**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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## 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 |
|---|---|---|---|
| Jul 28, 2017 | 2017_520622_0023 | 011732-17 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

THE CORPORATION OF THE COUNTY OF HASTINGS
1M Manor Lane Box #758 BANCROFT ON K0L 1C0

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

HASTINGS MANOR HOME FOR THE AGED
476 DUNDAS STREET WEST P.O. BOX 458 BELLEVILLE ON K8N 5B2

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

HEATH HEFFERNAN (622), CATHI KERR (641), SUSAN DONNAN (531)

## Inspection Summary/Résumé de l’inspection

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

**This inspection was conducted on the following date(s): July 10 - 14, 17 - 21, 24 - 25, 2017**

**The following intakes were included as a part of this inspection:**
**Log #s 012154-17, #009404-17, #012976-17 related to alleged resident to resident abuse,**
**Log #s 008045-17, #015303-17 related to resident fall with injury,**
**Log #012117-17 related to alleged staff to resident abuse,**
**Log #014715-17 related to medication incident**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), the Assistant Directors of Nursing (ADON), the Activation Coordinator, Environmental Services Managers, the Dietitian, RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers, a Dietary Aide, the Resident Council President, the Family Council President, resident Substitute Decision Makers (SDM) and residents.**

**Also during the course of the inspection, the inspectors conducted a tour of the home, observed dining service, observation of resident care and services, medication administration and infection control practices, reviewed resident health records, the Licensee's policies and procedures related to Nutrition and Hydration, Heights, Skin and Wound, Least Restraint - Last Resort, Critical Incidents, Medication Administration, Falls Prevention and the resident and family council minutes.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Critical Incident Response**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

The following observations were made during the course of the inspection:

Second floor - Spruce Villa

Dining room

Fireplace wall - 25 small chips in the drywall; beside point of care (POC) screen – 3 white chips in the drywall; left wall - corner of drywall chipped off to expose the metal and 12 small gouged areas in the drywall; a 30x22cm area with multiple small white scratch marks in the drywall with black scuff marks throughout; under the picture window - 8 small gouges in the drywall.

Stair1, level 2 doorway area:
Ten white gouges in the drywall; drywall on the corner of the wall missing exposing the metal corner; 12 white gouges on the west wall with multiple black scuff marks darkening the area.

West Hallway on Spruce Villa

Between room 254 and room 253 - 4 white gouges in the wall below the handrail; left side of doorway to room 252- sharp chip out of the wood at the base; between room 251 and 252 - blue wall - scarred white area in the paint; outside soiled utility room - rough gouge out of the wainscot board; between room 249 and the soiled utility room-7 linear gouges in the wallpaper; outside room 249 - gouge in the drywall; between room 247 and 248 -7 gouges in the wallpaper; between stairwell door and room 247 - 4 gouges in the wallpaper.

Lounge at the end of the West hallway:

To the right of the patio door - 9 chips in the drywall; wall behind the couch - 8 chips in the drywall in a 60 x 30 cm area; metal frame under the window surrounding the doorway - rusted area with chipped paint and scuff marks along the base of the window.

Between room 245 and 246 - 10 gouges in; left side of doorway to room 245 - sharp chip out of the wood at the base; left side of doorway to room 244 - sharp chip out of the wood at the base; right of room 243 doorway - wallpaper gouged; left of room 243 doorway - wallpaper gouged; between room 241 and 242 - 3 long gouges in wallpaper; to left of room 241- 6 long gouges; curved wall - 9 large areas of gouging; between clean utility and housekeeping rooms - 1 long gouged area and 4 smaller areas of gouges in the wallpaper; between housekeeping and the end of the hallway - 6 gouges.

Curved Hallway on Spruce Villa:

Baseboard area to left of the patio door - drywall missing exposing the metal in 2 areas; curved wall by resident care supply room - too many small gouges to count covering the complete area; between resident care room and family dining room - 6 long gouges in the wallpaper.

South Hallway on Spruce Villa

On the right corner at the entrance to the south hallway, the wainscot board was broken off and rough; wallpaper below this was gouged in 6 areas; outside the spa room there were 3 gouged areas; right side of doorway to room 239 - sharp chip out of the wood at the base; right side of doorway to room 238 - sharp chip out of the wood at the base; to the left of the laundry door under the hand sanitizer the wall is marked by the solution and the wall was stain dark and discoloured; left side of entrance to hall - 2 large gouges in the wallpaper; outside the therapy room door – large white chip in the drywall and a long black scuff mark.
Below the TV in the common area there were 15 gouges in the drywall.

Beech Villa

South Hallway on Beech Villa

Entrance to hallway by the Com. Closet - wood wainscot on both corners were chipped the width of the board; edge of wood frame outside of room #225 on the right side was broken off at the base with a sharp edge; wood frame outside room 223 on the right side - loose and pulled away from the wall up to the wainscot board and broken and sharp at the base; edge of wood frame outside of room #218 on the left side was broken off at the base and sharp.

East hallway on Beech Villa

Edge of wood frame outside of room #207 on the left side was broken off at the base and sharp; edge of wood frame outside of room #203 on the left side was broken off at the base and sharp and chipped in two other areas along the frame; entrance to east hallway by room 201 - wainscot chipped with sharp edges on both sides of the hallway.

All of the handrails on the second floor were worn and scratched.

Third Floor

Carpet at the entrance to the elevators had a worn white patch approximately 45cm x 60cm.

All of the handrail on the third floor were worn and scratched.

Elm Villa

Lounge

Wall to the left of the TV - drywall gouged length of the wall; entrance to common area - right side of wall at base - three gouges in the dry wall; common area - wall with TV on it - to the left of the TV - four patched gouges in drywall with dried drywall paste; end of same wall - patched drywall.

West Hallway on Elm Villa

Edge of wood frame outside of room #347 on the right side was broken off at the base and sharp; left side of the doorway at the base, the drywall was gouged; entrance to round lounge at the end of the west hall - metal frame under window - paint chipped at the base in four areas; on the inside of the entrance, the metal frame of the window had 2 areas where the paint had chipped off; edge of wood frame outside of room #344 on the left side was broken off at the base and sharp; ceiling stained yellow between room 343 and room 342 in a 60cm x 210cm area; curved wall outside clean utility room - 14 linear gouged areas on the red wallpaper; curved wall to the left of resident care supply room - three gouged areas in the wallpaper.

South Hallway on Elm Villa

Wainscot board on the right side of the entrance to the south hall - chipped and sharp; edge of wood frame outside of room #339 on the left side was broken off at the base and sharp; outside the soiled utility room the wainscot board was chipped with sharp edges; edge of wood frame outside of room #338 on the right side was broken off at the base and sharp and chipped in another area on the frame; edge of wood frame outside of room #337 on the left side was broken off at the base and sharp and chipped in another area above that one.

Worn areas of the carpet on Elm Villa

Outside room 352-worn white 75cm x 90cm; outside room 350, worn white -15cm x 15cm area; worn white at the entrance to the south hallway - 70cm x 20cm; carpet in the lounge at the end of the south hall was worn and faded white in front of the windows - 150cm x 60cm; in the hall outside of the family dining room - worn white - 60cm x 20cm; outside of the medication room - worn white - 280cm x 30cm.

Pine Villa

All of the handrail on the third floor were worn and scratched.

South Hallway on Pine Villa

Corners on both sided of entrance on the blue wallpaper gouged on both sides; handrail between rooms 321 and 322 - board under handrail was loose and hanging down; wallpaper gouged on wall under the Point of Care (POC) monitor by the spa room; wall gouged to the left of the spa room; curved wall in front of garbage chute - long linear gouge in blue
wallpaper.

East Hallway on Pine Villa

Curved wall by east hallway had 21 gouges in blue wallpaper; corner of wall by linen chute had one long gouge in the wallpaper; wood frame on end of wall outside room 310 was broken away from the wall up to the wainscot and flapping; in round lounge at the end of east hall - metal frame to the doorway window at the base on the inside - paint was chipped off; outside room 307 the blue wallpaper was gouged near the baseboard; gouge in wallpaper near the soiled utility room; edge of wood frame outside of room #303

on the left side was broken off at the base and sharp and chipped in another area above this; edge of wood frame outside of room #302 on the left side was broken off at the base and sharp.

Worn areas of the carpet on Pine Villa

Outside of the family room – worn white – 37cm x 20cm area; outside of the medication room – worn and white – 20cm x 15cm area; carpet worn white down the center of the entrance to the south hallway; outside room 325 - worn and faded -40cm x 40cm area; round lounge at end of south hall-worn and faded white in front of the window-120cm x 50cm; in front of room 304 - worn 60cm x20cm.

Fourth floor

Carpet as you get off of the elevator was worn white in a 45cm x 48cm area.

All of the handrail on the third floor were worn and scratched.

Birch Villa

Activity lounge - below picture window - drywall damaged and punched in plus three other spots with missing drywall; entrance to dining room - corner missing drywall exposing the metal on both sides; wall by med room gouged in 10 spots; left side of wall in common area - corner damaged with old patch; stairway entrance by stair 1 level 4 - corner wall - drywall missing.

West Hallway-Birch Villa

Between room 453 and room 454 - nine areas gouged in green wallpaper; edge of wood frame outside of room #451 on the left side was broken off at the base and sharp; edge of wood frame outside of room #450 on the left side was broken off at the base and sharp; green wallpaper between room 448 and room 449 - gouged along the baseboard; edge of wood frame outside of room #448 on the right side was broken off at the base and sharp and on the left side as well; between room 447 and room 448 the green wallpaper was gouged in 12 spots; left side of room 446 - drywall gouged; edge of wood frame outside of room #446 on the right side was broken off at the base and sharp; wallpaper gouged between room 445 and room 446 with multiple other gouges; edge of wood frame outside of room #444 on the left side was broken off at the base and sharp;

outside of room 443 the right side of the wood frame was pulled away from the wall and flapping from the floor to the wainscot; green wallpaper between room 443 and room 444 – long linear gouge plus multiple other gouges; edge of wood frame outside of room #443 on the left side was broken off at the base and sharp; between room 441 and room 442 the green wallpaper was gouged three quarters of the length of the wall; between end of wall and room 441 - 15 gouges; between housekeeping room and clean utility room - one long gouge in wallpaper; to left of housekeeping room- one long gouge in wallpaper -plus multiple small gouges; curved wall gouged along the base covering with multiple small gouges; hallway between the two wings - curved wall- 6 gouges in wallpaper – on opposite wall - one gouge.

South Hallway ????Birch Villa

Wallpaper between room 440 and spa room gouged along the baseboard; between room 439 and room 440 - six areas gouged; left side of doorway to room 439 rough drywall area; between room 438 and soiled utility room – multiple small gouges; between room 437 and room 438 wallpaper gouged in 8 areas; between room 435 and room 436 wallpaper gouged in five area; between room 433 and room 434 - one long gouge; outside room 431 on the left side, the wood frame was pulled away from the wall and the bottom was broken off and sharp; edge of wood frame outside of room #430 on the right side was broken off at the base and sharp; edge of wood frame outside of room #429 on the left side was broken off at the base and sharp; edge of wood frame outside of room #428 on the right side was broken off at the base and sharp.

Worn areas of the carpet on Birch Villa

Common area entrance - stained area 40cm x 20cm and 10cm x 10cm; outside of medication room - worn white - 270cm x 80cm area; left side of dining room entrance worn - 20cm x 10cm; between room 442 and room 443 there was a stained arc 6cm x 150cm; entrance to south hallway - long area worn brown with white areas -- 180cm x 30cm; outside room 428 worn brown and white - 70cm x 60 cm; outside of the family room area - worn brown and white - 60cm x 15cm.

Maple Villa

Dining room - wall under POC monitor - drywall by baseboard broken away and one large gouged area; wall in common area under TV - six gouges in the drywall.

South Hallway on Maple Villa

Entrance to south hallway - corners of wallpaper chipped down to the metal on both sides; wall between room 427 and laundry room gouged; edge of wood frame outside of room #427 and room #426 on the left side were broken off at the base and sharp; between room 424 and room 425 - two long gouged areas; edge of wood frame outside of room #424, room #423, room #422 and room #418 on the left side were broken off at the base and sharp; edge of wood frame outside of room #420 on the right side was broken off at the base and sharp and on the left side as well; between room 419 and room 420 the wallpaper at the base gouged in five areas; between room 417 and room 418 gouged along the complete length of the baseboard; edge of wood frame outside of room #417 on the right side was broken off at the base and sharp.

East Hallway of Maple Villa

Wall between fire door and housekeeping - linear gouged areas; between clean utility room and housekeeping - long gouge in wallpaper; curved wall - linear gouge in the wall from the clean utility room to the curve; wall to the right of room 414 – two large gouged areas; edge of wood frame outside of room #414, room #410, room #407 and room #406 on the left side were broken off at the base and sharp; wall between room 413 and room 414 – one gouged area; edge of wood frame outside of room #413 on the right side was broken off at the base and sharp, the left side of the same room broken and sharp and loose from the wall up to wainscot board; right side of stairway door - stair 2, level 4 - drywall missing.

Worn area of carpet on Maple Villa

Brown, bleached arched line from fire door to entrance to dining room; outside of the medication room two areas worn brown with white patches - 70cm x 40 cm and 75cm x 30cm; corner by the family dining room - carpet worn brown - 120cm x 30cm; right side around corner on south hallway - worn brown and white - 220cm x 40cm; by entrance to fire doors in south hallway - worn brown - 200cm x 60cm; round lounge at the end of the south hall - worn brown and faded in front of the window - 70cm x 70 cm; in front of the clean utility room - circular bleached white area - 11cm; in front of soled utility room - worn brown and white in 11cm x 12cm area; in round lounge at the end of the east hall worn brown in front of the windows - 25cm x 25cm; dark stain in front of room 406 - 15cm x 15cm.

Cedar Villa

Fifth floor

All of the handrails on this floor were worn and scratch.

Lounge at the end of South Hall

Face of the 5 heaters under the windows-marred with black scuff marks on each one; base of window at the entranceway-paint scratched off in two areas; walls of the room - drywall gouged and marked in a large area.

South hallway of Cedar Villa

Wall marred with gouges in the wallpaper below the handrail to the right of room 534; to the left of room 534 - wallpaper gouged; to the left of room 535 - two gouged areas in the wallpaper; edge of wood frame outside of room #533 on the left side was broken off at the base and sharp; edge of wood frame outside of room #538 on the right side was broken off at the base and sharp; wood frame outside of room #536 on left side was dislodged from the wall up to the wainscot board; wallpaper between room 538 and soiled utility room gouged in three areas; wallpaper between soiled utility room and room 539 - four gouges; edge of wood frame outside of room #528, loose and broken away from the wall up to the wainscot board; wallpaper between room 540 and the spa room - small gouges running the length of the wall up to 25cm from the baseboard; right side of the spa room door, a large piece of the drywall was broken in; there was a piece of molding missing on the right side of the entrance to the south hallway.

West hallway of Cedar Villa

Round lounge at end of west hall - the face of all five heaters were marred with black scuff marks; drywall broken in near the base of the wall; window by the door - paint on the base had been scratched off in two areas.
Outside of lounge on the wall by the stairwell – a large long area of the wallpaper was gouged out; edge of wood frame outside of room #549, loose and broken away from the wall up to the wainscot board; outside of room 542, the drywall was broken in on the left side of the doorway; edge of wood frame outside of room #542 and room #554 on the right side were broken off at the base and sharp; wallpaper between room 541 and 542 - gouges in the wall up to 18cm from the base board and running the length the wall

between the two rooms; wallpaper to the left of room 541 - gouges in the wall up to 18cm from the baseboard to the end of the wall; in the activity room lounge, the drywall was broken in under the picture window.

Worn areas of the carpet on Cedar Villa

Carpet worn white in two large areas of lounge at the end of South Hall - 90cm x 60 cm and 60cm x 60cm; worn white area outside of room 540; in front of room 529 - 12cm x12cm worn brown and with white areas; carpet at entrance to south hallway - worn area - brown and white - 30cm x 90cm and a darkened stain in the same area - 75cm diameter; outside of room 542 - worn white area - 120cm x 60cm; outside room 542 - worn white - 100cm x 70cm; between the stairway door and the dining room were three worn areas - 30cm x 30cm, 30cm x 45cm and 15cm x 60cm; outside of the medication room doorway – worn white area - 60cm x 210cm; hallway by the family dining room - worn brown/white - 20cm x 90cm.

Oak Villa

South hallway on Oak Villa

To the left of room 522 - old patched drywall on pink wallpaper dried and cracked; edge of wood frame outside of room #517 was broken off at the base and sharp; edge of wood frame on the right side of room #519, loose and broken away from the wall up to the wainscot board.

East hallway on Oak Villa

Pink wallpaper on wall to right of room 514 - gouged along the length of the baseboard; wallpaper on wall between room 513 and 514 – one long gouged area; edge of wood frame outside of room #507, room #505 and room #501 on the right side were broken off at the base and sharp; edge of wood frame outside of room #507, room 512, room #501 and room #504 on the left side were broken off at the base and sharp.

Worn areas of the carpet on Oak Villa

Outside of the med room - worn white - 60cm x 180cm area; in front of the family dining room - 60cm x 90cm area; at entrance to south hall – worn area - 180cm x 30cm with white bare patch 10cm x25cm; down center of south hall between room 524 and room

517 - 300cm x 60cm section faded with white areas; outside room 503 - 15cm x10cm worn patch; outside room 513 and room 512 - large worn area - 300cm x 60cm with several white patches.

During an interview with Inspector #641, the Environment Services Manager, (ESM) #142 indicated that all the carpets in the building had been approved for replacement and he expected the company to start work in September of this year. With respect to all the marks on the walls in the hallways, ESM #142 indicated that these items would be sent through the work hub and the maintenance staff repaired them as they were reported to them. The ESM indicated that the licensee had set up a timeline to work on repairing/ repainting all of the walls on each floor, doing one floor per year.

During an interview and observation of some of the homes identified areas of disrepair, the Administrator confirmed that the maintenance was a priority. The Administrator indicated that the repairs were being addressed with a plan in place to replace the carpets by the end of the year and to repair the walls on all resident floors within three years. [s. 15. (2) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home furnishings are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

**WN #2: 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 to ensure that the required levels of lighting were provided in all areas of the long term care home including: a minimum of 215.28 lux of continuous, consistent lighting throughout corridors, common area lounges, and dining areas.

On July 20 and 24, 2017 illumination levels were measured in the corridors, resident lounges, seating areas along the corridors, the sunroom and dining rooms. A hand held Amprobe LM-120 light meter was used. The meter was held 3 to 4 feet above the floor surface and all available window coverings and doors closed. All available light fixtures were turned on and warmed up. The illumination level was measured on both days from 1300 hours to 1700 hours on overcast days.

During the course of the RQI inspection July 10 to July 20, 2017 inspectors #641 and #531 noted low lighting levels in corridors, common/activity lounges, sun rooms, dining rooms and seating areas.
Resident #051 expressed concern to inspector #531 that the lighting level in the corridors and television/activity lounge was dark. The resident indicated that the light is dark at night.

The minimum level of 215.28 lux of continuous consistent lighting was not provided in corridors throughout the home. Levels of illumination in corridors were measured at 50 to 75 % of the required lighting levels including resident seating areas along the corridors of each home area.

Levels of illumination in the seating areas at the entrance counters into each dining area measured 50- 60 % of the required lighting levels of 215.28 lux of each home area.

The levels of illumination along the entrance vestibules to the adjoining common lounge and activity area measured 50% of the required levels of 215.28 lux of each home area.

On July 24, 2017 the Environmental Services Supervisor (ESM) and the Administrator accompanied inspector #531 and measured the corridors, lounges and seating areas along the corridors of the home areas.  The Administrator acknowledged that low levels of illumination and shadows may negatively impact residents' perception of the surroundings and that the illumination levels will be measured, prioritized to replace, install new lighting fixtures to provide the required lux level of 215.28 over the next three days. [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 required levels of lighting are provided in all areas of the long term care home, including a minimum of 215.28 lux of continuous, consistent lighting throughout corridors, and common lounges and dining entrance counters, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #048 who exhibited altered skin integrity, including pressure ulcers had been reassessed at least weekly by a member of the registered nursing staff.

Resident #048 who was a specified age with multiple diagnosis.

A review of the Resident Assessment Instrument (RAI) dated a specified date indicated

resident #048 had exhibited altered skin integrity which had deteriorated on the next RAI assessment dated a specified date.

A review of the progress notes within a three month period on Point Click Care and the Wound Team assessments on the hard copy of the resident's health record for the past three months indicated resident #048 had specified altered skin integrity. Further review of the progress notes and the Wound Team assessments indicated six assessments had been completed within the three month period.

During an interview with inspector #622, RPN #125 indicated that resident #048 had exhibited altered skin integrity which had improved and required specified treatments. RPN #125 said that residents with altered skin integrity would have a skin assessment completed weekly by the registered staff and this would be documented in the progress notes under the ulcer/wound note. RPN #125 and inspector #622 reviewed resident #048's progress notes for the last three months on point click care which indicated the wound assessments for resident #048's specified altered skin integrity were not being completed weekly.

During an interview with inspector #622, ADON #109 indicated resident #048 had altered skin integrity. ADON #109 also indicated wound assessments were to be completed weekly by the registered staff for residents who have wounds. Inspector #622 reviewed with ADON #109, the documentation of the wound assessments for resident #048. There were only six wound assessments completed for resident #048 within a specified three month period and 11 weekly wound assessments had not been completed.

2. The licensee has failed to ensure that resident #009, who exhibited altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

Resident #009 had altered skin integrity that had been ordered by his/her physician to have a wound/ulcer note to be completed, including measurements on a specified day of the week and the resident's care plan indicated that the altered skin integrity was to be measured weekly as well.

Inspector #641 interviewed ADON #109. The ADON indicated that the altered skin integrity was to be assessed weekly, including measuring the area and this would be signed for in the Treatment Administration Record (TAR) and charted in the progress notes, indicating what the measurement was and the staff's assessment of the altered skin integrity.

Inspector #641 reviewed resident #009's health care record related to altered skin integrity. Inspector #641 reviewed with the ADON the documentation of the wound assessments for resident #009. There were only three wound assessments documented for resident #009 during a specified month. These were done on three specified dates with no assessment completed during a specified week. Only two wound assessments were documented for the altered skin integrity during a specified month. These were completed on two specified days of the month, with no assessments done during two specified weeks of the month. Only four assessments were documented for the altered skin integrity during a specified month. These were done on four specified days, missing an assessment for the last week of the month. There was only one assessment documented for the wound during another specified month as of a specified date.

The licensee had failed to ensure that resident #009's pressure ulcer on the lateral aspect of her left ankle was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including pressure ulcers, is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs**

**Specifically failed to comply with the following:**

**s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,**
**(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).**
**(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).**
**(e) a weight monitoring system to measure and record with respect to each resident,**
**(i) weight on admission and monthly thereafter, and**
**(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the nutritional care and hydration program includes a weight monitoring system to measure and record with respect to each resident body mass index and height upon admission and annually thereafter.

During staff interviews and health care record review, it was noted by the inspection team that not all residents had a recorded annual height.

Inspectors #622, #531, #641 reviewed 40 residents from a random sample and it was noted that residents #011, #010, #024, #034, #005, #009, #006, #002, #013, #035, #032, #027, #016, #015, #014, #004, #003, had last recorded heights on specified dates in 2015.

Inspector #622 spoke with the DOC #111, RPN #113 and RPN #114 who indicated heights are to be taken on admission and annually. DOC #111, RPN #113 and RPN #114 further indicated the home had not completed annual heights on all residents. [s. 68. (2) (e) (ii)]

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was informed of an incident related to a missing or unaccounted for controlled substance no later than one business day after the occurrence of the incident.

During an interview with Inspector #641, RPN #124 indicated that a specified controlled substance was noted to be missing from resident #053 on a specified date. RPN #124 indicated that she wasn't able to find the specified controlled substance for resident #053, so she immediately notified the RN and ADON #111 who both came and searched for the specified controlled substance. When the specified controlled substance was not found, RPN #124 indicated she filled out the medication incident report as required. RPN #124 indicated that the directions on the Medication Administration Record (MAR) for the specified controlled substance for resident #053 required a specified protocol to be followed. RPN #124 indicated that orders were later received from resident #053's physician.

Inspector #641 interviewed ADON #109. ADON #109 reviewed with Inspector #641 the specified controlled substance return sheet for resident #053, where the used specified controlled substances were attached and signed for by two registered staff. The specified controlled substance return sheet had a specified number of doses of the specified controlled substance dated for specified dates. The ADON #109 was aware that, there should have been a specified controlled substance dose dated a specified date however the only dose on that date was the dose of the specified medication to replace the missing specified controlled substance.

Inspector #641 interviewed ADON #111. ADON #111 indicated that the process related to the specified controlled substance was for the oncoming registered nurse on days and evenings to visibly see each of the specified controlled substances at the beginning of their shift and then sign that they had seen it. ADON #111 indicated that the specified controlled substance was never found and a Critical Incident System report was not completed. ADON #111 indicated that no other authorities such as the police, were notified of the missing controlled substance.

The licensee failed to ensure that the Director was informed of the missing specified controlled substance for resident #053 no later than one business day after the specified date. [s. 107. (3)]

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident.

During an interview with Inspector #641, RPN #110 indicated that on a specified date during a specified medication pass, she had given resident #031 a specified medication which had not been prescribed to that resident. RPN #110 indicated that she had accidentally given the specified medication to resident #031 that was not prescribed for them. RPN #110 indicated that the physician, the resident's family and the ADOC and DOC were all notified of the incident.

During an interview with Inspector #641, RPN #144 indicated that on a specified date, she administered medication to resident #054 that was not prescribed for him/her. RPN #144 indicated that she immediately notified the RN and began monitoring the resident. RPN #144 indicated that she notified the ADON and the resident's POA. The resident's doctor was notified and further orders received for resident #054.

Inspector #641 interviewed ADON #109. ADON #109 indicated that she was aware of the medication incidents related to resident #031 and resident #054 and that the expectation of the home was that a resident would receive only medications that were prescribed for them by their physicians.

The licensee failed to ensure that no drug was administered to resident #031 and resident #054 that had not been prescribed for them by their physicians. [s. 131. (1)]

**Issued on this 28th day of July, 2017**

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

**Original report signed by the inspector.**