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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 8, 2017	2017_573581_0005	006348-17	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

DIANNE BARSEVICH (581), JESSICA PALADINO (586), LISA VINK (168), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 19, 20, 21, 24 and 25, 2017.

Inspector Lisa Bos, Inspector Number 683, participated in this inspection.

During the course of the inspection the following inspections were completed concurrently.
Complaints:
Log number 005117-17, for info line number IL-49697-HA related to prevention of abuse.
Log number 027742-16, for info line number IL-46729-HA related to responsive behaviours.

Critical Incidents:
Log number 19066-16 related to falls prevention.
Log number 22390-16 related to falls prevention and reporting and complaints.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care (DORC), Registered Nurses (RN), Registered Practical Nurses (RPN), Resident Assessment Instrument (RAI) Coordinator, Physiotherapist (PT), Physiotherapist Assistant (PTA), Registered Dietitian (RD), Personal Support Workers (PSW), Continuous Quality Improvement (CQI) Coordinator, Quality Improvement lead, Administrative Assistant, Accounting Manager, Environmental Supervisor, Maintenance Manager, laundry aide, activity staff, residents and families.

During the course of this inspection, the inspectors: observed the provision of care and services, toured the home, reviewed records including but not limited to: meeting minutes, training records, policies and procedures and clinical health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that restraining of a resident by a physical device under section 31 or 36 of the Act, was applied by staff in accordance with any manufacturer's instructions.

A. The physician's order for resident #055 included the use of a physical device with a special application while seated in a chair for safety due to self transferring. Interview with the Continuous Quality Improvement (CQI) lead confirmed the physical device was used as a restraint. The plan of care indicated the use of the physical device was to be applied with the special application and applied in a specific way on the resident. Interview with the CQI lead, DORC and Physiotherapist Assistant (PTA) stated that the resident continually tried to release the physical device.

On an identified day in July 2016, resident #055 had a fall from the chair after they removed their physical device independently and sustained an injury.

A progress note written after the fall by registered staff #132, on an identified day in July 2016, stated the resident's physical device was broken. The following day a Physiotherapist (PT) referral was sent by registered staff #129 which indicated they were to assess the physical device as it appeared to be broken.

In an interview, on an identified day in April 2017, the PTA explained that many physical devices had an acceptable adaptation and that if a resident played with this a lot, it could get damaged, which made it easier for the resident to remove the device. The PTA acknowledged that the adaptation on the resident's chair was identified to be broken after the fall and they contacted an outside vendor to have it repaired.

The DORC provided the Long Term Care Homes (LTCH) Inspector with the Rexall Drugs Instructions for the application of a specific physical device and this was demonstrated by the PTA. The PTA demonstrated how the adaptation was to be secured. Although, the resident's fall was unwitnessed, the PTA acknowledged that the broken adaptation on the resident's physical device would have made it easier for the resident to loosen and remove it and may have contributed to the fall on an identified day in July 2016, which resulted in an injury.
Resident #055's restraint was not applied in accordance with manufacturer's instructions. (586)

B. On two identified days in April 2017, resident #024 was observed seated in a chair with a physical device applied which was greater than five finger widths from their torso.

Review of the plan of care identified they required the physical device as a restraint. Interview and observation of the physical device with RPN #104 and RPN #100 confirmed that the physical device was not applied correctly, was too loose, according to the manufacturer's instructions and the staff members adjusted the device to two finger widths from the resident's torso.
The restraint was not applied in accordance with manufacturer's instructions. (581) [s. 110. (1) 1.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

Ontario Regulation 79/10 section 90 (2) (g) required that the temperature of water serving all bathtubs, showers and hand basins used by residents did not exceed 49 degrees Celsius and was controlled by a device, inaccessible to residents, that regulated the temperature and
Ontario Regulation 79/10 section 90 (2) (h) required that procedures were developed and implemented to ensure that immediate action was taken to reduce the water temperature in the event that it exceeded 49 degrees Celsius.

The home had a procedure, "Water Temperature Record", ND-W-03-01-01, last revised April 2015, in their nursing documentation manual.
This procedure directed nursing staff to record water temperatures three times a day and provided directions to follow if the temperature reading was above 49 degrees Celsius. This direction included to repeat the test with a second thermometer and then if still high to "make a notation in the Maintenance Work Order Book and the 24 hours report and to notify maintenance department immediately and notify Administrator/delegate, if after hours or on weekends" in addition to other activities.
A review of the 24 Hour Water Temperature Records identified that wash basins in resident rooms had hot water, above 49 degrees Celsius, on March 20, 22, 25, 26, 28, 29, 30, 31 and April 2, 2017, during the night shift and on March 24, 2017, during the evening shift, which was verified by the Director of Resident Care (DORC). A review of the 24 hour reports, for the resident home area where the hot water was identified, for March 24, 25, 26, 30, 31 and April 2, 2017, did not include any notations of the hot water temperatures as confirmed by the DORC.
The home was not able to produce the Maintenance Work Order Book, which included entries for hot water from March 24, 2017 until April 2, 2017, as confirmed by maintenance staff and the DORC. Interview with the DORC verified they had not received a call, outside of business hours, during the identified time period to report hot water.
The DORC identified that night staff would report the presence of hot water to staff in the home, to alert them of the issue and then communicate the issue to maintenance when they arrived just before 0700 hours.
The home did not follow their procedure related to hot water as required. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with, to be implemented voluntarily.

WN #3: 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 had fallen, the resident was assessed and that where the condition or circumstances for the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Review of the home's policies identified that when a resident had fallen, registered staff were to assess the resident using the following clinically appropriate assessment instrument.
i. The home's policy, "Falls Prevention and Management Program", revised September, 2015 and "Head Injury Routine Guidelines" revised April 2015, directed registered staff that when a resident had fallen, the registered staff would conduct the head to toe assessment.
ii. Initiate Head Injury Routine (HIR) for all suspected or confirmed head injuries, unwitnessed falls and upon physician's orders. Neurological vitals were to be taken

every 15 minutes for the first two hours and if stable every 30 minutes for two hours and every hour for four hours and if stable every four hours for 12 hours, then every shift up to 72 hours or as otherwise specifically ordered by the physician and document on the Vitals/Neurological Observation Record.
iii. Complete the Fall Risk Assessment within 24 hours of admission, quarterly and when a change in health status placed the resident at increased risk for falling such as: two falls in 72 hours, more than three falls in three months, more than five falls in six months, significant change in health status and falls resulting in serious injury.

On an identified day in June, 2016, resident #022 sustained an unwitnessed fall that resulted in an injury. Review of the plan of care identified the resident was transferred out and returned to the home on an identified day in June 2016 and then the Fall Risk Assessment was completed three days later. The next assessment was completed on an identified day in August 2016 and there were no further assessments completed quarterly at the time of this inspection. The HIR was initiated; however, vitals were not documented according to the home's policy. Interview with RPN #100 stated that the Fall Risk Assessment was to be completed quarterly and with a fall which resulted in serious injury and confirmed that the Falls Risk Assessment and the HIR were not completed as required by the home's policy.

Interview with DORC confirmed that resident #022 was not assessed using a clinically appropriate assessment tool that was designed for falls as outlined in the home's Falls Prevention and Management Program and the Head Injury Policy after they sustained a fall which resulted in an injury. [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 had fallen, the resident was assessed and that where the condition or circumstances for the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. The home's policy, "Hand Hygiene Program", IC-03-02-01, with an effective date of November 2014, identified that good hand hygiene practices included the following; "before preparing, handling, serving or eating food and before feeding a resident".
On April 19, 2017, the noon meal service was observed in the dining room. During the course of the meal observation it was identified that not all staff participated in the hand hygiene program when they failed to complete hand hygiene before serving food and feeding a resident.
RPN #104 was observed to feed a resident, clear soiled dishes and then serve food again before feeding a resident, all without preforming hand hygiene. PSW #105 was observed on a few occasions to serve food, clear soiled dishes and then serve food again without consistently preforming hand hygiene.

Staff did not participate in the hand hygiene program, which was part of the infection prevention and control program.

B. The home had a procedure titled, "Bath Tub and Associated Equipment Cleaning", IC-03-06-09, effective date November 2014, in their Infection Control Manual. This procedure identified that "staff shall ensure that bath tubs and associated equipment is cleaned prior to use, between use and after use" and that" using only the approved disinfectant, spray all areas of the tub chair, including inside of tub surfaces and scrub all areas of the shower chair and contact surfaces of the shower and let stand for 10 minutes".
A tub room was observed on April 19 and 20, 2017. The underside of the tub lift chair was noted with an accumulation of white debris under the chair, in the ridges, which could be removed by scraping and aggressive rubbing the areas. The chair was observed on April 20, 2017, by RPN #101 and PSW #102 who both verified that there was white debris on the underside of the tub chair and that it was not clean. PSW #102 proceeded to immediately clean the tub chair, which was effective in removing the debris.

The DORC observed the PSW during the cleaning process and verified that the white debris was on the underside of the chair and that the entire chair should of been clean at all times.

Staff did not participate in the implementation of the infection prevention and control program.

C. During the initial tour of the home a shower chair was noted to have brown build up measuring approximately one centimeter (cm) by 45 cm across the width of the chair. A brown area approximately one cm wide was noted at the edge of the shower floor and brown areas were noted around the drain. These areas were confirmed with the Maintenance Manager on April 24, 2017. (123) [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance failed to ensure that staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #5: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

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

Resident #055's physician orders, that were updated when they returned to the home on an identified day in July 2016, indicated the use of a physical device while in their chair for safety. The mobility/ambulation section of resident #055's documented plan of care indicated the application of the physical device was to be secured and a special application was to be applied. The falls section indicated the use of the physical device was to be applied in a different manner when the resident was in their chair.

The PTA acknowledged that plan of care had not been updated to provide clear directions to staff and others who provide direct care to resident #055. [s. 6. (1) (c)]

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

On two identified days in April 2017, resident #013 was observed in bed with both bed

rails raised in the transfer position. Review of the plan of care, logo at bedside and bed rail assessment indicated they required one bed rail up in the vertical position at all times when in bed for mobility and transfers. Interview with PSW #105 stated they required two bed rails raised for bed mobility; however, they reviewed the logo and confirmed that only one bed rail was to be raised and that care was not provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee failed to ensure the resident was 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 changed or care set out in the plan was no longer necessary.

A. Review of the plan of care for resident #022 identified they required specific falls interventions when they were in bed and in the chair. Observation of the resident and their bedroom revealed they did not use any of the falls interventions and this was confirmed by PSW #105. Interview with RPN #100 stated the resident no longer required the above interventions for falls prevention as they had not had a fall in several months and confirmed the plan of care was not reviewed and revised when the care set out in the plan was no longer necessary.

B. On an identified day in April 2017, resident #022 was observed in a location with visitors. Interview with both the resident and visitors stated they were in their preferred location. Review of the plan of care identified their preferred activity and location during the day and evening and they had no specified rest and sleep pattern provided by the resident or visitor. Review of MDS assessment completed in August and November 2016 and February 2017, indicated the resident had an identified routine. Interview with PSW #130 confirmed the resident's known preference for activity during the day. Interview with RPN #100 confirmed that the resident had specific activity patterns and this was not documented in the written plan of care and confirmed the plan of care was not reviewed and revised when their care needs changed.

C. Review of the plan of care for resident #022 identified they required assistance for the physical process of toileting and they were toileted with two staff and a full mechanical lift. Interview with PSW #130 stated they were no longer toileted and their continence product was changed. Interview with RPN #100 confirmed that the resident was no longer toileted and the plan of care was not reviewed and revised when their care needs changed.

D. Resident #022's written plan of care identified that the physiotherapy treatment program included but was not limited to, specific exercises and they were also transferred with a mechanical lift. Interview with Physiotherapist Assistant stated the resident no longer participated in exercises for the past several months and now used a different mechanical lift for transfers. Interview with the Physiotherapist confirmed that the plan of care was not reviewed and revised when their physiotherapy treatment changed.

E. Resident #040's plan of care was reviewed and indicated that a specific device was to be worn on a trial basis to improve feeding and eating. On an identified day in April 2017, lunch was observed in the dining room by inspectors #683 and #168 and the resident was observed without the device applied. The resident was observed again on an identified day in April 2017, at lunch and did not have the specific device applied. The device was noted to be available and the resident was observed in a specific position. RPN #100 confirmed that they required the device as a Personal Assistance Service Device (PASD) when they needed it and that they did not require it that day.

Review of the progress notes identified a physiotherapy referral was sent on an identified day in December 2014, by the Registered Dietitian (RD) for specific positioning during meal times and the device trial was initiated on an identified day in January 2015. On an identified day in February 2015, the physiotherapist documented that the SDM consented to using the device and that a referral was to be made to a specialist. There was no other documentation in the progress notes from either the PT or RD about further follow up of the device.

The RD was interviewed and stated that the specific device was to be used when the resident was in a specific position and that it was no longer a trial and was part of their current planned care. They indicated they had observed the resident to use the device a couple of times and that it worked well; however, was unsure if it was still necessary. The RD indicated that they had not included the application of the device in their documentation because they assumed it was the responsibility of the PT.

The Physiotherapist stated they worked at the home when the intervention was initiated in 2015. They noted that currently, the device was only used when necessary and that most of the time, the resident did not require it. The physiotherapist confirmed that they had not assessed the resident since the intervention was put into place in January 2015.

The RD and PT acknowledged that resident #040's care plan was not updated after the trial of the specific device was completed and confirmed the resident was not reassessed when their care needs changed. (586) [s. 6. (10) (b)]

WN #6: 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 failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On April 19, 2017, the counters at two sink areas in dining rooms were observed to have peeling and chipped laminate on the front and side facing surfaces. One wooden table was observed in a lounge that had cracked and chipped wood on the table top and side of the table top. Also, during the initial tour of the home, a pail of water approximately six liters was observed under the sink in a dining room catching water from a leaking pipe. Interview with the Maintenance Manager confirmed the above noted areas were not in a good state of repair. The wooden table was immediately removed and the Maintenance Manager reported the home would be ordering new counters for the sink areas and the leak was repaired the following Monday. [s. 15. (2) (c)]

WN #7: 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 failed to ensure that with respect with 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, any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #055's documented plan of care indicated the use of a physical device with a special application applied. The plan of care also identified the need for hourly safety checks for their physical device restraint. A physician's order included the use of a physical device with the special application for safety due to self transfer and document the safety checks hourly in Point of Care (POC).

On an identified day in July 2016, resident #055 fell from the wheelchair after removing their physical device independently. The resident was assessed and was diagnosed with an injury. A progress note written by RPN #132 on an identified day in July 2016, stated the resident's physical device was broken. A subsequent physiotherapy referral was sent by RPN #129, on an identified day in July 2016, which requested the physiotherapist to assess the physical device as it appeared to be broken.

Review of the monitoring of the physical restraint in the POC documentation from an identified day in July 2016, indicated that an hourly safety check was completed at a specific time in the morning; however, the next documentation was not until a specific time in the evening where it identified the "resident not available". The fall occurred at a specified time; however, there was no documentation to confirm that the resident's physical device was checked for a specified period of time. This was acknowledged by the Administrator, who also confirmed that it was the expectation for staff to document hourly safety checks during each shift. There was no documentation to demonstrate that staff monitored the resident's physical device, to have identified any damage or incorrect use prior to the resident's removal of the physical device and subsequent fall. [s. 30. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident 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. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraint plan of care included the consent by the resident or if the resident was incapable, by the SDM.

Resident #024 was observed during the course of this inspection seated in a chair with a physical device applied. Review of the plan of care identified they had two physical devices applied as a restraint; however revealed there was no consent signed for one of the physical devices as a restraint by the SDM. Interview with the CQI Coordinator stated that the resident had two physical devices applied as a restraint and confirmed that one of the physical devices did not have consent signed by the SDM in the plan of care. [s. 31. (2) 5.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home had their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

A. On April 24, 2017, a number of personal items, specifically two watches and a bracelet and a pair of glasses were located at a specified nursing station. On observation it was identified that the items were not labelled. Interview with RN #106 verified that the items were not labelled, that they were unaware of which resident(s) the items belonged to and was not able to identify when the items were placed at the nursing station. The RN identified the staff labeled personal aids such as glasses when a resident was first admitted to the home or when they acquired new items; however there was no process in place for personal items to be labelled.
B. On April 24, 2017, a ring, a necklace and two bracelets were located at a second nurses station along with four pairs of glasses, three of which were not labeled and one which the label was no longer legible. Interview with RPN #129 verified that the items were not labeled and had been at the nursing station for some time as they were not aware of which residents they belonged to.
C. Resident #022 was resting in bed. A lower denture was in the resident's bathroom, in a denture cup. The denture was inspected and did not include any marks or label to identify that it belonged to the resident. RPN #129 inspected the denture and confirmed that it was not labeled and identified that the home had a denture labeling kit and that this task was assigned to the charge nurse; however, was not completed for this resident.
D. Resident #044 was observed in the lounge area wearing glasses. The resident's glasses were not labelled when inspected by the Inspector or RPN #129, as confirmed by the staff member.

Interview with the DORC verified that the home did not have a process in place to label residents' personal items.

The home did not ensure that personal items and personal aids were labelled within 48 hours of admission and of acquiring, in the case of new items. [s. 37. (1) (a)]

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

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, that procedures were developed and implemented to ensure that, in the case of new clothing there was a process to report and locate residents' lost clothing and personal items.

When requested, the home was not able to provide a process to report and locate residents' lost clothing and personal items. A number of "found" personal items were located in two nurses stations on April 24, 2017. Interview with the DORC and Environmental Supervisor verified that the home did not have a formalized process in place to locate lost clothing or personal items. That the staff just communicated the issue verbally and if located would be returned to the resident; however, there was no written record of missing clothing and personal items to communicate to different staff on different shifts.

The home did not have a process to report and locate residents' lost clothing and personal items. [s. 89. (1) (a) (iv)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the course of this inspection, the faucet at the sink in a specified dining room was observed to be rusty and the faucets at the sinks in a second dining area were observed with greenish white build up of material on the metal faucet. This was confirmed by the Maintenance Manager who reported the faucets would be replaced. [s. 90. (2) (d)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that where a drug that was to be destroyed and was not a controlled substance, it would be done by a team acting together and composed of: one member of the registered nursing staff appointed by the Director of Nursing and Personal Care and one other staff member appointed by the Director of Nursing and Personal Care.

The DORC was interviewed and reported that where a drug that was to be destroyed and was not a controlled substance it was placed in a locked disposal bin by the registered staff. Non controlled medications were disposed directly into the container without emptying of contents by individual registered staff. When the locked disposal bin was full the lid was securely closed and pharmacy picked it up. The DORC confirmed that this was not completed by two staff as required. [s. 136. (3) (b)]

Issued on this 26th day of May, 2017

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANNE BARSEVICH (581), JESSICA PALADINO (586), LISA VINK (168), MELODY GRAY (123)
Inspection No. / No de l'inspection :	2017_573581_0005
Log No. / Registre no:	006348-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 8, 2017
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

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. 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.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall complete the following:

1. Develop an education plan to ensure that all staff responsible for the application and monitoring of physical devices are re-educated on their roles and responsibilities regarding the application of physical devices including but not limited to seat belts.

2. Develop and implement a system to support, monitor and an evaluation of staff compliance to ensure that all physical restraints are applied according to manufacturer's instructions and are in good working order.

Grounds / Motifs :

1. Previously issued as a voluntary plan of correction (VPC) in January 2016.

2. This order is based upon three factors where there has been a finding of noncompliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the noncompliance is isolated (1), the severity of the non-compliance has actual harm/risk (3) and the history of non-compliance under Ontario Regulation 79/10, s. 110. (1) 1 is ongoing (4) with a VPC issued in January 2016.

3. The licensee failed to ensure that staff applied the physical restraint device in

accordance with any manufacturer's instructions.

1. The licensee failed to ensure that restraining of a resident by a physical device under section 31 or 36 of the Act, was applied by staff in accordance with any manufacturer's instructions.

A. The physician's order for resident #055 included the use of a physical device with a special application while seated in a chair for safety due to self transferring. Interview with the Continuous Quality Improvement (CQI) lead confirmed the physical device was used as a restraint. The plan of care indicated the use of the physical device was to be applied with the special application and applied in a specific way on the resident. Interview with the CQI lead, DORC and Physiotherapist Assistant (PTA) stated that the resident continually tried to release the physical device.

On an identified day in July 2016, resident #055 had a fall from the chair after they removed their physical device independently and sustained an injury.

A progress note written after the fall by registered staff #132, on an identified day in July 2016, stated the resident's physical device was broken. The following day a Physiotherapist (PT) referral was sent by registered staff #129 which indicated they were to assess the physical device as it appeared to be broken.

In an interview, on an identified day in April 2017, the PTA explained that many physical devices had an acceptable adaptation and that if a resident played with this a lot, it could get damaged, which made it easier for the resident to remove the device. The PTA acknowledged that the adaptation on the resident's chair was identified to be broken after the fall and they contacted an outside vendor to have it repaired.

The DORC provided the Long Term Care Homes (LTCH) Inspector with the Rexall Drugs Instructions for the application of a specific physical device and this was demonstrated by the PTA. The PTA demonstrated how the adaptation was to be secured. Although, the resident's fall was unwitnessed, the PTA acknowledged that the broken adaptation on the resident's physical device would have made it easier for the resident to loosen and remove it and may have contributed to the fall on an identified day in July 2016, which resulted in an injury.

Resident #055's restraint was not applied in accordance with manufacturer's instructions. (586)

B. On two identified days in April 2017, resident #024 was observed seated in a chair with a physical device applied which was greater than five finger widths from their torso. Review of the plan of care identified they required the physical device as a restraint. Interview and observation of the physical device with RPN #104 and RPN #100 confirmed that the physical device was not applied correctly, was too loose, according to the manufacturer's instructions and the staff members adjusted the device to two finger widths from the resident's torso. The restraint was not applied in accordance with manufacturer's instructions. (581) [s. 110. (1) 1.] (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 09, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 8th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dianne Barsevich

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