Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 6, 2015	2015_327570_0024	O-002374-15	Resident Quality Inspection

Licensee/Titulaire de permis

HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION
7199 Gelert Road Box 115 HALIBURTON ON K0M 1S0

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

HYLAND CREST
6 McPherson Street P.O. Box 30 Minden ON K0M 2K0

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

SAMI JAROUR (570), KELLY BURNS (554), LYNDA BROWN (111)

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): August 10-14, 17-21, 2015

Two Complaints (log# O-001629-15 & Log #O-000069-14), Critical Incident (Log #O-002616-15) and Follow-Up (Log #O-001486-15) were inspected concurrently during the RQI.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Interim Director of Care (DOC), Interim Assistant Director of Care (ADOC), Life Enrichment Program Manager, Dietary Manager, Director of Facility and Projects, Family Council Co-chair, Residents’ Council President, Residents, Families, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist and activity aide.

The inspectors also completed an initial tour of the home, observed dining service, reviewed health care records, reviewed Family and Residents’ Council meeting minutes, maintenance logs, and reviewed the following policies: Fall Prevention & Management, Preventative Skin Care, Skin and Wound Care Management Protocol , Pain and Symptom-Assessment and Management Protocol, Patient, Resident & Client Relations Process, Restraints, Bed Rail and Pad Use, Prevention of Abuse and Neglect, maintenance, Responsive Behaviours, TB screening, Pneumococcal Vaccine Patient Administration, Medication Storage, Destruction and Disposal of Surplus Drugs and Sharps, National pharmacy policy manual (pharmacy provider).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
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
Quality Improvement
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

30 WN(s)
11 VPC(s)
5 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_360111_0026	570

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).
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).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. Related to Resident #30, #32 and #42:

The licensee failed to comply with LTCHA, 2007, s. 31, (2), by ensuring 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 area satisfied:
2. Alternatives to restraining the resident have been considered and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other persons provided for in the regulations has ordered or approved the restraining.
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.

Under LTCHA, 2007, s. 33. (1) , this section applies to the use of a PASD if the PASD

has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release themselves from the PASD.

Under LTCHA, 2007, s. 33. (2), "PASD" means personal assistance services device, being a device used to assist a person with a routine activity of living.

Related to Resident #030:

Resident #30 was observed to have two ¼ bed rails in place; bed rails were positioned mid bed.

RN #104 and PSW #106 indicated bed rails were used as a PASD, for safety and positioning when Resident #30 is in bed. Both staff indicated that Resident #30 is dependent on staff, and would not be able to release the bed rail independently.

Resident #30's plan of care indicated that PASDs were in place for safety, but were not specific as to which devices were in use.

Upon further review of the clinical health record for Resident #30, there was no documented evidence of alternatives to PASDs having had been tried or considered, of the resident and or substitute decision maker having consented to the use of bed rails as a PASD or that there had been an order by physician, or approved by a registered nursing staff, Physiotherapist or Occupational Therapist for use of the PASD.

2) Related to Resident #32:

Resident #32 was observed for two days wearing a seatbelt while in the wheelchair. Interview with the resident indicated the seatbelt was used to prevent from falling from the wheelchair.

PSW #106 indicated the seatbelt was used as a safety device to prevent resident from falling and to remind resident to not slide forward in the wheelchair.

RN #104 indicated not being aware that a seatbelt was being used for Resident #32, but was aware of resident having had recent falls and resident's fear of falling from wheelchair. The RN indicated the use of a seatbelt would be considered a PASD.

A review of the clinical record for Resident #32 failed to provide documented evidence of

a seatbelt being used for Resident #32, nor is there documentation of alternatives to PASDs having had been tried or considered, of the resident and or substitute decision maker having consented to the use of a seatbelt as a PASD or that there had been an order by physician, or approved by registered nursing staff, Physiotherapist or Occupational Therapist for use of the PASD.

3) Related to Resident #42:

Resident #42 was observed to have two ¼ bed rails in place.

RN #104 indicated Resident #42 uses the bed rails as a PASD for safety and repositioning when in bed and further indicated the resident is dependent on staff to release the bed rails.

The plan of care indicated two bed rails are to be up at all times when Resident #42 is in bed.

A review of the clinical health record for Resident #42 failed to provide documented evidence of alternatives to PASDs having had been tried or considered, of the resident and or substitute decision maker having consented to the use of bed rails as a PASD or that there had been an order by physician, or approved by registered nursing staff, Physiotherapist or Occupational Therapist for use of the PASD.

RN #104, indicted seatbelts and bed rails were considered PASDs for Resident #30, #32 and #042, indicating that use of a PASD would require approval by a physician, registered nursing staff, and or physiotherapist (occupational therapist not used at the home) and would require consent by resident or substitute decision maker.

RN #104 confirmed that alternatives to PASDs having had been considered or tried,approval for use of a PASD and consent for use of a PASD was not in place for Resident #30, #32 and #42.

LTCHA, 2007, s. 31 (2), was previously issued as a Voluntary Plan of Correction (VPC) during Resident Quality Inspection #2014_360111_0026. [s. 31. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (3) The licensee shall ensure that the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations. 2007, c. 8, s. 86. (3).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, s. 86 (3), by ensuring the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations.

Under LTCHA, 2007, s. 86 (1), every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home.

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

During the initial tour of the home, four of the four tub/shower rooms were observed to have three to five sets of nail clippers on counter-tops; the nail clippers were unlabelled and the nail clippers contained nail clippings.

PSW #103 indicated that residents were not provided individual nail clippers for personal use and that communal nail clippers were used by the home in the provision of nail care to all residents; PSW #103 indicated being unsure of how the communal nail clippers are cleaned. PSW #103 indicated bringing her own nail clippers from home for use with resident care.

RN #104 indicated no awareness if nail clippers are individually assigned to each resident or how nail clippers are cleaned.

Interim Director of Care and Interim Assistant Director of Care indicated that the expectation would be for all resident's to have their own nail clippers but was unsure if such was the practice within the home. Currently the home has no policy or procedure specific to nail clippers being assigned individually to residents or no policy or procedure specific to the cleaning of nail clippers.

Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment and Devices in All Health Care Settings, 3rd Edition, Provincial Infectious Diseases Advisory Committee (PIDAC) is the prevailing best practice document in Ontario for the reprocessing of shared and/or re-usable resident care equipment. Critical equipment/devices include foot care instruments and any instruments that enter sterile tissues, including the vascular system. These items present a high risk of infection if the equipment/device is contaminated with any microorganism, including bacterial spores. Reprocessing critical equipment/devices involve meticulous cleaning followed by sterilization. Semi critical equipment/devices include shared use nail clippers. Reprocessing semi-critical equipment/devices involves meticulous cleaning followed by, a minimum, high-level disinfection.

Measures are not in place for the cleaning, disinfection or sterilization of re-usable and/or shared resident equipment (e.g. nail clippers) which poses a potential cross infection risk to residents.

2. Related to Resident(s) #21, 28, 29, 48 and #49:

Under O. Reg. 79/10, s. 229 (10) 1, the licensee shall ensure each resident admitted to the home screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

The LTCH Licensee Confirmation Checklist-Infection Prevention and Control, provided to the home by the inspector during the initial tour, and signed by the Interim Director of Care indicated the following:
-TB screening done for residents in your long term care home (LTCH) was, chest x-ray within 6 months of admission for all residents 65 years and older; and TST testing for all residents under 65 years of age.

A random review of the clinical health record (including CCAC admission package, status report, immunization history, progress notes, physician's orders, diagnostic imaging (CXR), and medication administration records) for five residents (over 65years) admitted to the home in 2015 indicated no TB screening had been completed within 14 days.

Review of the following resident's files indicated the following:
- Resident #020, there is no CXR or other TB screening on file;
- Resident #021, there is no CXR or other TB screening on file;
- Resident #028, there is no TB screening on file;
- Resident #029, there is no CXR or other TB screening on file;
- Resident #048, there is no TB screening on file;
- Resident #049, there is no TB screening on file.

Interim Director of Care, and Interim Assistant Director of Care indicated that they believed that the process is that there is to be a discussion with CCAC prior to new residents being admitted to the home that resident was to have a chest x-ray prior to admission; and if the chest X-ray had not been completed, that upon arrival to the home, physician orders would be obtained for a chest x-ray or TST testing as part of the home's screening protocol for tuberculosis.

The Interim Director of Care indicated that the home follows the recommendations of the Public Health Unit and PIDAC; Interim DOC indicated she wasn't aware that chest X-Rays were to be within 90 days, but thought 6 months. Interim DOC indicated the TB screening policy is currently being updated to reflect best practice guidelines.

RN #104 and RPN #115 indicated the home has no current process for ensuring TB screening has been completed within 14 days of admission.
The Interim Director of Care, RN #104 and RPN #115 all indicated no awareness of the above five residents not having TB screening completed.

3. Related to Resident(s) #26, 29, 48 and #49:

Under O. Reg. 79/10, s. 229 (1) (3), the licensee shall ensure residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

A random review of five resident's clinical health record, including CCAC packages,

immunizations records (historical and current), medication administration records, progress notes, failed to provide documentation that four of the five residents were provided immunization specific to Pneumococcal and or Tetanus /Diphtheria (Td). The following was noted:
- Residents #26, 29, 48, and 49, on admission, consented and signed the Authorization and Consent to Treatment specific to having pneumococcal and tetanus/ diphtheria (Td). These residents have not received pneumococcal and Td immunization, despite consenting to such.

RN #104 and RPN #115 indicated that upon admission residents are offered immunizations and if consent is received the immunizations will be given to the resident. Registered Nursing Staff both indicated that there is no process as to when the immunizations will be given or who is responsible to immunize the resident.

RN #104, RPN #115 and Interim Director of Care, all, indicated no awareness of resident immunizations (pneumococcal and Td) not being current as per resident or SDMs’ consent.

The home’s policy, Pneumococcal Vaccine, Patient Administration, directs that all patients and residents of LTC (long-term care) with an expected length of stay of three or more months should be offered this vaccine; consent will be obtained from the patient/resident or substitute decision maker (SDM) or Public Trustee; a physician’s order will be obtained and vaccine administered.

Interim Director of Care indicated that the home currently does not have a policy in place for the administration of Td (tetanus) vaccination. Interim Director of Care indicated that normally, residents in the home are not provided with a Td vaccination, unless the resident has cut themselves and then the vaccination would be administered in the emergency department.

Measures are not in place to ensure vaccines consented to by residents or SDM’s are administered, which poses a potential secondary infection risk to residents.

LTCHA, 2007, s. 86, was previously issued as a Voluntary Plan of Correction (VPC) during Inspection #2013_178102_0021. [s. 86. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. Related to Log #O-001629-15:

The licensee has failed to comply with LTCHA, 2007, s. 20 by ensuring that the home's policy to promote zero tolerance of abuse and neglect of residents is complied with,

include all the requirements listed under subsection (2) (a) to (h) and that the policy is communicated to all staff, residents and residents' substitute decision-makers.

Under LTCHA, 2007, s. 20 (1), the licensee shall ensure the written policy that promotes zero tolerance of abuse and neglect is complied with.

A review of the home's policy, Abuse and Neglect of a Resident-Actual or suspected (#VII-G-10.00, last revised February 2014) directs the following:
-when the staff member (or volunteer) becomes aware of potential or actual abuse, the following
steps must be taken: safe guard the resident immediately, notify the charge nurse.
-the charge nurse will assess the resident for injuries and provide medical intervention if indicated,
notify the RN, and initiate the nursing checklist.The checklist includes: interview and request written account of all possible witnesses,
-upon hire and annually thereafter, all staff and volunteers will receive in-service education on the
topic of abuse and the reporting of abuse.

The Director of Care submitted a Critical Incident Report, specific to an incident of resident to resident physical abuse.

Progress notes indicated that Resident #44 was pushed to the floor by Resident #08; Resident #44 sustained injury; following an assessment by Registered Practical Nurse #115, the resident was taken to hospital for assessment and treatment.

Registered Practical Nurse #115 indicated that the Registered Nurse was not notified of the abuse incident until after Resident #44 was transferred to hospital.

Interim Director of Care and Chief Executive Officer indicated having no documentation as to the home's investigation of this resident to resident abuse incident.

The home's policy was not complied with as indicated by the following:
- Registered Practical Nurse #115 did not notify the Registered Nurse of Resident #44 requiring medical intervention until after resident was transferred to hospital;
- RPN #115 indicated not initiating the Nursing Checklist for Reporting and Investigating Alleged Abuse; nor is there documented evidence of this form being completed by the Registered Nurse, or Director of Nursing following the report of abuse incident;

- There is no documentation that witnesses of the alleged abuse incident or the resident #44 were interviewed;
- Interim Director of Care indicated that not all employees were provided education in 2014 specific to zero tolerance of abuse.

Interim Director of Care indicated it is an expectation that the home's policies be followed.

LTCHA, 2007, s. 20 (1), was previously issued as a Written Notification, linked to Compliance Order #001 issued under LTCHA, 2007, s. 19, duty to protect, during Resident Quality Inspection #2014_360111_0026, which took place October 2014.

Under LTCHA, 2007, s. 20 (2), the policy to promote zero tolerance of abuse and neglect of residents shall, include all the requirements listed under subsection (2) (a) to (h).

A review of the home's policy, Abuse and Neglect of a Resident- Actual or Suspected (#VII-G-10.00, last revision February 2014) identified that the policy fails to contain:
- (c) provide for a program that complies with the regulations, for preventing abuse and neglect of a resident, as the homes policy did not address alleged incidents of abuse or neglect; nor does the policy include what actions to take when abuse of a resident is by another resident; or long term actions to be taken to prevent a reoccurrence.
- (d) an explanation of the duty under Section 24 of the Act to make mandatory reports.

Interview with Interim Director of Care and CEO, both were unable to provide documented evidence of the home's policy, Abuse and Neglect of a Resident- Actual or Suspected being revised, following February 2014.

LTCHA, 2007, s. 20 (2), was previously issued as a Written Notification, linked to Compliance Order #001 issued under LTCHA, 2007, s. 19, duty to protect, during Resident Quality Inspection #2014_360111_0026, which took place October 2014. [s. 20.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

Findings/Faits saillants :

1. Related to Resident #32:

Resident #32 was observed to have areas of altered skin integrity that were not covered with a dressing. Resident indicated those areas were the result of a recent fall.

The clinical health record was reviewed for Resident #32, indicated that the areas of altered skin integrity were assessed by registered nursing staff and that various dressings, were applied.

Review of the clinical health record failed to provide evidence of any physician's orders specific to the areas of altered skin integrity, or was there any indication in the written care plan as to identify skin integrity issues, goals intended nor interventions relating to skin and wound care.

RN #104 indicated that any resident exhibiting altered skin integrity should have a written plan of care.

RN #104 indicated that there was currently no specific planned care for Resident #32's skin tear and or abrasions.

Interim Director of Care indicated it would be an expectation that the planned care for each resident is identified and provided.

A review of the clinical health record for Resident #32, failed to provide any evidence of planned care specific to skin and wound care, or collaboration between nursing staff or physician relating to the skin and wound care management or promotion of healing for resident’s areas of altered skin integrity. [s. 6. (4)(a)]

2. Related to Log #O-000069-14 for Resident #34:

The licensee has failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan related to treatments.

Review of the progress notes for Resident #34 for a two month period indicated:
-On a specified date, the resident sustained an unwitnessed fall with no injury.
-Two days later, the resident began complaining of pain to a specified area, and began having pain related to urinary changes. The resident was sent to hospital for assessment and returned from hospital with a mobilizing device and a diagnostic treatment and test to be completed related to the urinary changes. The treatment and test was not transcribed. The diagnostic treatment and test was not completed until the following day.
-The resident continued to have the urinary changes and two weeks later, the physician ordered the initial diagnostic treatment discontinued and additional diagnostic testing related to the urinary changes. The diagnostic treatment was not discontinued until two days later. Two weeks later, the physician ordered three specific diagnostic tests to be completed. The documentation indicated the second diagnostic test was completed but there was no indication the first test was completed.
The following month, a verbal order was received by the physician for further diagnostic tests to be completed related to the urinary changes. There was no documented evidence the physician’s order was transcribed and no documented evidence of the results for that diagnostic test.[s. 6. (7)]

3. The licensee has failed to ensure that the plan of care was provided related to dressing, specifically, appropriate clean footwear.

Resident’s # 30, #37, #39, #40 & #43 were observed sitting in their wheelchairs wearing socks but no shoes.

Interview of PSW #101 indicated it was "resident requests" not to wear footwear.

Interview of interim DOC indicated that Residents #37, #39 & #40 should have been wearing appropriate footwear.

The interim DOC indicated that only Resident #39 would refuse to wear slippers due to issues with skin integrity.

Review of the care plans for Resident #37, #39 & #40 did not indicate the residents' requested not to wear appropriate footwear or refused to wear appropriate footwear.

Non-compliance was identified under O.Reg. 79/10, s.40 during the Resident Quality Inspection (RQI) on October 6, 2014 under inspection # 2014_360111_0026. [s. 6. (7)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 53 (3) (b), by ensuring the Responsive Behaviour Program is being evaluated annually and updated in accordance with evidence-based practices.

Interim Director of Care indicated that the home did not evaluate the Responsive Behaviour Program in 2014; this was confirmed by the former Assistant Director of Care. [s. 53. (3) (b)]

2. Related to Resident #35:

The licensee has failed to ensure that the behavioural triggers were identified for Resident #35 in response to the resident's responsive behaviours, and strategies were

developed and implemented to respond to the resident's responsive behaviours.

Review of Resident #35's health care record indicated the resident was admitted with a cognitive impairment.

Review of progress notes for Resident #35 for 6 months period indicated the resident demonstrated the following responsive behaviours:
-increased agitated behaviours during meal times,
-throwing dishes at meal time,
-taking food from other residents,
-attempting to strike out at other residents,
-threatening and striking out at staff,
- wandering/pacing in the hallways at night.

Review of the plan of care for Resident #35 indicated the resident demonstrated responsive behaviours including verbal/physical aggression, resistance to treatment and personal care, screaming, and wandering and cognitive impairment.

The progress notes and plan of care for Resident #35 did not identify the behavioural triggers and strategies to respond to the resident's responsive behaviours.

There was no referral for additional behavioural support to manage Resident #35’s responsive behaviours. [s. 53. (4) (a)]

3. Related to Resident #37:

The licensee has failed to ensure that the behavioural triggers were identified for Resident #37 in response to the resident's responsive behaviours, and strategies were developed and implemented to respond to the resident's responsive behaviours.

Review of Resident #37 health care record indicated the resident has a diagnosis of cognitive impairment.

Review of progress notes for Resident #37 for 4 months indicated the following documented responsive behaviours demonstrated by Resident#37:
- agitated behaviour was documented more than 20 times
- yelling/screaming/calling out behaviour was documented more than 43 times and the resident was disruptive to roommate and other residents more than 13 times.

- swinging/waving arms while yelling aloud was documented 3 times.

Review of clinical documentation indicated staff noted the resident was calling out when thirsty or hungry.

The plan of care for Resident #37, indicated the following focus areas related to responsive behaviours:
- Verbal/ physical Aggression related to: sensory deficits and anger.
- Agitation related to: frustration, constant yelling, cognitive impairment,
- Anxiety related to: loss of control
- Resistive to treatment/care related to: cognitive Impairment and depression.
- Repetitive actions related to: cognitive impairment

Interventions included under agitation focus related to frustration, constant yelling, cognitive impairment, and vision impairment, included:
- Give medication as prescribed by MD
- Keep schedules routine & predictable.
- Place headphones on and listen to music
- Praise/ reward resident for demonstrating consistent desired/ acceptable behavior.
- Remove resident from public area when behavior is disruptive/ unacceptable.
- Talk with resident in a low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity.

The plan of care for Resident #37 did not identify the behavioural triggers and strategies to respond to the resident's responsive behaviours identified as agitation and yelling/screaming/calling out though an entry in the progress notes indicated the resident was quiet other than when thirsty or hungry. Resident #37’s plan of care did not identify thirst and/or hunger or any other triggers of yelling/calling out and there was no referral for additional behavioural support to manage Resident #37’s responsive behaviours.

O. Reg. 79/10, s. 53 (4)(a) was previously issued as a Written Notification, linked to Compliance Order #001 issued under LTCHA, 2007, s. 19, duty to protect, during Resident Quality Inspection #2014_360111_0026, which took place October 2014. [s. 53. (4) (a)]

4. Related to Log #O-001629-15:

The licensee has failed to comply with O. Reg. 79/10, s. 53 (4) (c), by ensuring that actions taken to meet the needs of the resident with responsive behaviours include,

reassessments, interventions and documentation of resident's response to the interventions.

Resident #08 has a diagnosis that includes cognitive impairment, mood and behavioural disorders.

Interviews with RPN #115 and #130 and RN #104 all indicated Resident #08 lacks judgement and insight; resident does not know the difference between right or wrong.

According to registered nursing staff and personal support workers interviewed, Resident #08 exhibits several responsive behaviours, including pacing, wandering, restlessness, physical aggression intrusiveness, anxiety, agitation, takes things from other residents and staff and resistance to care.

A review of the progress notes for the period of two months indicated Resident #08 exhibited the following responsive behaviours, pacing running' in the halls, wandering, exit seeking, going into and out of other residents rooms, , hovering, removing articles from the medication cart and from co-residents, resistance to care, physical aggression, agitation.

There were approximately 131 progress notes detailing responsive behaviours exhibited by Resident #08.

Progress notes, reviewed during the above time period indicated that interventions initiated by staff when Resident #08 was exhibiting responsive behaviours, were to redirect resident (using 1-2 staff), encourage resident to go back to bed, to place resident into Broda chair with table top and a magazine, locked out of dining room or to administer 'as needed' medication; the majority of progress notes reviewed, indicated that the intervention utilized was to administer the 'as needed medications for anxiety or agitation.

Progress notes reviewed indicated interventions tried, including 'as needed medications' were often ineffective and as per registered nursing staff, medications seemed to escalate Resident #08's responsive behaviours. Progress notes, indicated that when the 'as needed' medication was noted as 'ineffective', no other interventions were documented as tried; the responsive behaviour of Resident #08 continued.

Other progress notes, during this period failed to provide evidence of actions that staff

took during times when Resident #08 exhibited responsive behaviours and failed to identify the response of the resident during this same time period.

Interviews, with registered nursing staff and personal support workers indicated Resident #08 was intrusive, and impulsive; staff commented that Resident #08's behaviours were unpredictable in nature.

Staff, interviewed, indicated Resident #08 became increasingly disruptive to the resident home area and the responsive behaviours placed the resident and others at risk for safety. [s. 53. (4) (c)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 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 comply with O. Reg. 79/10, s. 8 (1) (b), by ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to Falls Prevention and Management.

Under O. Reg. 79/10, s.48(1)1 every licensee of a long-term care home shall ensure that the following interdisciplinary program is developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury

Related to Resident #25:

Review of the licensee's Fall Prevention and Management policy # VII-G-60.00 dated February 2014 directs:
The Registered staff will:
7. Complete falls incident report.
Each member of the interdisciplinary team (Registered staff, PT, OT and Recreation) will:
1. Complete their respective assessments and discuss the appropriate interventions with the multidisciplinary care team.

Review of clinical health record for Resident #25 indicated the resident sustained six falls in an identified period of six month. There were two completed falls incident reports for the six documented falls.

Resident #25 sustained a recent fall on an identified date. A falls incident report was not completed for this fall.

Interview of RN #104 and RN #109 indicated that the falls incident report under risk management should be completed following each fall. RN #104 indicated the physiotherapist reviews the falls incident reports to track falls and completes post fall physiotherapy assessment.

Interview with the physiotherapist indicated he was not able to track this fall under risk management/fall incident reports and he did not receive a referral related to this fall, hence a post fall assessment by the physiotherapist was not completed following Resident #25’s fall.

Review clinical records for Resident #25 indicated physiotherapy post fall assessment was not done for four falls sustained over a period of several months.

Related to Intake #O-001629-15 for Resident #44:

A Critical Incident Report was submitted by the Director of Care, specific to an incident in which Resident #44 was pushed by Resident #08; Resident #44 fell to the ground as a result of being pushed and sustained an injury.

Progress notes, written by RPN #115 indicated the following:

- Staff witnessed Resident #44 falling to the ground following being pushed by another resident; Resident #44 was transferred to the emergency department for further assessment and treatment.

There is no indication in the progress notes of a Registered Nurse being contacted to assess Resident #44 post-fall/incident.

The home’s policy, Falls Prevention and Management (#VII-G-60.00) directs that if a fall occurs, and the Registered Nursing Staff have a suspicion or evidence of injury that the resident should not be moved; the policy directs that the physician should be contacted, and or arrange for immediate transfer to the hospital.

Interim Director of Care indicated that RPN #115 should have contacted the Registered Nurse on duty to assess Resident #44.

Related to Log #O-000069-14 for Resident #34:

Review of the home's "Fall Prevention & Management" policy (VII-G-60.00)(revised May 2013) indicated:
The Registered staff will:
-conduct the Falls Risk Assessment in PCC as triggered by the MDS RAP, within 24 hours of admission or re-admission, when there is a physiological, functional or cognitive change in status.
-the associated score will be documented in the care plan: a score greater than 16 is considered a high risk; a score of 5-16 is considered a moderate risk.
-ensure that preventative interventions are included in the resident's care plan
If a fall occurs, the Registered staff will (on page 3 of 3):
-initiate a head injury routine if a head injury is suspected or if the resident fall is un-witnessed and he/she is on anticoagulant therapy.
-monitor for HIR for 48 hours post fall for signs of neurological changes
-complete a falls incident report in PCC
-if a resident is transferred to hospital related to this fall, notify the charge nurse/DOC/ADOC to initiate the MOHLTC critical incident report system.
-re-valuate the resident's care plan make the appropriate interdisciplinary referrals, and document appropriate interventions.

Review of the progress notes for Resident #34 indicated on a specified the resident was found on the floor. The resident denied any pain and denied hitting head. Full ROM and

no injury noted. POA notified.

The resident was assessed by physiotherapy post-fall and indicated "no major complications from the fall".

Later that same day the resident was complaining of pain and unable to weight bear. The resident was sent to ER for further assessment which confirmed the resident had sustained an injury.

Review of the Falls Risk Assessment in PCC indicated there was no completed post fall assessment for Resident #34.

Interview of RN #104 & #109 indicated a "Falls Risk Assessment" tool is completed on PCC for all residents on admission, quarterly and after a resident sustains a fall, and indicated the physiotherapist (PT) or Physiotherapy Assistant (PTA) accesses this information under "Risk Management" on PCC when they are in the home to alert PT/PTA that a resident has had a fall and to be assessed by PT/PTA. They indicated it is nursing staff and the RAI Coordinator's responsibility to update the resident's care plans (post-fall). They also indicated that PT/PTA is responsible for posting the "falling leaf symbol" at the resident's bedside to alert staff that the resident is a "moderate to high risk" for falls
.
RN #104 indicated Resident #34 should have had a HIR completed post fall. RN #104 indicated there was no documented evidence to indicate the resident had a HIR completed or had a Falls Risk Assessment Tool completed on PCC.

Interview of the PT (by Inspector # 570) indicated that PT/PTA is in the home approximately 3x/week and track all resident falls via the Risk Management dashboard in PCC. The PT indicated the Risk Management dashboard identifies which residents are at risk for falls and which residents that have fallen, based on Nursing staff completing the "Falls Risk Assessment" tool (on admission, quarterly, and post-fall). The PT indicated then they complete a post-fall assessment of the resident, document assessment findings and recommendations to reduce fall risk on the progress notes.

The PT was unaware of a Falling Leaf symbol that indicated residents were at moderate to high risk for falls and indicated they did not post them.

Review of the physician's book and Resident #34's health record had no documented

evidence to indicate the physician was notified of the fall until three days later when the resident was transferred to hospital for assessment.

Review of the Care plan (pre-fall) for Resident #34 indicated "Risk for falls characterized by history of falls/ injury, multiple risk factors Interventions included: call bell pinned to gown when in bed, check every hour to ensure safety, encourage resident to use handrails or assistive devices properly, ensure environment is free of clutter, have commonly used articles within easy reach, resident to wear proper and non- slip footwear. The care plan was not revised again until nine days post fall.

Therefore, the home's policy was not complied with as there was no evidence;
-a Fall Risk Assessment was completed (post- fall),
-no indication the level of risk for falls was identified on the resident's care plan,
-no indication the resident was assessed using a HIR for 48 hours post fall
-no indication the care plan was reviewed and revised related to falls risk
-no indication the physician was notified of the fall until the resident was transferred to hospital. (111) [s. 8. (1) (a),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 the policy related to Falls Prevention and Management is complied with, to be implemented voluntarily.

WN #7: 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 comply with LTCHA, 2007, s. 15 (2) (a), by ensuring that the home, furnishings and equipment are kept clean and sanitary.

The following observations were made during this inspection:
- all four shower rooms were noted to have dried yellow build up along the flooring and wall tiles of the shower stall; one shower room on the lower unit was observed to a blackish substance build up in the corner of the wall/floor area of the shower stall.
- the Alenti bath chair-lifts - in three of the four tub rooms were noted to have white film dried onto the seating of the assistive device.

Director of Facility and Projects (oversees housekeeping) indicated the housekeeping staff are to thoroughly clean the tub/shower rooms on a daily basis, which includes scrubbing the flooring and shower stall tiles; he indicated nursing staff would be responsible for cleaning the bath chairs.

Interviews with a Housekeeping Staff indicated that the spa room flooring, including shower stalls are washed daily, but the staining on the flooring is embedded in the flooring; housekeeping staff indicated the yellow staining in the shower stalls is hardened on the tiles and can't be removed.
Personal Support Worker indicated the bath chair is cleaned between resident's but that the whitish film is a residue from the cleaning agent used.

Director of Facility and Projects indicated the expectation is the home, furnishings and equipment are to be kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee has failed to comply with LTCHA, 2007, s. 15 (2) (c), by ensuring that the

home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following was observed during this inspection.
- Walls – were observed scuffed, gouged in areas, paint lifting and or visible dry wall patching (putty) in eleven resident rooms as well as throughout the hallways on the upper and lower resident home areas;
- Walls – were observed in three of the four tub/shower rooms to have wall damage; wall tiles were broken or missing with dry wall exposed. Areas exposed were jagged and sharp;
- Toilets – were observed to have dark brownish or rust coloured staining around base of toilet (and flooring) in seven resident rooms
- Door Frames – were observed chipped and paint missing in areas, in four resident rooms
- Transfer poles located in tub rooms (three of the four) located on the upper and lower resident home areas, and in eight resident rooms were observed rusted at the base, leaving unprotected metal exposed. Note: This was previously issued as an area of non-compliance, under O. Reg. 79/10, s. 90 (2) (b), as a Voluntary Plan of Correction, during Resident Quality Inspection #2014_360111_0026)
- Bedside Tables –were observed to have laminate lifting or areas gouged, located in three resident room(s)
- Wardrobes (closets) – were observed to have laminate lifting along sides or base, located in three resident room(s
- Dresser – was observed to have the front of the second dresser drawer missing; the door of the dresser was seen leaving against the side of it – in one resident room;
- Flooring – was observed to have a 12 cm crack along the flooring in one resident room;
- Flooring – laminate flooring was observed to have seams splitting (in 2 of the 4 tub rooms) and one tub room on the upper resident home area had a cracked area (approximately 50cm x 5cm) with dust and debris visible, sub-flooring was wet;
- Tub – the edges of the rubber tub surround (outer aspect) were noted to be loosely fitting with visible debris and dust exposed – located in both lower unit tub rooms and one upper unit tub rooms. The acrylic surface inside one of the tubs on the upper unit had multiple scratches (scratches below surface of acrylic);
- Counter-top Vanity- located in two of the four lounges on both the upper and lower resident home areas, were observe d gouged and or laminate missing or loose;
- Cupboard – metal storage cupboard in two of the four tub rooms were noted to be rusted

A review of the Maintenance Request forms for the period of five months failed to provide documentation of the above repairs and or replacement
required.

The Director of Facility and Projects (oversees maintenance) indicated that all staff are required to report required maintenance repairs and or damage within the home using the maintenance request forms. Director of Facility and Projects indicated no awareness of the maintenance deficiencies identified above, except the flooring in tub rooms, which he indicated bringing forth as an area of concern on a previous date, but indicated has\ not had approval for any such repairs.

Chief Executive Officer (CEO) indicated that the Director of Facility and Projects had brought inspectors concerns forward, relating to repairs required within the home. CEO indicated no awareness of the above maintenance deficiencies prior to speaking with his manager, except the flooring in the tub rooms, and indicated agreement with the Director of Facility and Projects, that no plans were in place for the required repair and or replacement of the flooring. [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 that the home, furnishings and equipment are kept clean and sanitary, maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 16, by ensuring that every window in the home that opens to the outdoors and is accessible to residents has a

screen and cannot be opened more than 15 centimetres.

The following observations were made during the initial of the home during this inspection.
-a slider window located in the upper floor lounge was open; the opening of the window was approximately 38.2 cm. This window is not on ground level of the home (two storey drop); there were two residents occupying the room at the time of the observation.
-a window located in the dining room of the lower floor of the home was open; the slider window could be opened approximately 38.2 cm.
-a slider window in the upper floor dining room was observed open; the window did not have a screen in place.

Additional observations indicated the following resident rooms had slider windows in place that opened completely (greater than 15cm):
- Upper Floor – two resident rooms, in the Snozlen Room and in the Resident Computer/Palliative Room; all of which are located on the upper floor of the home.
- Lower Floor – ten resident rooms.

RN #104 indicated that there were two cognitively impaired female residents residing on the upper unit that wander and had the potential to exit seek; as well as a resident on the lower unit. The one resident indicated by RN #104 was seen wandering from room to room, on the upper unit, during the above observations.

A Personal Support Worker indicated that all windows within resident rooms and lounges have a stopper mechanism to prevent the windows from opening greater than 15cm, but the mechanism is being disengaged, allowing the window to open completely; PSW indicated nursing staff disengage the mechanism to allow air into the home.

Interim Director of Care, Interim Assistant Director of Care and Director of Projects all indicated no awareness of the windows opening greater than fifteen centimetres.

CEO/President of the home indicated being aware that O. Reg. 79/10, s. 16 was a deficiency during the October 2014 inspection and indicated that it was his understanding the deficiency (windows opening greater than 15cm) had been addressed at that time.

O. Reg. 79/10, s. 16, was issued as a Written Notification (WN) during inspection #2014_ 360111_0026 [s. 16.]

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 every resident accessible window in the home that opens to the outdoors cannot be opened more than 15 cms, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 17 (1) (e), by ensuring that a resident-staff communication and response system is available in every area accessible by residents.

The following rooms, which are accessible to residents, were observed to have no resident-staff communication and response system:
-activity rooms in both upper and lower floors, physiotherapy room, snozlen room – all located within the resident home areas;
- hairdressing room and resident computer and palliative room, both of which are located off of the resident home areas; both isolated rooms.

Activity Aide indicated being aware that there was no call bell or phone within the activity rooms and indicated no awareness of how she would contact anyone for assistance if an emergency situation arose when residents were in the activity room.

Interim Director of Care, Interim Assistant Director of Care and Director of Projects "oversees maintenance" all indicated no awareness of the above rooms not having a communication and response system. [s. 17. (1) (e)]

Additional Required Actions:

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

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 23, by ensuring staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions, specific to Alenti bath chair-lift.

The home (nursing staff) utilizes an ARJO Huntleigh Alenti bath chair-lift for assisting residents into and out of the bathtub.

The Alenti bath chair/lift was observed in three of the four tub rooms without a safety belt applied; there was only one safety belt noted available for use during the initial tour of the home.

On two occasions the Alenti bath chair-lifts were observed by the inspector in tub rooms on the upper and lower floor, all lifts were observed wet and no safety belts were observed on the lift or within the tub room

The ARJO HuntLeigh, Alenti’s – instructions for use manual directs the following:
On page 16 - Safety Belt:
- use the safety belt at all times (this is written in bold print; this is also noted on page 18, 22, 26, and 34)
- the safety belt helps resident to stay positioned properly on the seat
- always attach the safety belt before the resident is seated in the Alenti
- warning (in bold letters) - to avoid falls, make sure that the resident is positioned correctly and that the safety belt is being used, properly fastened and tightened;
On page 5 - equipment use by appropriately trained caregivers with adequate care and knowledge of the environment and in accordance with instructions in 'instruction for use’;
On page 5 – Assessment:
- resident should understand and respond to instructions to stay seated and in an upright position
- if does not meet this criteria an alternate lift and hygiene chair shall be used

PSW #103 indicated the safety belt was rarely used when bathing a resident, using the Alenti bath chair-lift; PSW #103 indicated the safety belt may occasionally be used if a resident was agitated prior to or during bathing or if a resident had the potential to jump off the lift.

PSW #103 indicated having had no training specific to use of the Alenti bath chair-lift.

Interim DOC indicated, that nursing staff are not using the safety belt, when bathing

residents, using the bath chair-lift and further indicated only knowing this morning that there are not enough safety belts for use. Interim DOC indicated no awareness of staff education for the Alenti bath chair-lift. [s. 23.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use Alenti bath chair-lift in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that written response is provided within 10 days of receiving Resident's Council advice related to concerns or recommendations.

Interview of the Residents' Council president indicated that the council did not receive written responses to concerns; responses to concerns will be recorded in the minutes on the following month on what was said or done about it.

During an interview, the CEO confirmed that a response is not provided in writing within10 days to the concerns.

This non-compliance was previously issued as a Written Notification (WN) during the October 2014 inspection (#2014_ 360111_0026). [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written response is provided within 10 days of receiving Residents’ Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that written response is provided within 10 days of receiving Family Council advice related to concerns or recommendations.

Interview with the co-chair of the Family Council indicated that the Family Council does not receive written responses to concerns. The CEO provides verbal responses to any concerns and it is recorded in the minutes.

During an interview, the CEO confirmed that a response was not provided in writing within 10 days to the above concerns. [s. 60. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written response is provided within 10 days of receiving Family Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (2) Every licensee of a long-term care home shall ensure that the required information is communicated, in a manner that complies with any requirements that may be provided for in the regulations, to residents who cannot read the information. 2007, c. 8, s. 79. (2).

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents’ Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home’s mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home’s policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home’s procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home’s policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care

home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 79 (3), by ensuring the required information for the purposes of subsection (1) is posted in the home.

Under LTCHA, 2007, s. 79 (1), the licensee of a long term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirement, if any established by the requirements.

The following required information was not posted within the home during the initial tour:
- the long term care home's policy to promote zero tolerance of abuse and neglect of residents;
- notification of the long term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained;
- copies of inspection reports from the past two years for the long term care home;
- orders made by an inspector or the Director with respect to the long term care home that are in effect or that have been made in the last two years;
- the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council.

LTCHA, 2007, s. 79 (3), was previously issued as a Written Notification (WN), during Resident Quality Inspection #2014_360111_0026. [s. 79. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the required information communicated to residents who cannot read the information include an explanation of a person’s duty to make mandatory reports to the Director, an explanation of whistle-blowing protections and the home’s procedure for making a complaint; and all the required information included in s.79(3) is posted in the home, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the satisfaction survey have been made available to the Residents' Council and Family Council in order to seek the advice of the councils about the survey.

Interview with the Residents' Council president indicated the results of the satisfaction survey were not communicated to the council.

Interview of the co-chair of the Family Council indicated the Family Council did not receive the results of the survey for the council to act upon the results.

Interview with the CEO confirmed the results of the satisfaction survey have not been made available to the Residents' Council and the Family Council.

This non-compliance was previously issued as a Written Notification (WN) during the October 2014 inspection (#2014_ 360111_0026). [s. 85. (4) (a)]

2. The licensee has failed to ensure that the survey results and actions taken to improve the home, are made available to residents and their families.

Interview with the CEO confirmed the results of the satisfaction survey have not been made available to residents and their families. [s. 85. (4) (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 that the results of the satisfaction survey are made available to the Residents' Council and the Family Council to seek their advice and in acting on the results of the survey; and the survey results including actions taken to improve the home, are made available to residents and their families, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 129 (1), by ensuring that drugs area stored in an area or medication cart, which is used exclusively for drugs and drug related supplies and that is secure and locked; the licensee further failed to ensure controlled substances are stored in a separate, double locked stationary cupboard in the locked area.

Medication and controlled substances were found in an office desk, which was storing the medications, and was not locked.

Interim Director of Care and RN #104 indicated that only the medication room(s) and or the medication cart(s) are the only designated storage areas for medications. Interim DOC, further indicated no documented evidence of the narcotics and controlled substances in this office being counted.

The home failed to ensure that medication are stored in a locked area, which is used for drugs or drug related supplies and further failed to ensure controlled substances are stored in a separate, double-locked stationary cupboard in a locked medication room or medication cart. [s. 129. (1)]

2. The licensee has failed to ensure that drugs are stored in an area or a medication cart, iv. that complies with manufacturer's instructions for the storage of the drugs.

Interview of RPN #102 stated "the pharmacy is supposed to check monthly for expired drugs and remove any medications not used or expired" (as per manufacturer’s instructions). RPN #102 also indicated that the Registered Nursing staff are also to store all of the discontinued/expired medications in the plastic bin for pharmacy to pick up to destroy in the locked medication room.

Interview of the interim DOC indicated that both the Registered Nursing staff and the pharmacy are to check medication supply cupboards monthly for expired drugs and to remove them (as per manufacturer’s instructions).

Review of medication room on 2nd floor indicated the following medications were observed to be expired: 2 boxes of 50 mg gravol, (expired November 2014); 1 box of bisacodyl suppositories (expired March 2015); and 7 bottles of koffex (4 bottles exp. December 2014, 2 bottles expired September 2014, and 1 bottle expired December 2013).

The manufacturer’s instructions regarding expiry dates and removal of drugs was not complied with. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in a locked area, which is used for drugs or drug related supplies and that controlled substances are stored in a separate, double-locked stationary cupboard in a locked medication room or medication cart, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 222 (1), by ensuring that staff received training related to:
-falls prevention and management.
-residents restrained by a physical device, including application, use of and potential dangers of these physical devices; and
-residents with Personal Assistance Services Device (PASD), including application, use and potential dangers of the PASDs.

Under O. Reg. 79/10, s. 221 (1) 1, all staff who provide direct care to residents shall receive training in falls prevention and management.

Several staff RN #109, RPN #100, PSW #101 and #116 interviewed indicated that they have not received training in falls prevention and management during 2014 and 2015.

Interview with the interim DOC indicated training in falls prevention and management has not been provided at the home since 2013.

Review of the content of online education (Surge Learning) available for staff to complete annually did not include any content related to falls prevention and management.

Under O. Reg. 79/10, s. 221 (1) 5, all staff who provide direct care to residents and who apply physical devices or who monitor residents restrained by physical devices, shall receive training in the application, use and potential dangers of these physical devices.

Interim Director of Care indicated being unable to locate any staff education/training records specific to restraints for staff upon hire and or annually.

Interim Director of Care indicated that there has been no education for direct care staff specific to use, application and or dangers of using a physical device as a restraint.

Under O. Reg. 79/10, s. 221 (1) 6, all staff who provide direct care to residents and who apply PASDs or who monitor residents with PASDs, shall receive training in the application, use of and potential dangers of the PASDs.

No staff education/training records were available specific to the application, use of and potential dangers of the PASDs.

Interim Director of Care indicated that there has been no education for direct care staff specific to use, application and or potential dangers of using PASDs. [s. 221.]

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 direct care staff are provided training related to:
- falls prevention and management.
- residents restrained by a physical device, including application, use of and potential dangers of these physical devices; and
- residents with PASDs, including application, use and potential dangers of the PASDs, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 15 (1) (a), by ensuring where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidenced-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Resident #30, 34, and 36 were all observed to have two quarter bed rails in place, positioned mid bed.

RN #104 and PSW #106 indicated all three residents were using bed rails as a PASD, when in bed, indicating all three residents were dependent on staff to apply and release bed rails. RN #104 indicated all three residents have a cognitive impairment.

The clinical health records for Resident #30, 34 and 36 were reviewed and failed to provide evidence of documentation specific to residents being assessed for use of bed rails.

The home’s policy, Bed Rail and Pad Use (#VII-G-10.34), directs that the Registered Nursing Staff (RN/RPN) will assess the resident’s need for the use of bed rails and to document on the care plan the resident’s need for the bed rail, including the number of rails to be raised and pad use.

RN #104 indicated the home currently has no process in place for assessing the residents need for bed rail use; The RN further indicated the home currently utilizes bed rails for all residents.

Note: no immediate safety risk was identified for bed rails in use of Resident #30, 34 and #36 during this inspection. [s. 15. (1) (a)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. The licensee does not have written procedures that comply with the regulations for initiating complaints to the license, and for how the licensee deals with complaints.

Under O.reg.79/10, s. 101(1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
3. A response shall be made to the person who made the complaint, indicating,
i. What the licensee has done to resolve the complaint, or
ii. That the licensee believes the complaint to be unfounded and the reasons for the belief.
(3)The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly;
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and
(c) a written record is kept of each review and of the improvements made in response.

Under O.Reg. 79/10, s. 103(1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act, shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101(1).
Review of the home's policy "Patient, Resident & Client Relations Process" (02-02-10) (revised Nov.25, 2010) indicated under Process:
-Stage 1(immediately): client relations/feedback forms will be used to document concerns and complaints.
Unresolved forms will be forwarded to the next stage of three stage process.
-Stage 2 (within 24 hrs or next business day): manager will investigate the concern/complaint by speaking with all relevant stakeholders. The manager will report back to the client on their findings and on recommended solution to the concern/complaint. If unable to resolve the concern/complaint to satisfaction of the client, the manager will forward to Senior Management for follow-up.
-Stage 3 (within 24 hours or next business day): a Senior Management representative or delegated Manager (CEO) will contact the client to review the concern/complaint. The Senior Manager will collaborate with the client/representative on obtaining a satisfactory

resolution to the concern/complaint and the response to the concern/complaint will be documented.

Interview of the CEO indicated that this was the home’s most current complaint process.

This policy does not contain procedures to include the requirements related to section 101 of immediately investigating complaints that pertain to section 24 (abuse and neglect),a response provided to the complainant within 10 business days, forwarding all written complaints to the Director, along with response to the Director within 10 business days, and the requirement of documenting and analyzing complaints at least quarterly for trends and to determine what improvements are required in the home. [s. 21.]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. Related to Log #O-001629-15:

The licensee has failed to comply with LTCHA, 2007, s. 22 (1), by ensuring that every written complaint concerning the care of a resident or the operation of the long-term care is immediately forward it to the Director.

The Chief Executive Officer (CEO) and Director of Care (DOC) received a written letter of complaint, regarding an incident specific to the safety of Resident #44.

The CEO indicated it is the responsibility of the DOC to forward such letters to MOHLTC and it was his understanding that the letter had been forwarded to the Director.

As of the date of this inspection, the letter from Family of Resident #44 had not been received by MOHLTC. [s. 22. (1)]

2. Related to Log #O-000069-14:

The Chief Executive Officer (CEO) and Director of Care (DOC) received a written letter of complaint by the family of Resident #39 which indicated "lodging a formal complaint" regarding concerns about the care of Resident #39. A second written complaint was received at a later date related to similar concerns.

Interview of the CEO indicated "do not believe either of the complaint letters was forwarded to the Ministry.

As of the date of this inspection, neither of the two letters from Family of Resident #39, had been received by MOHLTC. [s. 22. (1)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. Related to Log #O-001629-15:

The licensee has failed to comply with O. Reg. 79/10, s. 54 (a), by ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

Critical Incident Report (CIR) was received by the Director reporting a resident to resident incident of physical abuse. The CIR documentation indicated that Resident #44 was pushed by Resident #08; Resident #44 sustained an injury as a result to the incident. Staff indicated, Resident #08's exhibited responsive behaviours which include agitation, anxiety, aggression, impulsiveness and had a tendency to pace or walk fast in the hallways of the home.

Review of clinical documentation, including the plan of care and interview with PSWs, and Registered Nursing Staff indicated, within two months Resident #08 had 120 documented episodes responsive behaviours including physical aggression towards other residents and inappropriate social behaviour.

Progress note indicated Resident #08 was disruptive to the unit and that staff were unable to distract resident, interventions being ineffective.

There is no indication that identifying factors, including triggers, interdisciplinary assessments and observations of Resident #08's responsive behaviours were addressed so that steps could have been taken to minimize the risk of altercations and potentially harmful interactions between Resident #08 and co-residents. [s. 54. (a)]

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff at the home received required training before performing their responsibilities.

Interview with interim DOC indicated when she assumed her role as an interim DOC, she did not receive training or orientation related to regulations or policies that pertains to this role.

Interview with interim ADOC , when she assumed her role as an interim ADOC indicated she did not receive any training or orientation related to regulations or policies that pertains to this role expect for procedures related to incident reports and vacant beds. [s. 76. (2)]

2. The licensee has failed to ensure that all staff have received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

Review of the home's training record to the home’s policy “abuse and neglect of residents” and observed the following:
- All nursing staff were directed to read and sign off that they have read and understand the policy on Abuse and Neglect of a Resident by December 31, 2014.
- 12 out of 54 employees did not sign off reading/understanding the policy.
- 17 out of 54 employees have signed off reading/understanding the policy on later dates from January 2015 to March 2015.

During an interview, the Interim DOC indicated not all staff completed and signed off on reading/understating the policy on “Abuse and Neglect of a Resident” by December 31,2014.

The interim DOC indicated that the home utilizes the online Surge Learning for staff education and confirmed that the online Surge Learning does not include any training related to prevention of abuse and neglect. [s. 76. (4)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 87 (2) (d), by ensuring that procedures are developed and implemented for addressing incidents of lingering offensive odours.

During this inspection, the following was noted:
- four resident room(s) were noted to have odours;
- the pervasive malodour (strong urine like odour) in these rooms were easily detected upon entering into the washrooms, despite the time of the day;
- the upper floor, resident home area was noted to have a strong 'musty' odour.

Housekeeping staff interviewed, indicated no specific procedure was in place to address the odours in the home.

Director of Facility and Projects indicated having no knowledge of the odours within resident rooms, indicating he would rely on nursing and housekeeping to bring this concern forward.

Director of Facility and Projects, who oversees the housekeeping department, indicated the musty-stale odour in both home areas is coming from the carpets (hallways and resident rooms), and worsens as the humidity outdoor increase; he indicated that the home has an extraction process for the carpets, but unfortunately it is dependent on the weather; if temperatures outside is too warm, then can't use as the carpets won't dry which causes further issues. Director of Facility and Projects indicated
the home currently has no procedure for addressing lingering offensive odours within the home, other than routine cleaning. [s. 87. (2) (d)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 96 (b), (c) and (e) by ensuring the homes written policy to promote zero tolerance of abuse and neglect of residents: contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate; identifies measures and strategies to prevent abuse and neglect; and identifies the training and retraining requirements for all staff including: i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

A review of the home's policy, Abuse and Neglect of a Resident - Actual or Suspected (#VII-G-10.00) (last reviewed February 2014), fails to contain:
- procedures and interventions to deal with residents who abused or allegedly abused
- measures and strategies to prevent abuse and neglect of residents, instead only provided actions taken after incidents occur;
- training and or requirements for staff specific to power imbalances between staff and residents; and the potential for abuse by those in a position of power and trust.

Interim Director of Care indicated being unable to locate any revisions to the above policy.

O. Reg. 79/10, s. 96 (b) and (c), was issued as a Written Notification (WN) during inspection #2014_ 360111_0026 [s. 96. (b)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident’s substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Related to Log #O-001629-15:

The licensee has failed to comply with O. Reg. 79/10, s. 97 (2), by ensuring that the resident and resident's substitute decision maker were notified of the alleged abuse investigation immediately upon completion.

The Director of Care submitted a Critical Incident Report regarding a witnessed resident to resident physical abuse incident.

The incident involved Resident #08 pushing Resident #44; Resident #44 sustained injury and was transferred to emergency department.

The home was unable to provide documentation that Resident #44’s substitute decision maker having had been contacted, by the home, as to the outcome of the home's investigation, specific to the resident to resident physical abuse incident which occurred, despite family of Resident #44 requesting a response as to safety measures for Resident #44.

Chief Executive Officer indicated having no knowledge as to the outcome of the resident to resident abuse investigation, indicating this was left in the hands of the Director of Care. [s. 97. (2)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 99 (b), by ensuring that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

The Interim Director of Care indicated the 2014 Program Evaluation, specific to Zero Tolerance of Abuse and Neglect was not completed; Interim DOC indicated contacting the former Assistant Director of Care (ADOC) (who left the position May 29, 2015), to confirm that no evaluation was completed for 2014. [s. 99. (b)]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

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

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. Related to Log #O-001629-15:

The licensee has failed to comply with O. Reg. 79/10, s. 101 (1) 1, by ensuring that every written or verbal complaint made to the licensee or staff member concerning the care of a resident or operation of the home, has been investigated, resolved where possible, and

response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately.

Family of Resident #44, indicated sending a letter to both the Director of Care (DOC) and the Chief Executive Officer/ President of Hyland Crest (CEO), voicing concerns as to an incident involving Resident #44 being injured by Resident #08. In this letter, the family, of Resident #44, voiced concerns for the safety Resident #44 as well as other residents residing at Hyland Crest; family requested information at to the home's safety plan and requested what measures had been put into place to safeguard residents.

CEO indicated he had replied to the family of Resident #44 and indicated the DOC would follow up with the family directly with respect to the home's future course of action on this matter. The CEO indicated he himself did not reply to the family's complaint, but he had responded to the family indicating receipt of the concern.

The CEO indicated no awareness as to if the concerns of Resident #44's family had been investigated, CEO indicated being unable to recall the outcome of the investigation if one had been initiated.

A second inquiry was sent, by the Family of Resident #44, to the CEO and DOC, indicating that they had sent their first inquiry a month ago and have not heard back from the Director of Care as to their concerns relating to the incident nor have they heard from the management or nursing staff as to the marked decline of Resident #44's cognitive and functional abilities.

The CEO provided, the inspector, with an email response written by the Director of Care, The home's policy, Patient, Resident, Client Relations Process (#02-02-10) directs that a senior management representative or delegated Manager (CEO, CNO/DOC, CFO or Quality Manger) will contact the client to review the concern or complaint, within 24 hours or next business day; the senior manager will collaborate with the client/resident on obtaining a satisfactory resolution to the concern or complaint and the response will be documented.

Chief Executive Officer indicated that the Director of Care should have promptly investigated and responded to the family of Resident #44, indicating response time was not satisfactory nor did the response of the Director of Care answer the concerns of the family of Resident #44. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record was kept in the home and that included: (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolved the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required.

Review of the home's policy "Patient, Resident & Client Relations Process" (02-02-10) (revised Nov.25, 2010) indicated under Process:
Stage 1(immediately): client relations/feedback forms will be used to document concerns and complaints. Staff will forward all documentation of resolved and unresolved concerns to their manager. Client relations/feedback forms if resolved are to be forwarded to the Quality Manager. Senior Management representative or delegated Manager (CEO) will contact the client to review the concern/complaint. The Senior Manager will collaborate with the client/representative on obtaining a satisfactory resolution to the concern/complaint. The response to the concern/complaint will be documented.

Interview of the CEO indicated that all complaints received are kept off-site and would have to have the complaints brought to the home. The CEO indicated that he was the designated ‘Quality Manager’. The CEO indicated all concerns/complaints are documented on the ‘client relations/feedback form’ which included if complaint was resolved or unresolved, and actions taken to resolve the complaint. The CEO indicated no knowledge of any complaints (verbal or written) received regarding telephone communication in the home.

Review of Family Council meeting minutes (March 23, 2014) indicated "some complaints about voice mail messages not being forwarded in a timely way or calls not being returned". The (former) DOC responded to the concerns by indicating the home would “attempt to get general email address for the 2 charge nurses so that families can have another option to reach nursing staff and remind nurses to check voice mail in a timelier manner".

There was no indication a ‘client relations/feedback form’ was used to document verbal complaints received by the (former) DOC regarding the operation of the home (during Family Council Meeting), the date the complaints were received, or any follow-up action required.

Interview of RN #104 indicated the home had received several verbal complaints from

families and the physicians regarding the telephone system in the home. RN #104 indicated the complaints were regarding the families and physicians not unable to reach the nursing staff in a timely manner. RN #104 indicated approximately a month ago, a 'client relations/feedback form' was completed, forwarded to the interim DOC and RN #104 also spoke to the CEO regarding the family and physician concerns re: telephone system. RN #104 indicated the CEO provided the charge nurse on each floor a cell phone to resolve the concern.

Interview of the interim DOC (I-DOC) indicated a 'client relations/ feedback form' was received from the family of Resident #13 regarding concerns of how messages left at nursing station desk were not responded to in a timely manner. I-DOC indicated the CEO was notified and the family was contacted the following day. A copy of the form was provided to the inspector. The form indicated a verbal complaint from the family of Resident #13 was received regarding the telephone system in the home and how messages are not returned in a timely manner.

The home had received verbal complaints from Family Council (in March 2014) and ongoing from families/physician regarding the operation of the home's telephone system.

Review of the home's complaints from 2014 & 2015 indicated the verbal complaints regarding the telephone system were not documented on 'client relations/feedback forms' until August 12, 2015 and the actions taken by the home were not followed-up to determine if any further actions were required.

There were also two written complaints received by the CEO and did not have a 'client relations/feedback forms' completed, as per the home's policy. [s. 101. (2)]

3. Interview of the CEO on August 20, 2015 indicated there was no documented record (of complaints received) to indicate the complaints are reviewed and analyzed for trends, at least quarterly, the results of the review and analysis are taken into account in determining what improvements are required in the home, and a written record is kept of each review and of the improvements made in response. [s. 101. (3)]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

s. 103. (2) The licensee shall comply with subsection (1) immediately upon completing the licensee's investigation into the complaint, or at an earlier date if required by the Director. O. Reg. 79/10, s. 103 (2).

Findings/Faits saillants :

1. Related to Log #O-001629-15:

The Chief Executive Officer (CEO) and Director of Care (DOC) received a written complaint from the family of Resident #44, the letter indicated that Resident #44 was assaulted by another resident; Resident #44 sustained physical injury, resulting in transfer to hospital and police being involved. In this letter, the family voiced ongoing concern for the safety of Resident #44 as well as others residing within the home.

According to the family of Resident #44, two subsequent letters were sent to the home.

CEO indicated that the Director of Care is responsible for forwarding letters of concern to the Ministry of Health and Long Term Care; CEO indicated it was his understanding the letter was forwarded to MOHLTC.

As of the date of this inspection the letters from the family of Resident #44 has not been received by MOHLTC. [s. 103. (1)]

2. Related to Log #O-001629-15:

The Chief Executive Officer (CEO) indicated no awareness of any submissions being made to the Director specific to the licensee's investigation of the complaint and or the response made to the family of Resident #44. CEO indicated leaving this in the hands of the Director of Care.

As of this inspection, no response specific to family of Resident #44's complaint has been received by the MOHLTC. [s. 103. (2)]

WN #28: 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):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. Related to Log #O-002616-15:

The licensee has failed to comply with O. Reg. 79/10, s. 107 (3) 3, by ensuring 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), a missing or unaccounted for controlled substance.

A concern, surrounding the suspicion of missing or unaccounted for controlled substances, was reported to an inspector during this inspection. It was reported that, controlled substances and other medications were found inside an unoccupied office desk.

The licensee did not report the missing or unaccounted for controlled substances to the Ministry of Health and Long Term Care until the time of this inspection, at which time a Critical Incident Report was submitted and indicated the police was contacted about this incident. [s. 107. (3) 3.]

2. Related to Log #O-000069-14:

Review of the health care record for Resident #34 indicated the resident sustained a fall and was transferred to the hospital for further assessment and treatment. The resident sustained an injury which resulted in a significant change in the resident's health condition.

Interview of the CEO and interim DOC indicated a CIS was not submitted to the Director related to the fall that resulted in injury.

Review of the critical Incident reporting system had no documented evidence a CIS was ever reported to the Director. [s. 107. (3.1)]

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. Related to Resident #32:

The licensee has failed to comply with O. Reg. 79/10, s. 111 (1) (b), by ensuring that a PASD under section 33 of the Act, is applied by staff in accordance with the manufacturer's instructions (if any).

Resident #32 was observed, wearing a seatbelt while in the wheelchair; the seatbelt was observed loosely applied. The seatbelt was approximately 20 cm from resident's waist and resting upon resident's mid-thigh.

PSW #106 indicated being aware that resident utilizes a seatbelt while in wheelchair indicated seatbelt was for safety, as resident has a history of falls and tends to slide forward in wheelchair and thus has slid out of wheelchair with past falls.

PSW #106 further indicated that resident self applies seatbelt; PSW indicated that she herself doesn't normally check to ensure resident seatbelts are securely fastened and or that they are snugly fitting.

RN #104 indicated that if a resident was wearing a seatbelt, that the belt should be properly secured, not loose and that a staff should be only able to fit two fingers between the seatbelt and residents waist/hips. RN #104 indicated no awareness of manufacturer's instructions specific to seatbelt use.

Interim Director of Care and Life Enrichment Program Manager both indicated being unaware of any manufacturer's instructions specific to use of or application of a seatbelt.

Physiotherapist (PT) indicated that a seatbelt should fit snugly against the residents hips, and you should only be able to place 1-2 finger-widths between the resident's hips and the seatbelt; PT indicate the loosely fitting seatbelt being utilized for Resident #32 would not meet with manufacturer's instructions. [s. 111. (2) (b)]

WN #30: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Observation of Resident #07 indicated the resident had an analgesic infusion via an IV pump which was in place at the resident's bedside. The resident indicated inability to self-administer and the medication was
administered/monitored by the Registered Nursing staff.

Interview of RPN #100 indicated the IV analgesic pump is checked at beginning and end of shift by two Registered Nursing staff to determine amount in the bag is accurate.

RPN #100 indicated that the resident receives continuous infusion but also receives additional analgesic as via infusion pump by simply selecting the button on the pump.

Review of the National pharmacy policy manual (pharmacy provider) does not have a policy related to the use of infusion pump systems, the use of a controlled substance through that system, or direction related to the safe storage of the narcotic.

Interview of the interim DOC indicated that the pharmacy provider was not aware of the use of the infusion pump in the home and the home had no policy to ensure the accurate dispensing and storage of a controlled substance by infusion. [s. 114. (2)]

Issued on this 17th day of December, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SAMI JAROUR (570), KELLY BURNS (554), LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2015_327570_0024
Log No. / Registre no:	O-002374-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 6, 2015
Licensee / Titulaire de permis :	HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION 7199 Gelert Road, Box 115, HALIBURTON, ON, K0M-1S0
LTC Home / Foyer de SLD :	HYLAND CREST 6 McPherson Street, P.O. Box 30, Minden, ON, K0M-2K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Varouj Eskedjian

To HALIBURTON HIGHLANDS HEALTH SERVICES CORPORATION, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
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.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that residents who have physical devices including PASDs for the purpose of restraining meet all of the legislated provisions and requirements related to the use of physical devices including PASDs in their plans of care.

The plan shall include:
- training for all staff on the application, assessment, monitoring, repositioning, removal and documentation related to the use of physical devices for the purpose of restraining and legislated requirements.
- a process in place to monitor the effectiveness and to ensure sustained compliance relating to legislative requirements for the use of restraint by physical devices and PASDs
- where bed rails are used, the resident is assessed and his or her bed system is evaluated to minimize risk to the resident.

The plan shall include who shall undertake each item and the date of completion.

The plan is to be submitted in writing to the MOHLTC by October 20, 2015, Attention: Sami Jarour, Fax (613) 569-9670.

While this plan is being prepared, the licensee must ensure the following:
- The home shall identify all residents who are wearing physical devices including PASDs for the purpose of restraining and will ensure that the devices are applied as per manufacturers' instructions.

Grounds / Motifs :

1. Related to Resident #30, #32 and #42:

The licensee has failed to comply with LTCHA, 2007, s. 31, (2), by ensuring 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 area satisfied:
2. Alternatives to restraining the resident have been considered and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other persons provided for in the regulations has ordered or approved the restraining.
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.

Under LTCHA, 2007, s. 33. (1) , this section applies to the use of a PASD if the PASD has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release themselves from the PASD.

Under LTCHA, 2007, s. 33. (2), “PASD” means personal assistance services device, being a device used to assist a person with a routine activity of living.

Related to Resident #30:

Resident #30 was observed to have two ¼ bed rails in place; bed rails were positioned mid bed.

RN #104 and PSW #106 indicated bed rails were used as a PASD, for safety and positioning when Resident #30 is in bed. Both staff indicated that Resident #30 is dependent on staff, and would not be able to release the bed rail independently.

Resident #30's plan of care indicated that PASDs were in place for safety, but were not specific as to which devices were in use.

Upon further review of the clinical health record for Resident #30, there was no documented evidence of alternatives to PASDs having had been tried or considered, of the resident and or substitute decision maker having consented to the use of bed rails as a PASD or that there had been an order by physician, or approved by a registered nursing staff, Physiotherapist or Occupational Therapist for use of the PASD.

Related to Resident #32:

Resident #32 was observed for two days wearing a seatbelt while in the wheelchair. Interview with the resident indicated the seatbelt was used to prevent from falling from the wheelchair.

PSW #106 indicated the seatbelt was used as a safety device to prevent resident from falling and to remind resident to not slide forward in the

wheelchair.

RN #104 indicated not being aware that a seatbelt was being used for Resident #32, but was aware of resident having had recent falls and resident's fear of falling from wheelchair. The RN indicated the use of a seatbelt would be considered a PASD.

A review of the clinical record for Resident #32 failed to provide documented evidence of a seatbelt being used for Resident #32, nor is there documentation of alternatives to PASDs having had been tried or considered, of the resident and or substitute decision maker having consented to the use of a seatbelt as a PASD or that there had been an order by physician, or approved by registered nursing staff, Physiotherapist or Occupational Therapist for use of the PASD.

Related to Resident #42:

Resident #42 was observed to have two ¼ bed rails in place.

RN #104 indicated Resident #42 uses the bed rails as a PASD for safety and repositioning when in bed and further indicated the resident is dependent on staff to release the bed rails.

The plan of care indicated two bed rails are to be up at all times when Resident #42 is in bed.

A review of the clinical health record for Resident #42 failed to provide documented evidence of alternatives to PASDs having had been tried or considered, of the resident and or substitute decision maker having consented to the use of bed rails as a PASD or that there had been an order by physician, or approved by registered nursing staff, Physiotherapist or Occupational Therapist for use of the PASD.

RN #104, indicted seatbelts and bed rails were considered PASDs for Resident #30, #32 and #042, indicating that use of a PASD would require approval by a physician, registered nursing staff, and or physiotherapist (occupational therapist not used at the home) and would require consent by resident or substitute decision maker.

RN #104 confirmed that alternatives to PASDs having had been considered or

tried,approval for use of a PASD and consent for use of a PASD was not in place for Resident #30, #32 and #42.

The licensee further failed to comply with:

- O. Reg. 79/10, s. 15 (1) (a), by ensuring that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the residents (as identified by Written Notification (WN) #17);

- O. Reg. 79/10, s. 111 (2) (b), by ensuring that a PASD used under section 33, of the Act, is applied by staff in accordance with any manufacturer's instructions (as identified by WN #29);

- O. Reg. 79/10, s. 221 (1) subsections 5 and 6, by ensuring that for staff, who apply physical devices or PASDs, or who monitor residents restrained by physical devices or PASDs, are provided training in the application, use and potential dangers of these physical devices or PASDs (as identified by WN #16).

As a result of reviewing the severity and scope of the findings and the home's compliance history, the Inspector identified that a compliance order was warranted. During the initial stage of the Resident Quality Inspection, three resident's triggered as having potential restraints; of the identified resident's, all three were observed using physical devices that have the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release themselves from the physical device (e.g. bed rails and or a seatbelt). A review of the clinical health record for Resident #30, 32 and #42 all failed to provide documented evidence of the alternatives to restraints and or PASDs being considered or tried, orders or approval for use nor was there consent by the resident and or substitute decision maker; Discussion with Registered Nursing Staff and Interim Director of Care, indicated the home currently does not assess use of bed rails nor have staff who apply and monitor physical devices (restraints and or PASDs) been trained in the application, use and potential dangers associated with use of these physical devices.

The home's compliance history was reviewed for the past three years; LTCHA, 2007, s. 31 (2), was previously issued as a Voluntary Plan of Correction (VPC)

during Resident Quality Inspection #2014_360111_0026. (554)

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 86. (3) The licensee shall ensure that the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations. 2007, c. 8, s. 86. (3).

Order / Ordre :

The licensee will prepare, implement and submit a plan for achieving compliance to ensure that the infection prevention and control program and what is provided for under that program, including the matters under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations.

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

The plan shall include:
- Policies and procedures are in accordance with evidence-based best practices for the cleaning, disinfection and sterilization of all resident care equipment, especially nail clippers, are to be implemented immediately;
- Policies and procedures relating to Tuberculosis (TB) screening protocols and all other resident vaccination are to be in keeping with Provincial Infectious Diseases Advisory Committee (PIDAC), other best practice guidelines and/or publicly funded immunization schedules posted on MOHLTC website, to be implemented immediately;
- Staff who are involved in the reprocessing of shared or reusable resident care equipment are to be trained on the policies, including correct use of any chemical or equipment as per manufacturer's directions, which must be identified for product use;
- Registered Nursing staff and Nursing Management are to be provided training

specific to the home's policies and procedures, relating to TB screening for all resident's admitted to long-term care, and offering of, consent and administration of resident immunization
- a process in place to monitor the effectiveness and to ensure sustained compliance relating to cleaning, disinfection and sterilization;
- a process in place to ensure that TB screening is being completed within 14 days of admission and all negative outcomes are reported to the physician, so that follow up as needed can be completed within appropriate time frames;
- all residents are offered immunization and if the resident and or substitute decision maker consents to such that the vaccination will be administered in accordance with physician's orders.

The plan shall include who shall undertake each item and the date of completion.

The plan is to be submitted in writing to the MOHLTC by October 20, 2015, Attention: Sami Jarour, Fax (613) 569-9670.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, s. 86 (3), by ensuring the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations.

Under LTCHA, 2007, s. 86 (1), every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home.

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

During the initial tour of the home, four of the four tub/shower rooms were observed to have three to five sets of nail clippers on counter-tops; the nail clippers were unlabelled and the nail clippers contained nail clippings.

PSW #103 indicated that residents were not provided individual nail clippers for personal use and that communal nail clippers were used by the home in the provision of nail care to all residents; PSW #103 indicated being unsure of how the communal nail clippers are cleaned. PSW #103 indicated bringing her own

nail clippers from home for use with resident care.

RN #104 indicated no awareness if nail clippers are individually assigned to each resident or how nail clippers are cleaned.

Interim Director of Care and Interim Assistant Director of Care indicated that the expectation would be for all resident's to have their own nail clippers but was unsure if such was the practice within the home. Currently the home has no policy or procedure specific to nail clippers being assigned individually to residents or no policy or procedure specific to the cleaning of nail clippers.

Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment and Devices in All Health Care Settings, 3rd Edition, Provincial Infectious Diseases Advisory Committee (PIDAC) is the prevailing best practice document in Ontario for the reprocessing of shared and/or re-usable resident care equipment. Critical equipment/devices include foot care instruments and any instruments that enter sterile tissues, including the vascular system. These items present a high risk of infection if the equipment/device is contaminated with any microorganism, including bacterial spores. Reprocessing critical equipment/devices involve meticulous cleaning followed by sterilization. Semi critical equipment/devices include shared use nail clippers. Reprocessing semi-critical equipment/devices involves meticulous cleaning followed by, a minimum, high-level disinfection.

Measures are not in place for the cleaning, disinfection or sterilization of re-usable and/or shared resident equipment (e.g. nail clippers) which poses a potential cross infection risk to residents.

2. Related to Resident(s) #21, 28, 29, 48 and #49:

Under O. Reg. 79/10, s. 229 (10) 1, the licensee shall ensure each resident admitted to the home screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

The LTCH Licensee Confirmation Checklist-Infection Prevention and Control, provided to the home by the inspector during the initial tour, and signed by the Interim Director of Care on identified date, indicated the following:

-TB screening done for residents in your long term care home (LTCH) was, chest x-ray within 6 months of admission for all residents 65 years and older; and TST testing for all residents under 65 years of age.

A random review of the clinical health record (including CCAC admission package, status report, immunization history, progress notes, physician's orders, diagnostic imaging (CXR), and medication administration records) for five residents (over 65years) admitted to the home in 2015 indicated no TB screening had been completed within 14 days.

Review of the following resident's files indicated the following:
- Resident #020, there is no CXR or other TB screening on file;
- Resident #021, there is no CXR or other TB screening on file;
- Resident #028, there is no TB screening on file;
- Resident #029, there is no CXR or other TB screening on file;
- Resident #048, there is no TB screening on file;
- Resident #049, there is no TB screening on file.

Interim Director of Care, and Interim Assistant Director of Care indicated that they believed that the process is that there is to be a discussion with CCAC prior to new residents being admitted to the home that resident was to have a chest x-ray prior to admission; and if the chest X-ray had not been completed, that upon arrival to the home,
physician orders would be obtained for a chest x-ray or TST testing as part of the home's screening protocol for tuberculosis.

The Interim Director of Care indicated that the home follows the recommendations of the Public Health Unit and PIDAC; Interim DOC indicated she wasn't aware that chest XRays were to be within 90 days, but thought 6 months. Interim DOC indicated the TB screening policy is currently being updated to reflect best practice guidelines.

RN #104 and RPN #115 indicated the home has no current process for ensuring TB screening has been completed within 14 days of admission.

The Interim Director of Care, RN #104 and RPN #115 all indicated no awareness of the above five residents not having TB screening completed.

In accordance with Canadian Tuberculosis Standards, 7th Edition, The

Haliburton, Kawartha, Pine Ridge District Health Unit recommends that all new residents be screened for active disease within 90 days prior to admission or within 14 days after admission. It is recommended that this assessment include, a system review for active TB disease; a chest x-ray (posterior-anterior and lateral) taken within 90 days prior to admission to the facility; if signs and symptoms and or chest x-ray indicate potential pulmonary TB disease, the resident should not be admitted to the home until thee sputum samples taken at least one hour apart and submitted to the Public Health Lab for testing (Acid Fast Bacilli and Culture) are negative. In addition to the above, any residents < 65 years of age who are previously skin test negative should receive a 2-step TST.

The home's policy, Surveillance, Tuberculosis, has not been updated to reflect best practice based on Canadian Tuberculosis standards, nor are there measures in place and/or monitored for Tuberculosis (TB) screening requirements, for residents being admitted to the home, which poses a potential cross infection risk to residents.

3. Related to Resident(s) #26, 29, 48 and #49:

Under O. Reg. 79/10, s. 229 (1) (3), the licensee shall ensure residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

A random review of five resident's clinical health record, including CCAC packages, immunizations records (historical and current), medication administration records, progress notes, failed to provide documentation that four of the five residents were provided immunization specific to Pneumococcal and or Tetanus /Diphtheria (Td). The following was noted:
- Residents #26, 29, 48, and 49, on admission, consented and signed the Authorization and Consent to Treatment specific to having pneumococcal and tetanus/ diphtheria (Td). These residents have not received pneumococcal and Td immunization, despite consenting to such.

RN #104 and RPN #115 indicated that upon admission residents are offered immunizations and if consent is received the immunizations will be given to the resident. Registered Nursing Staff both indicated that there is no process as to when the immunizations will be given or who is responsible to immunize the

resident.

RN #104, RPN #115 and Interim Director of Care, all, indicated no awareness of resident immunizations (pneumococcal and Td) not being current as per resident or SDMs' consent.

The home's policy, Pneumococcal Vaccine, Patient Administration, directs that all patients and residents of LTC (long-term care) with an expected length of stay of three or more months should be offered this vaccine; consent will be obtained from the patient/resident or substitute decision maker (SDM) or Public Trustee; a physician's order
will be obtained and vaccine administered.

Interim Director of Care indicated that the home currently does not have a policy in place for the administration of Td (tetanus) vaccination. Interim Director of Care indicated that normally, residents in the home are not provided with a Td vaccination, unless the resident has cut themselves and then the vaccination would be administered in the emergency department.

Measures are not in place to ensure vaccines consented to by residents or SDM's are administered, which poses a potential secondary infection risk to residents.

LTCHA, 2007, s. 86, was previously issued as a Voluntary Plan of Correction (VPC) during Inspection #2013_178102_0021. (554)

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, s. 20 to ensure that the home's written policy that promotes zero tolerance of abuse and neglect is revised and complied with.

This plan shall include:
-Review and revise the home's policy "Prevention of Abuse and Neglect of Residents" to include all alleged, suspected, and witnessed incidents of abuse; contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate, identifying measures and strategies to prevent abuse and neglect (as the policy only provided procedures after the incidents occur); identifying the training and retraining requirements for all staff, including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations.
-A mandatory, comprehensive and interactive education session for all direct care staff offered in various formats to meet the learning needs of adult learners on all forms of abuse and or neglect, mandatory reporting, and the revised home's policy "Prevention of Abuse and Neglect of Residents". As well as defined interventions to support staff in the integration of this education into their day to day practice,
-A system to monitor and evaluate staff adherence to the revised home's policy "Prevention of Abuse and Neglect of Residents".
- A system to monitor and ensure that all staff complete the Licensee's retraining requirements on an annual basis in areas as specified under s.76 (2) of the LTCHA, 2007.

The plan shall include who shall undertake each item and the date of completion.

The plan is to be submitted in writing to the MOHLTC by October 20, 2015, Attention: Sami Jarour, Fax (613) 569-9670.

Grounds / Motifs :

1. Related to Log #O-001629-15:

The licensee has failed to comply with LTCHA, 2007, s. 20 (1), by ensuring the written policy that promotes zero tolerance of abuse and neglect is complied

with.

A review of the home's policy, Abuse and Neglect of a Resident-Actual or suspected (#VII-G-10.00, last revised February 2014) directs the following:
-when the staff member (or volunteer) becomes aware of potential or actual abuse, the following steps must be taken: safe guard the resident immediately, notify the charge nurse.
-the charge nurse will assess the resident for injuries and provide medical intervention if indicated, notify the RN, and initiate the nursing checklist. The checklist includes: interview and request written account of all possible witnesses,
-upon hire and annually thereafter, all staff and volunteers will receive in-service education on the topic of abuse and the reporting of abuse.

The Director of Care submitted a Critical Incident Report, specific to an incident of resident to resident physical abuse.

Progress notes indicated that Resident #44 was pushed to the floor by Resident #08; Resident #44 sustained injury; following an assessment by Registered Practical Nurse #115, the resident was taken to hospital for assessment and treatment.

Registered Practical Nurse #115 indicated that the Registered Nurse was not notified of the abuse incident until after Resident #44 was transferred to hospital.

Interim Director of Care and Chief Executive Officer indicated having no documentation as to the home's investigation of this resident to resident abuse incident.

The home's policy was not complied with as indicated by the following:
- Registered Practical Nurse #115 did not notify the Registered Nurse of Resident #44 requiring medical intervention until after resident was transferred to hospital;
- RPN #115 indicated not initiating the Nursing Checklist for Reporting and Investigating Alleged Abuse; nor is there documented evidence of this form being completed by the Registered Nurse, or Director of Nursing following the report of abuse incident;
- There is no documentation that witnesses of the alleged abuse incident or the resident #44 were interviewed;

- Interim Director of Care indicated that not all employees were provided education in 2014 specific to zero tolerance of abuse.

Interim Director of Care indicated it is an expectation that the home's policies be followed.

The licensee has failed to comply with LTCHA, 2007, s. 20 (2), by ensuring that the policy to promote zero tolerance of abuse and neglect of residents shall, include all the requirements listed under subsection (2) (a) to (h).

A review of the home's policy, Abuse and Neglect of a Resident- Actual or Suspected (#VII-G-10.00, last revision February 2014) identified that the policy fails to contain:
- (c) provide for a program that complies with the regulations, for preventing abuse and neglect of a resident, as the homes policy did not address alleged incidents of abuse or neglect; nor does the policy include what actions to take when abuse of a resident is by another resident; or long term actions to be taken to prevent a reoccurrence.
- (d) an explanation of the duty under Section 24 of the Act to make mandatory reports.

Interview with Interim Director of Care and CEO, both were unable to provide documented evidence of the home's policy, Abuse and Neglect of a Resident- Actual or Suspected being revised, following February 2014.

The licensee further failed to comply with:

- LTCHA, s. 79 (3), by ensuring the long term care home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home (as identified in Written Notification (WN) #13);

- LTCHA, s. 76. Training Specifically failed to comply with the following: s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations (as identified in WN #21);

- O.Reg 79/10, s. 96. Policy to promote zero tolerance. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20

of the Act to promote zero tolerance of abuse and neglect of residents,
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg.79/10, s. 96. (as identified in WN #23)

- O. Reg. 79/10, s. 97 (2), by ensuring that the resident and resident's substitute decision maker were notified of the alleged abuse investigation immediately upon completion (as identified in WN #24)

- O. Reg. 79/10, s. 99 (b), by ensuring that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences (as identified in WN #25)

As a result of reviewing the severity and scope of the findings and the home's compliance history of ongoing noncompliance related to policy to promote zero tolerance of abuse and neglect not being revised and complied with, a compliance order was warranted.

LTCHA, 2007, s. 20 (1) and s.20 (2) were previously issued as a Written Notification, linked to Compliance Order #001 issued under LTCHA, 2007, s. 19, duty to protect, during Resident Quality Inspection #2014_360111_0026 conducted on October 2014. (570)

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

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 s.6(7) to ensure the care set out in the plan of care is provided to the resident, as specified in the plan, related to falls management, pain management, treatments, and continence care.

The plan shall include:
- review and revision of the plan of care for Resident #34 to ensure the plan is based on the resident's assessed needs, related to falls risk, pain management, continence care, and treatments to be provided.
- review and revise the plan of care of all residents who have needs in relation to falls prevention, pain management and continence care to ensure the plan of care is based on their assessed needs.
- retrain Registered Nursing staff on the following: the home's pharmacy policy for receiving & transcribing physician orders, the home's policy on Pain Management, Falls Prevention and Management, and Continence Care.
- a process to be put in place to ensure compliance with the home's policies

The plan shall include who shall undertake each item and the date of completion.

The plan is to be submitted in writing to the MOHLTC by October 20, 2015, Attention: Sami Jarour, Fax (613) 569-9670.

Grounds / Motifs :

1. The licensee has failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan related to falls, pain, treatments, and continence care.

Related to Log # O-000069-14:

Review of the progress notes for Resident #34 for a two month period indicated:
-On a specified date, the resident sustained an unwitnessed fall with no injury.
-Two days later, the resident began complaining of pain to a specified area, and began having pain related to urinary changes. The resident was sent to hospital for assessment and returned from hospital with a mobilizing device and a diagnostic treatment and test to be completed related to the urinary changes. The treatment and test was not transcribed. The diagnostic treatment and test was not completed until the following day.
-The resident continued to have the urinary changes and two weeks later, the physician ordered the initial diagnostic treatment discontinued and additional diagnostic testing related to the urinary changes. The diagnostic treatment was not discontinued until two days later. Two weeks later, the physician ordered three specific diagnostic tests to be completed. The documentation indicated the second diagnostic test was completed but there was no indication the first test was completed.
-The following month, a verbal order was received by the physician for further diagnostic tests to be completed related to the urinary changes. There was no documented evidence the physician's order was transcribed and no documented evidence of the results for that diagnostic test.

As a result of reviewing the severity related to potential of actual harm to Resident #34 when care was not provided to the resident as specified in the plan of care, and the home's compliance history of ongoing noncompliance related to LTCHA, 2007, s. 6 (7), a compliance order was warranted.

The home's compliance history was reviewed for the past three years; LTCHA, 2007, s. 6 (7), was previously issued as a Voluntary Plan of Correction (VPC) during complaint inspection # 2012_031194_0046 on October 10, 2012, and inspection # 2013_031194_0030 on August 26, 2013.
(111)

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance to ensure that behavioural triggers are identified and strategies developed to respond to responsive behaviours exhibited by Residents #08, #35, and #37 and any other resident. The licensee will further ensure that actions taken to respond to the needs of Residents #08, #35 and #37, including assessments, reassessments, interventions and that the residents' responses to the interventions are documented.

The plan shall include:
- review and revise the plan of care for Residents #08, #35 and #37 to ensure that behavioural triggers are identified and strategies developed to respond to responsive behaviours exhibited by the residents.
- how and when the home will seek appropriate support if implemented strategies provided prove to be ineffective.
- a process for monitoring to ensure that assessments, reassessments and planned interventions for responding to responsive behaviours are implemented by staff and the effect of the interventions is documented.
- a process to ensure Responsive Behaviour Program is evaluated annually and updated in accordance with evidence-based practices.

The plan shall include who shall undertake each item and the date of completion.

The plan is to be submitted in writing to the MOHLTC by October 20, 2015, Attention: Sami Jarour, Fax (613) 569-9670.

Grounds / Motifs :

1. Related to Resident #35:

The licensee has failed to ensure that the behavioural triggers were identified for Residents #35 and #37in response to the resident's responsive behaviours, and strategies were developed and implemented to respond to the resident's responsive behaviours.

Related to Resident #35:

Review of Resident #35's health care record indicated the resident was admitted with a cognitive impairment.

Review of progress notes for Resident #35 for 6 months period indicated the resident demonstrated the following responsive behaviours:
-increased agitated behaviours during meal times,
-throwing dishes at meal time,
-taking food from other residents,
-attempting to strike out at other residents,
-threatening and striking out at staff,
- wandering/pacing in the hallways at night.

Review of the plan of care for Resident #35 indicated the resident demonstrated responsive behaviours including verbal/physical aggression, resistance to treatment and personal care, screaming, and wandering and cognitive impairment.

The progress notes and plan of care for Resident #35 did not identify the behavioural triggers and strategies to respond to the resident's responsive behaviours.

There was no referral for additional behavioural support to manage Resident #35's responsive behaviours.

Related to Resident #37:

Review of Resident #37 health care record indicated the resident has a diagnosis of cognitive impairment.

Review of progress notes for Resident #37 for 4 months indicated the following documented responsive behaviours demonstrated by Resident #37:
- agitated behaviour was documented more than 20 times
- yelling/screaming/calling out behaviour was documented more than 43 times and the resident was disruptive to roommate and other residents more than 13 times.
- swinging/waving arms while yelling aloud was documented 3 times.

Review of clinical documentation indicated staff noted the resident was calling out when thirsty or hungry.

The plan of care for Resident #37, indicated the following focus areas related to

responsive behaviours:
- Verbal/ physical Aggression related to: sensory deficits and anger.
- Agitation related to: frustration, constant yelling, cognitive impairment,
- Anxiety related to: loss of control
- Resistive to treatment/care related to: cognitive Impairment and depression.
- Repetitive actions related to: cognitive impairment

Interventions included under agitation focus related to frustration, constant yelling, cognitive impairment, and vision impairment, included:
- Give medication as prescribed by MD
- Keep schedules routine & predictable.
- Place headphones on and listen to music
- Praise/ reward resident for demonstrating consistent desired/ acceptable behavior.
- Remove resident from public area when behavior is disruptive/ unacceptable.
- Talk with resident in a low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity.

The plan of care for Resident #37 did not identify the behavioural triggers and strategies to respond to the resident's responsive behaviours identified as agitation and yelling/screaming/calling out though an entry in the progress notes indicated the resident was quiet other than when thirsty or hungry. Resident #37's plan of care did not identify thirst and/or hunger or any other triggers of yelling/calling out and there was no referral for additional behavioural support to manage Resident #37's responsive behaviours.

Related to Log #O-001629-15 for Resident #08:

The licensee failed to comply with O. Reg. 79/10, s. 53 (4) (c), by ensuring that actions taken to meet the needs of the resident with responsive behaviours include, reassessments, interventions and documentation of resident's response to the interventions.

Resident #08 has a diagnosis that includes cognitive impairment, mood and behavioural disorders.

Interviews with RPN #115 and #130 and RN #104 all indicated Resident #08 lacks judgement and insight; resident does not know the difference between right or wrong.

According to registered nursing staff and personal support workers interviewed, Resident #08 exhibits several responsive behaviours, including pacing, wandering, restlessness, physical aggression intrusiveness, anxiety, agitation, takes things from other residents and staff and resistance to care.

A review of the progress notes for the period of two months indicated Resident #08 exhibited the following responsive behaviours, pacing running' in the halls, wandering, exit seeking, going into and out of other residents rooms, , hovering, removing articles from the medication cart and from co-residents, resistance to care, physical aggression, agitation.

There were approximately 131 progress notes detailing responsive behaviours exhibited by Resident #08.

Progress notes, reviewed during the above time period indicated that interventions initiated by staff when Resident #08 was exhibiting responsive behaviours, were to redirect resident (using 1-2 staff), encourage resident to go back to bed, to place resident into Broda chair with table top and a magazine, locked out of dining room or to administer 'as needed' medication; the majority of progress notes reviewed, indicated that the intervention utilized was to administer the 'as needed' medications for anxiety or agitation.

Progress notes reviewed indicated interventions tried, including 'as needed medications' were often ineffective and as per registered nursing staff, medications seemed to escalate Resident #08's responsive behaviours. Progress notes, indicated that when the 'as needed' medication was noted as 'ineffective', no other interventions were documented as tried; the responsive behaviour of Resident #08 continued.

Other progress notes, during this period failed to provide evidence of actions that staff took during times when Resident #08 exhibited responsive behaviours and failed to identify the response of the resident during this same time period.

Interviews, with registered nursing staff and personal support workers indicated Resident #08 was intrusive, and impulsive; staff commented that Resident #08's behaviours were unpredictable in nature.

Staff, interviewed, indicated Resident #08 became increasingly disruptive to the

resident home area and the responsive behaviours placed the resident and others at risk for safety.

The licensee further failed to comply with:

-O. Reg. 79/10, s. 53 (3) (b), by ensuring the Responsive Behaviour Program is being evaluated annually and updated in accordance with evidence-based practices (as identified by WN #5);

- O. Reg. 79/10, s. 54 (a), by ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations (as identified by WN #20)

As a result of reviewing the severity and scope of the findings and the home's compliance history of ongoing noncompliance related to residents with responsive behaviours where behavioural triggers were not identified and strategies were not developed and implemented to respond to the residents' responsive behaviours, a compliance order was warranted.

O. Reg. 79/10, s. 53 (1)1, s. 53 (4)(a), and s. 53 (4)(b), were previously issued as Written Notifications, linked to Compliance Order #001 issued under LTCHA, 2007, s. 19, duty to protect, during Resident Quality Inspection #2014_360111_0026, which took place October 2014. (570)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 6th day of October, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Sami Jarour

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