without adjusting the lap belt to within manufacturer's instructions.

ii. Resident #011 was observed being pushed in a wheelchair with a loose fitting lap belt that was applied approximately 12 cm from the resident's torso. The resident was asked to release the buckle and demonstrated that they could not. Even though staff person #003 observed that the lap belt was loose fitting, they did not adjust it and continued to transport the resident to the dining room.

During interview the DOC confirmed that these lap belts applied to residents #043 and #011 were loose fitting and not according to manufacturer's instructions. She stated that she tightened them. However, upon re-inspection at 1400 hours, the lap belt applied to resident #043 continued to be loose fitting and was approximately 10 cm from the resident's torso. (526) [s. 110. (1) 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 lap belts are applied by staff in accordance with any manufacturers instructions, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment for its residents.

Several environmental safety concerns were observed in the home that had not been identified by management or staff as possible risks to residents.

A) On January 28, 2016, a portable heater was observed in the end lounge off Lilac Lane, which was accessible to residents. The center cone of the heating unit, which was accessible, was hot to touch and caused staff to pull their hand away to prevent injury. Home staff, including the Administrator, was aware that the safety heater, which would shut off if it fell down, was in use as there was a lack of heat in the room. The portable heater was a safety concern for residents and was removed once it was identified that the unit was unsafe. (536)

B) On February 3 and 4, 2016, a tour of all of the resident rooms was conducted at which time 20 over bed lights were observed with objects on top of the fluorescent tube lights directly over the head of each bed. The lights were approximately four feet long and designed with an opening along the top to allow heat to escape, and were not designed to store objects for this purpose. The objects on the lights ranged from large, heavy picture frames, small picture frames, stuffed animals, baskets, artificial plants, and other decorative objects. The bottom of some of the objects were very warm to the touch. The concern of fire safety and injury from heavy falling objects was discussed with the Administrator who was not aware of the objects on the lights. According to the Administrator, during her short time in the position, she was not aware if their health and safety inspections included over bed lights for safety concerns or whether or not residents and families were informed of the risks. On February 5, 2016, the Administrator reported that most of the objects had been removed from the over bed lights.

C) On February 4, 2016, three humidifiers were observed in the home, in resident rooms.

The humidifiers were not inspected prior to use by either the maintenance person or approved for use by the DOC. The home's health and safety inspection checklist did not include humidifiers. No policy had been developed to manage the humidifiers as the DOC indicated that they did not allow them. The DOC was unaware that families or residents had brought in the humidifiers or how long they had been in use in the home. The DOC was aware of the risks, namely the ability for all types of humidifiers to breed fungi and bacteria. If the reservoir was not kept clean and the water changed daily, the organisms would be propelled into the air with the mist where it can be breathed in increasing the potential for respiratory irritations and infections. [s. 5.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Where the Act or this Regulation required the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee did not ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

A) The licensee has failed to ensure home's tub cleaning policy was complied with.

Four tub rooms were toured and the tub lift seat in Rose Arbour had a very heavy layer of scum and scale on the underside of the tub lift seat. Some minor residue was seen on the underside of the tub seat in the Ivy Lane tub room. A PSW was seen cleaning the tub on February 3, 2016, in the Rose Arbour tub room after a bath was given, but not the underside of the tub lift seat. Policy IC-03-06-09, which was developed for cleaning tubs and tub lifts as required under s. 87(2)(b), stated that all areas of the tub chair were to be

sprayed with disinfectant and scrubbed after use. The PSW's responsible for cleaning the equipment did not comply with the policy. (120)

B) The licensee has failed to ensure the home's pleasurable dining protocol was complied with.

During lunch meal service commencing at 1200 hours, on January 28, 2016, in the Lilac dining room, the following was observed:

i. Resident #041 ordered the cold entrée option of a sandwich. When the resident was served their lunch, they said it was too cold and needed it warmed up. The staff said it was not to be warmed up as it was a cold sandwich. Several minutes later the resident said again that their food was cold and was not eating, and staff said it was supposed to be cold. The resident later asked if their food could be warmed up, but staff did not acknowledge the resident. The resident was never offered the hot entrée option in replacement. By 1245 hours, the dietary aide was gone from the servery and all food had been cleared. No residents were offered seconds.

ii. Resident #041 was asking questions about their food. PSW #001, #003 and registered staff #002 were responding to the resident by yelling across the dining room. Registered staff #002 was feeding a resident while shouting across the room to resident #041. This occurred several times throughout the meal service.

iii. Resident #041 requested a cup of coffee. PSW #003 told the resident they would get it for them; however, they went on to feed another resident and did not provide the resident their coffee until they requested it again 10 minutes later.

v. PSW #001 served desserts to residents on a tray which had only regular textured options. Each resident at an identified table were served their dessert except for resident #042, who requested their dessert. The PSW said they were coming back, though they continued to serve other residents their desserts. Resident #042 shouted again; however, the resident was not acknowledged. PSW #001 finished serving the regular desserts from the tray before they went back to the servery to get pureed desserts, then served this resident #042.

Interview with the DM and RD confirmed the home's expectation was to approach all residents individually when speaking to them, and confirmed yelling across the dining room did not promote a pleasurable dining experience for residents. They also

confirmed all residents should be acknowledged when voicing concerns and these concerns should be addressed and their needs met within an appropriate amount of time. (586)

C) The licensee has failed to ensure the home's hand hygiene program was complied with.

During lunch meal service on January 28, 2016, PSW #001 was observed touching their hair and wiping their nose with their bare hand while feeding resident #044. The PSW then went on to feed resident #045 without having washed or sanitized their hands. The PSW was later observed rubbing their nose again and continuing to assist residents without washing or sanitizing their hands. Interview with the NM and RD confirmed hand hygiene practices were not carried out by staff during dining as per the home's protocol. [s. 8. (1) (b)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment was kept clean and sanitary.

On January 28, 2016, eleven plastic cups were noted to be worn, stained and cracked, some with food debris, and five spoons to be stained and poorly cleaned. The cups and cutlery were set on the tables ready to be used for lunch meal service. The DM and Administrator confirmed the visual findings. Review of the home's Food Committee Meeting minutes from May and December 2015, confirmed residents brought forward concerns about the appearance of the dishes, particularly being stained. The home did not ensure equipment was kept clean (526). [s. 15. (2) (a)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the home's abuse policy was complied with.

A) The home's policy "Resident Abuse Policy – Resident Policies" (policy number ND-R-10-01-01) directed any person who witnessed or had knowledge of an incident of abuse to notify the Charge Nurse/Supervisor immediately, and to immediately investigate the alleged abuse, including documenting the findings in the resident's progress notes.

A progress note, and interview with registered staff #002 who witnessed the incident, revealed that on an identified date in 2015, resident #052 and resident #052 were involved in an incident involving sexual behaviour.

Review of resident #053's documented plan of care revealed they had a history of inappropriate sexual behaviour and staff were to document a summary of each episode.

Interview with registered staff #002, who witnessed the incident, confirmed that they reported the incident to the Social Worker, not the Charge Nurse/Supervisor as per policy, and also confirmed they did not document the incident in resident #053's health record. Staff #002 and the DOC confirmed the Charge Nurse should have been notified and the incident should have been documented in both residents' charts.

B) The home's policy "Resident Abuse Policy – Resident Policies" (policy number ND-R-10-01-01) defined sexual abuse as "any non-consensual touching, behaviour or remarks of sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or a staff member".

A progress note, and interview with registered staff #002 who witnessed the incident, revealed that on an identified date in 2015, resident #052 and resident #052 were involved in an incident involving sexual behaviour. Interview with the DOC and Administrator confirmed both residents had cognitive impairment and therefore could not consent to the situation which could be considered potential sexual abuse. A Critical Incident Report was not submitted to the Director. The DOC and Administrator confirmed this should have been reported to the Director. [s. 20. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Interview with the DOC and registered staff #009 revealed resident #014's behaviours were to be monitored every 30 minutes and documented on the Resident Behaviour Observation Record. The staff confirmed the resident was mobile and walked around the home, at times wandering into other resident rooms. The home's policy "Resident Behaviour Observation Record" (policy number ND-R-03-01-02, last revised September 2015) directed PSW staff to complete the form and observe the resident every half hour, and to closely monitor residents behaviour and document observations (a minimum of every half hours) by using assigned codes under applicable dates and times.

On an identified date in 2015, resident #014 demonstrated a responsive behaviour towards resident #051 after entering resident #051's room. The Resident Behaviour Observation Record for that date was observed to be blank. Additionally, review of the observation records from November 2015 to January 2016, inclusive, identified the records were not fully completed for all 74 days in that time period. This was confirmed by registered staff #009 and the DOC. [s. 30. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure written strategies were developed to include techniques and interventions to prevent, minimize or respond to resident #014's responsive behaviours.

Interview with the DOC and registered staff #009 revealed resident #014's behaviours were to be monitored every 30 minutes and documented on the Resident Behaviour Observation Record as this information was used by members of the care team to regularly assess the resident's responsive behaviours. Interview with PSW #008 confirmed they thought this was only temporary and was unaware that this was an ongoing intervention, therefore was not completing this for the resident. Interview with registered staff #009 confirmed this information was passed along to staff verbally, but was not documented in the resident's chart or their care plan. The staff member and the DOC confirmed the intervention was not included in the resident's plan of care and did not provide clear direction for staff. [s. 53. (1) 2.]

WN #18: 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,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure standardized recipes and production sheets were in place to direct staff in the consistent preparation of some menu items.

A) Observation of meal preparation in the kitchen occurred on February 8, 2016. Dietary staff #006 was observed preparing and pouring thickened beverages into cups for lunch service. The jug of pudding-thick milk had very large chunks floating in it. Staff #006 indicated the milk was prepared in the morning by a casual staff person who did not prepare it properly. The staff indicated they use one large scoop (a one cup measuring cup) of thickener from the tub for each pitcher of fluid; however, did not have any standardized recipes to follow, except for the direction on the box in the storage room that had direction for 100ml of liquid only. The staff member and DM confirmed there was no direction for staff on how to prepare other volumes of thickened beverages, and there were no recipes to ensure the proper consistency in the product. The staff confirmed the thickened milk was unsafe for resident consumption.

B) Interviews with dietary staff #005, DM and RD confirmed the home currently had two residents requiring vegetarian diets. Review of the kitchen's recipe binder confirmed there were no standardized recipes for the vegetarian items. Observation on February 8, 2016, revealed dietary staff #005 was preparing tomato soup, a vegetarian patty, and macaroni and cheese for lunch on February 8, 2016, without following a recipe, and the staff member confirmed they did not have any recipes to follow; they just make the vegetarian items on their own.

C) Review of the butternut squash soup recipe confirmed chicken stock was to be used. Interview with dietary staff #005 confirmed they were preparing tomato soup for the resident requiring a vegetarian diet as they cannot have the regular soup due to the

chicken stock. Review of the home's production sheet indicated the vegetarian diet could receive the regular soup, and the production sheet did not include the preparation of the tomato soup.

D) Observation of meal preparation in the kitchen on February 8, 2016, confirmed the recipe for pureed beef macaroni was not followed. The recipe directed the staff person to top the beef macaroni with shredded cheese and bake in the oven, then take servings of that and puree it in the robo coupe along with hot beef broth. Observation confirmed dietary staff #005 pureed the macaroni along with shredded cheese without being put in the oven to bake first, as directed by the recipe. Additionally, beef broth was not added to the puree, potentially affecting the taste and consistency. [s. 72. (2) (c)]

2. The licensee has failed to ensure documentation was completed on production sheets of any menu substitutions.

The home's menu for lunch on February 8, 2016, was a first choice of pulled pork on a bun (69 servings to be prepared) and a second choice of beef macaroni (40 servings to be prepared). In an interview with dietary staff #005 on February 8, 2016, they indicated they knew the residents preferred the second choice of beef macaroni over the pulled pork; therefore they switched the production values to make more of the beef macaroni than the pulled pork (69 servings of macaroni and 40 servings of pork). The changes were not documented on the production sheet. [s. 72. (2) (g)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had no more than a three month supply of government stock medications.

On February 5, 2016, an inspection of the government stock supplies identified that the home the following:
i. Vitamin B12 1000 micrograms (mcg) -60 vials,
ii. Dulcolax suppositories-14 boxes-100 suppositories per box,
iii. Calamine lotion 500 millilitres (mls)-12 bottles.

When the inspector asked the DOC if these identified government stock items would be used within three months, she identified it would not. She also stated that she had transferred the responsibility of ordering government stock to another manager and had not advised them of ordering no more than a three month supply. [s. 124.]

WN #20: 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 drugs comply with the manufacturer's instruction for expiration dates.

On February 5, 2016, all government stock, as well as all medication carts in the home, were checked for expired medications. This included eye drops and insulin's to ensure they were dated as to when they were opened, and when they were to be discarded as per the manufacturer's instructions. The discard date for insulin's was 28 days as per manufacturer's instructions and pharmacy directive. The discard date for eye drops was 28 days as per pharmacy directives.

The inspector noted the following:
i. Tears Plus dated November 22, 2015; Isopto tears 1% dated September 22, 2015; Isopto tears 0.5% dated Dec 27, 2015, and Latanoprost eye drops 500 mcg no open date identified. All were labelled that they had to be discarded in 28 days,
ii. Lantus insulin not dated as to when it was opened, was labelled to be discarded in 28 days
iii. Senekot 1000 tablets in one of the medication carts was noted to have expired in November 2015.

This review was completed with registered staff #004 and non-compliance confirmed. [s. 129. (1) (a)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Specifically failed to comply with the following:

s. 305. (4) A licensee who is applying for the Director's approval under subsection (3) shall provide the Director with,
(a) plans or specifications relating to the work to be done; and O. Reg. 79/10, s. 305 (4).
(b) a work plan describing how the work will be carried out, including how residents will be affected and what steps will be taken to address any adverse effects on residents. O. Reg. 79/10, s. 305 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that alterations to the home did not commence without first receiving the approval of the Director and that a plan describing how the work was carried out, including how residents would be affected and what steps would be taken to address any adverse affects on residents.

The resident-staff communication and response system was replaced in the home over the course of six months ending in February 2016. During this inspection, it was discovered that a new panel was installed at the nursing station and that contractors were still finalizing the project. No advance details or plans were provided to the Director to determine how the work would be carried out, how many workers would be in the building, what if any cutting of drywall would be necessary, what safety precautions were in place if workers were using ladders in corridors and other resident accessible spaces, the name of the company conducting the project and whether the new system was going to be compliant with the existing regulations. [s. 305. (4)]

Issued on this 4th day of March, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	JESSICA PALADINO (586), BERNADETTE SUSNIK (120), CATHIE ROBITAILLE (536), GILLIAN TRACEY (130), THERESA MCMILLAN (526), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2016_344586_0002
Log No. / Registre no:	002269-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 26, 2016
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 :	Karen Verhaeghe

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee shall ensure procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that actions are taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

These procedures and interventions shall include, but not be limited to, the use of one-to-one staffing in situations where a resident's aggressive or violent behaviour poses a risk to others in the home, until the situation is diffused and the risk minimized, as per the home's policy. The interventions are to be documented in the residents' plans of care to provide clear direction for staff, as well as to be documented in the resident progress notes to effectively monitor and evaluate the effectiveness.

Grounds / Motifs :

1. The licensee has failed to ensure procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

Resident #048 was admitted to the home in 2014. Since admission, the resident had exhibited aggression. Interviews and progress notes confirmed that on four occasions in 2014 and 2015, the resident demonstrated responsive behaviours towards a staff member and three other residents.

Over a 46-day period in 2015, the resident had 29 incidences of aggression toward co-residents. On another occasion in 2015, resident #048 demonstrated responsive behaviours towards a family member of another resident while visiting the home.

The home's policy "Responsive Behavior – Resident Approaches" (policy number ND-R-03-01-01, last revised September 2015) stated, "in situations where the aggressive or violent behaviour poses a risk to others in the Home, the Home will arrange one-to-one staffing until the situation is diffused and the risk minimized". Interview with registered staff #002 on February 11, 2016, confirmed they had the potential to put other residents at risk. Progress notes revealed on several occasions, staff could not locate the resident and would find them in other residents' rooms.

Interview with the DOC confirmed one-to-one staffing was only implemented for up to 72 hours after certain instances of aggression. After the incident on the identified date in October 2015, one-to-one staffing was implemented for 72 hours, and a progress note stated there had been no issues with the resident over the weekend with the availability of a one on one staff member to keep them occupied. The DOC confirmed ongoing one-to-one supervision should have been in place for the resident until their physical aggression was managed. They confirmed interventions and strategies were not put into place to assist residents and staff who were at risk of harm or were harmed as a result of resident #048's responsive behaviours. (586)

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 : Mar 18, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 26th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jessica Paladino

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