Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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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
Sep 23, 2016	2016_343585_0013	024795-16	Resident Quality Inspection

Licensee/Titulaire de permis

IDLEWYLD MANOR
449 SANATORIUM ROAD HAMILTON ON L9C 2A7

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

IDLEWYLD MANOR
449 SANATORIUM ROAD HAMILTON ON L9C 2A7

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

LEAH CURLE (585), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581)

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 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, 30, 31 and September 1, 2016.

Concurrent to the Resident Quality Inspection (RQI), 18 addition inspections were completed, including three follow-ups from inspection #2015_240506_0030: log #035240-15, s. 6. (10)(b) under the Long-Term Care Homes Act (LTCHA) 2007 regarding responsive behaviours, safety, lifts and transfers, toileting, restraints and changes in condition; s. 26 (4) under Ontario Regulation (O. Reg.) 79/10, regarding hydration assessments; and s. 110. (1) under O. Reg. 79/10, regarding application of physical devices, two complaint inspections log #012602-16 regarding admissions and 019523-16 regarding responsive behaviours and abuse; and, thirteen critical incident inspections (CIS): log #000414-16, #012826-16 and #013666-16 related to injury, log #018700-16 and #025385-16 regarding abuse, log #002910-14, #003147-16, #015107-16, #016900-16, #006259-16, #018162-16, #018593-16 and #019330-16 regarding responsive behaviours.

During the course of the inspection, the inspector(s) spoke with residents, families, registered staff, personal support workers (PSWs), dietary staff, laundry staff, administrative staff, the Resident Assessment Instrument (RAI) coordinator, Registered Dietitian (RD), Physiotherapist (PT), Physiotherapy Assistant (PTA), Accountant, Manager of Recreation and Volunteer Services, Food Service Manager (FSM), Assistant Food Service Manager (AFSM), Director of Nursing (DON), Manager of Program Development (MPD), Administrative Assistant and the Executive Director (ED).

During the course of the inspection, the inspector(s) toured the home, observed care and services provided to residents, reviewed relevant documents, including but not limited to: resident health records, dietary records, logs, critical incident system reports/documentation, policies, meeting minutes, training and quality improvement records as well as staffing schedules and files.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 26. (4)	CO #002	2015_240506_0030	585
LTCHA, 2007 s. 6. (10)	CO #001	2015_240506_0030	528 581 585

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. 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).

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

Findings/Faits saillants :

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

A) Resident #012's Minimum Data Set (MDS) assessments for January and April 2016, identified that they had an infection during both periods. Review of the registered staff assessments and documentation revealed that they only displayed symptoms of infection in April 2016. Interview with registered staff #100 confirmed that the resident did not have an illness in January 2016, and the infection was coded in error. The resident's MDS assessment from January 2016, was not consistent with registered staff assessments in relation to infection.

B) Resident #013's MDS assessment for May 2016, identified that they had an infection.

Review of the registered staff assessment in progress notes did not include any symptoms of infection or investigations related to infection during the assessment period. Interview with registered staff #100 confirmed that the resident did not have an infection in May 2016, and the MDS assessment was not consistent with registered staff daily assessments of the resident.

C) On an identified date in April 2016, resident #060 was diagnosed with an injury. Review of their MDS assessment completed on an identified date in April 2016, did not identify that they experienced an injury in the last 180 days and that they had pain. Further review of their clinical record revealed that another assessment, completed the day prior to the MDS assessment, identified they experienced increased pain and had a change in their interventions for pain management due to the injury. Interview with registered staff #101 confirmed that the assessments were not consistent with each other.

D) Resident #001's MDS assessments for March and June 2016, identified they used one type of ambulation device as their primary source of locomotion. Review of the resident's written plan of care revealed that they required a different type of ambulation device. During the course of the inspection, the resident was observed using the ambulation device as specified in their written plan of care. Personal support worker (PSW) #126 and registered staff #128 reported in interviews that the resident's primary ambulation device was the one as outlined in the written plan of care and registered staff #128 confirmed the MDS assessment and written plan of care were not consistent with each other.

E) Resident #014's MDS assessment completed in June 2015, indicated they were incontinent. In September 2015, their MDS assessment noted they were frequently incontinent. Interview with the registered staff #101 stated there was an improvement in their continence between quarterly assessments; however, was coded as no change, and confirmed the assessments were not consistent with each other.

F) Resident #004's MDS assessment completed in June 2016, indicated they were occasionally continent. Review of Point of Care (POC) documentation in June 2016, identified they were continent. Interview with registered staff #101 stated the resident was continent during the assessment review date (ARD) and confirmed the POC and the MDS assessments were not consistent with each other.

G) Resident #004's MDS assessment completed in June 2016, indicated they required

assistance for transferring. Review of a Transfer Assessment completed in July 2016, identified they transferred independently and used an ambulation device. Review of the written plan of care indicated they transferred with assistance of staff. Interview with PSW #154 stated the resident transferred with assistance but would also self-transfer. Interview with registered staff #123 stated the resident required different levels of assistance depending on the day. Review of the POC during the MDS ARD look-back period in June 2016, indicated the resident transferred with no assistance to total dependence. Registered staff #123 stated the Transfer Assessment should have been completed for all the transfers they required and confirmed that the Transfer Assessment and the MDS assessment from June 2016, were not consistent with each other.

H) Resident #064's MDS assessment completed in January 2016, identified they demonstrated behaviours which were easily altered. Review of the MDS assessment completed in April 2016, identified they demonstrated behaviours which were not easily altered; however, was noted as having no change in their behavioural symptoms. Interview with registered staff #101 confirmed that the resident's behavioural status had deteriorated and the MDS assessments were not consistent with each other.

I) Resident #062's Transfer Assessment completed in June 2016, identified they were transferred using one type of transferring device for all transfers. Review of POC documentation indicated they were required a different level of assistance and transferring device. Registered staff #157 reported the resident transferred using the device as indicated in POC documentation. Registered staff #157 confirmed that the two assessments were not consistent with each other. [s. 6. (4) (a)]

2. The licensee failed to ensure that the plan of care was not provided to the resident as specified in the plan.

The home's policy, "Bowel Continence Care Protocol", included a Bowel Protocol Medication Directive outlined the following Treatment of Acute and/ or Chronic Constipation:

i. If no bowel movement for two days, registered staff to administer fiber-rite at breakfast and an additional 125 millilitres (mLs) of fluid each shift; to continue to provide if no bowel movement on days three, four and five.
ii. If no bowel movement on day three, milk of magnesia administered at bedtime, to be given again in the morning if no bowel movement on day four.
iii. If no bowel movement on day four, dulcolax suppository to be given at bedtime.

iv. If no bowel movement on day five, rectal exam followed by dulcolox suppository in the morning. If not effective, assess for bowel sounds. If no bowel sounds insert one fleet enema. Physician to be contacted if ineffective.

A) Resident #010's plan of care identified they had an order to receive the bowel protocol medical directive as outlined above. Review of the resident's bowel movement sheets and electronic medical directive records identified that in June and July 2016, registered staff did not implement day two interventions on six occasions when the resident had no bowel movement for two days. Interview with registered staff #120 and the Director of Nursing (DON) confirmed that the bowel protocol was not administered when the resident did not have a bowel movement for two days.

B) Resident #004's plan of care identified they were on the bowel protocol. Interview with PSW #110 stated staff documented the resident's bowel movements after each shift on the bowel movement sheet as well as in POC. Review of the bowel movement sheets from June to August 2016, which identified when resident #004 did not have a bowel movement on day one, two, three and four. Bowel protocol interventions, which were documented under medical directives and interventions, were to be administered by the registered staff after reviewing the PSW's documentation of the number of days the resident did not have a bowel movement. Review of the bowel protocol identified the protocol was not followed and interventions were not administered on 29 occasions. Interview with registered staff #123 confirmed that the bowel protocol was not followed when the resident did not have a bowel movement on day two, three and four and the care set out in the plan of care was not provided to the resident as specified in the plan.

C) In August 2016, resident #042 had a bowel treatment plan ordered. Review of the bowel movement records and electronic medical directive records, identified that in August 2016, bowel protocol was not followed on two occasions. Interview with registered staff #136 confirmed bowel treatment was not administered as ordered when the resident did not have a bowel movement.

D) Resident #048's clinical record revealed that their physician ordered a specific bowel intervention. In May 2016, review of the bowel movement sheet and electronic medication administration record (eMAR) revealed the resident did not receive the bowel intervention as directed. Interview with registered staff #136 confirmed that the intervention was not given as ordered; therefore, care was not provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

A) Resident #001's written plan of care indicated they required a specified transfer device with two staff for transfer in and out of bed. Interview with PSW #126 and PSW #127 stated the resident was transferred out of bed with one specified transfer device and occasionally would transfer with assistance with two staff and was transferred back to bed with a different specified transfer device. Interview with registered staff #128 stated the resident required one of the specified transfer devices for all transfers when they were weaker and confirmed that the plan of care was not reviewed and revised when their care needs changed.

B) On two identified dates in August 2016, resident #006 fell and sustained minor injuries. Review of the progress notes indicated that a falls intervention device was implemented after the second fall. Observation of the resident's room and interview with PSW #133 revealed that the falls intervention device was implemented. Interview with registered staff #120 confirmed the falls intervention was in place; however, the written plan of care was not reviewed and revised when their care needs changed.

C) Resident #004's written plan of care indicated they used a specific falls intervention device. Interview with PSW #153 stated they used the device, as well as an additional device for falls management and prevention. Interview with registered staff #123 stated the resident used both devices and confirmed the written plan of care was not reviewed and revised when the second device was required for falls prevention.

D) On an identified date in December 2015, resident #062 experienced a fall that resulted in injury. Review of their written plan of care at the time of the inspection identified they were dependent for mobility, had one intervention on hold and required a transfer device for all transfers. Interview with PSW #110 who stated the resident was no longer totally dependent for mobility, the intervention was no longer on hold and they self-transferred for one activity of daily living (ADL). Interview with registered staff #123 stated that the resident required more care after their injury; however, their plan of care was not reviewed and revised when their care needs improved.

E) In February and March 2016, resident #064 exhibited an increase in responsive behaviours. According to progress notes, a specific intervention was implemented to manage the behaviours. Review of their written plan of care did not identify that the specific intervention was in place. Interview with registered staff #103 stated the

intervention was in place; however, confirmed that the written plan of care was not reviewed and revised when the intervention was implemented. [s. 6. (10) (b)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

A) Resident #004's plan of care identified they were at nutrition risk and had an individual daily fluid requirement, as confirmed by the Registered Dietitian (RD). Review of their fluid intake look back report from a period between June to August 2016, revealed they did not meet their fluid requirement on 61 out of 63 days.

i. In June 2016, a monthly progress note completed by registered nursing staff did not include an assessment of whether their hydration goals were met as per their plan of care.
ii. In June 2016, the RD noted in an annual nutrition assessment that the resident was not meeting their daily calculated fluid requirement and did not implement a hydration strategy.
iii. The resident's plan of care indicated they had a specific hydration intervention to receive 250 mL of water at meals; however, the RD confirmed it was not a hydration intervention as it was standard practice that all residents be offered 250 mL of water at meals.
iv. Interview with PSW #105 and PSW #110 reported the resident had poor fluid intake.
v. Registered staff #119 reported referrals to the RD were made based on clinical judgement, that the home had no specific criteria for placing referrals and was unaware of residents having specific fluid goals.

The RD reported they did not receive a referral to assess the resident's hydration status since May 2016, and confirmed the resident was not reassessed nor was their plan of care reviewed and revised at when care set out in the plan had been ineffective.

B) Resident #006's plan of care identified they were at nutrition risk and had an individual daily fluid requirement, as confirmed by the RD. Review of their fluid intake look back report from a period between June to August 2016, revealed they did not meet their requirement on 61 out of 63 days.

i. On an identified date in February 2016, the RD documented in a progress note that the resident was not meeting their fluid requirement and would continue to monitor; however,

at the time of the inspection, the RD confirmed they had not reassessed the resident regarding their hydration status.
ii. On an identified date in April 2016, an assistant food service manager (AFSM) documented the resident was not meeting their daily fluid requirement and did not implement a hydration intervention.
iii. On an identified date in June 2016, a monthly progress note competed by registered nursing staff stated the resident usually consumed foods and fluids well; however, PSW documentation indicated the resident was not meeting their hydration requirement.
iv. On an identified date in July 2016, a monthly progress note stated the resident's intake was well; however, PSW documentation indicated the resident was not meeting their hydration requirement.
v. On an identified date in August 2016, an AFSM noted in a quarterly nutrition assessment that the resident was not meeting their daily calculated fluid requirement and implemented an intervention to receive 250 mL of water at meals.
vi. Interview with PSW #108 and PSW #109 reported the resident did not always consume fluids at nourishment.

The RD reported no individualized hydration intervention had been implemented for the resident as water at meals was provided to all residents. The RD confirmed the resident was not reassessed when the care set out in their plan of care had not been effective.

C) Resident #005's plan of care identified they were at nutrition risk and had an individual fluid requirement per day, as confirmed by the RD. Review of their fluid intake look back report from a period in July and August 2016, revealed they did not meet their fluid requirement on 16 out of 26 days, which included a period of 11 consecutive days. Interview with PSW #105 and PSW #110 reported the resident's fluid intake fluctuated. Review of the home's documentation revealed the resident's hydration status was last assessed on a identified date in July 2016, where registered staff documented that the resident drank well; however, no reassessment was completed when the resident was not meeting their fluid requirement, as confirmed by the RD. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, that the care set out in the plan of care is provided to the resident as specified in the plan and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the physical device was applied in accordance with the manufacturer's instructions.

On an identified date in August 2016, resident #005 was observed with a physical device applied more than four finger widths from their body. Interview with registered staff #123 confirmed the physical device was too loose, was a restraint and not applied according to manufacturer's guidelines. The physical device was adjusted to two finger widths from their body by Shoppers Home Health service provider who stated that the manufacturer's guidelines was two finger widths from their body. [s. 110. (1) 1.]

2. The licensee failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: that the resident was released from the physical device and repositioned at least once every two hours.

A) Resident #002's plan of care identified they required a physical device as a restraint to prevent injury. On multiple days during the course of the inspection, the resident was observed positioned in a device with a physical device applied and unable to release the physical device independently.

On an identified date in August 2016, for two hours and 45 minutes, the resident was observed positioned in a device with the physical device applied; their physical device was not released and reapplied and they were not repositioned during the period. Interview with registered staff #122 and registered staff #123 stated that the resident was to be monitored every hour and every two hours the physical device was to be released and the resident repositioned. Record review with both registered staff confirmed that the resident was not released from the physical device and repositioned at least once every two hours.

B) Resident #005's plan of care identified they required a physical device as a restraint to manage their risk of falling and noted staff were to apply the physical device when positioned in another device, and remove and readjust at least once every two hours. During the course of the inspection, the resident was observed positioned in their device with the physical device applied and unable to release the physical device independently.

i. On one identified date in August 2016, for three hours and 45 minutes, the resident was observed positioned in the device and the physical device was not released during the period. Interview with PSW #154 stated the resident was restrained and was monitored every hour; however, confirmed the physical device was not released and the resident was not repositioned.

ii. On another identified date in August 2016, for approximately three hours, the resident was observed positioned in their device, was not repositioned and the physical device was not released during the period. Interview with registered staff #122 and registered staff #123 stated the resident was to be monitored every hour and every two hours the physical device was to be released, reapplied and the resident repositioned. Record review with both registered staff confirmed that the resident was not released from the physical device and repositioned at least once every two hours. [s. 110. (2) 4.]

3. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented, including, every release of the device and

all repositioning and the removal or discontinuance of the device, including time of removal or discontinuance.

A) Resident #005's plan of care identified they used a physical device as a restraint to prevent falls and injury. During the course of the inspection, the resident was observed positioned in a device with the physical device applied. Review of POC documentation under restraint use from the previous three months did not consistently identify every release, when the resident was repositioned, monitored or when the device was removed; as confirmed by registered staff #123.

B) Resident #002's plan of care identified they used a physical device as a restraint related to history of falls. During the course of the inspection, the resident was observed seated positioned in a device with the physical device applied. Review of POC documentation under restraint use for the previous three months did not consistently identify every release, when the resident was repositioned, monitored or when the device was removed, and was confirmed by registered staff #123. [s. 110. (7) 7.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: that the resident is released from the physical device and repositioned at least once every two hours and that every release of the device and all repositioning are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) As part of the required Nutrition and Hydration Programs, the home's policy regarding monitoring resident fluid intake monitoring, titled "Hydration Monitoring - RC 05-08-02", revised July 1, 2015, stated, "whenever intake is less than 1000 millilitres (mLs) for three consecutive days, the nurse is expected to make an entry into the individual progress note, Hydration Weekly Assessment. The nurse is expected to make a referral to the dietitian whenever fluid intakes is less than 1000 mLs for three or more consecutive days and based on nursing judgement."

i. Review of resident #004's fluid intake record during an identified period in August 2016, revealed two occasions when their intake was less than 1000 mLs for three or more consecutive days. Progress notes revealed no weekly fluid assessment or referral to the RD were completed, as confirmed by registered staff #123.

ii. Review of resident #005's fluid intake record during an identified period in July and August 2016, revealed two occasions when their intake was less than 1000 mLs for three or more consecutive days, one which lasted eight consecutive days. Progress notes revealed no no weekly fluid assessment or referral to the RD were completed, as confirmed by registered staff #123.

iii. Review of resident #006's fluid intake record during an identified period from June to August 2016, revealed three occasions when their intake was less than 1000 mLs for three or more consecutive days, one which lasted five consecutive days. Progress notes revealed no no weekly fluid assessment or referral to the RD were completed, as

confirmed by the DOC.

B) As part of the required Nutrition and Hydration Programs, the home's policy, "Hydration Management - FS 04-01-22", revised February 27, 2016, stated "each resident is offered with a minimum of 2200 mL fluids per 24 hours period unless contraindicated. Sample guidelines for minimum daily fluid intake include water 250 mL offered at all meals".

On an identified date in August 2016, during a lunch observation in the Creek side dining room, water was not offered to all residents, as confirmed by dietary staff #145. The FSM confirmed the home's expectation was that all residents be offered water at all meals.

C) The home's policy, "Resident Privacy", last revised May 2015, stated that facility staff were to discuss issues related to residents in a setting where confidentiality can be maintained. Furthermore, the home's Privacy and Confidentiality Agreement, identified that staff were to respect the privacy of clients and residents, their families, and other employees and volunteers; and directed staff to receive and give information in a private area.

On an identified date in August 2016, a loud conversation was overheard between the substitute decision maker (SDM) of resident #044 and registered staff #122 regarding the resident's status. Interview with registered staff #122 and registered staff #100 confirmed that the conversation was not conducted in a way that ensured the resident and their SDM privacy.

D) The home's policy, "Cleaning of Basins, Bedpans, Urinals", dated July 2015, directed that staff can replace basins bedpans or urinals when they need a thorough cleaning. The dirty equipment is placed in the dirty shelf in the utility room for cleaning. Staff are to use the Tornado and follow cleaning instructions. If residents are in a room with a shared bathroom, each item needs to be labelled to identify whom it belongs to.

During and initial tour of the home the following was observed:
i. one unlabelled used basin and one bedpan were stored in tub room #2W13 in Oakwood home area.
ii. two used unlabelled commode basins were stored on the floor of shower room #2E04 on Oakview home area.
iii. one unlabelled used bed pan stored on the back of the toilet seat in shower room

#GE04 on Creekside home area.

Interview with PSW #141 confirmed that residents' basins, bedpans and urinals were not to be shared between residents and were to be labelled in a shared area or location, as outlined in the policy. [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 and ensuring that where the Act or this Regulation requires the licensee of to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee ensures that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #4: 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 failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

On an identified date in August 2016, resident #047 was observed with a device that was approximately five fingers breadth from their body. Interview with Physiotherapist Assistant (PTA) #136 indicated that they applied the device for safety; however, the resident did not regularly use the device. Interview with registered staff #135 confirmed that the device was not applied according to manufacturers' instructions which was two fingers breadth from the resident's body. [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 and ensuring that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the home's policies, identified below, outlined that when a resident experienced a fall, registered staff were to assess the resident using the following clinically appropriate assessment instruments:

i. The home's policy, "Fall Prevention and Management", dated February 2011, stated:
- Registered staff to assess the resident for potential and actual injuries and document the fall in the progress notes, (Fall/Incident Note), complete the Resident Injury/Incident Report, (Post Falls Assessment in PCC), and if the resident hit their head or there were no witnesses to the fall, the Head Injury Routine (HIR) was to be followed.
- Conduct the Falls Risk Assessment within 24 hours of admission, quarterly, when a change in health status puts the resident at increased risk for falling such as: two falls in

72 hours, more than three falls in three months, significant change in health status and falls that resulted in serious injury.
- Document the fall or incident in PCC Risk Management notes within one hour after the incident occurred or was discovered.
ii. The home's policy, "Head Injury Routine", dated July 1, 2015, indicated that the resident was observed by registered staff and non-registered nursing staff for at least 24 hours and registered staff documented responses on the Neurovitals Record every 15 minutes for one hour and if stable every one hour for three hours and if stable every four hours for eight hours and then every shift for 24 hours.

A) On identified dates in January, February and August 2016, resident #008 experienced falls which were all unwitnessed. Review of their plan of care identified the following:
i. The post fall assessment was not completed in PCC after each fall.
ii. HIR was not initiated after all unwitnessed falls.
iii. Falls risk assessments were completed on an identified date in October 2015, and August 2016; however, were not completed quarterly or after they had three falls in three months.
iv. Risk management notes was not completed after three falls.

Interview with registered staff #119 and registered staff #156 who reported resident #008 had unwitnessed falls and confirmed that the resident was not assessed using a clinically appropriate assessment tool that was designed for falls as outlined in the home's Falls Prevention and Management Program and the Head Injury Policy.

B) On two identified dates in July and August 2016, resident #004 experienced unwitnessed falls. Review of their plan of care identified that the Neurovital Record was not completed in all sections post both unwitnessed falls. Interview with registered staff #123 stated the resident had two unwitnessed falls and confirmed the HIR was not completed according to the home's policy.

C) On three identified dates in August 2016, resident #006 experienced unwitnessed falls. Review of their plan of care and record review indicated that the Neurological Assessment Records were not completed in all sections post both falls and was confirmed by registered staff #123.

D) On three identified dates in January, February and March 2016, resident #060 experienced falls. Review of the plan of care identified that the Fall Risk Assessment

was last completed in July 2015, and was not completed after the three falls in three months and quarterly and this was confirmed by registered staff #101. [s. 49. (2)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #011 was identified on admission with altered skin integrity. Weekly re-assessments were not completed consistently from October 2015 to May 2016 after registered staff documented changes in the resident's skin integrity, as confirmed by registered staff #137. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee of a long-term care home failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The home's policy, "Safe Lift Policy", revised August 10, 2016, directed registered staff to complete a mobility assessment within 24 hours of admission, and all caregivers reassess the resident's mobility through initial and quarterly detailed mobility assessments and mini resident mobility assessments prior to each handling. For approval of alternate lifting technique, registered practical nurse (RPN) must add progress note to the resident's chart, in conjunction with physiotherapy, report change to charge nurse, and update care plan if a permanent change.

In June 2016, resident #044 was readmitted to the home.
i. Review of the resident's plan of care did not include a mobility assessment when they were readmitted; however, the document the home referred to as the written care plan identified the resident was using a specified transfer device.
ii. Review of POC documentation identified that from June and July 2016, PSWs documented thirty-seven times that the specified transfer device was used.
iii. On an identified date in July 2016, registered staff documented that the resident required use of a different transfer device due to their status. POC documentation identified that the resident was transferred using the originally specified device an additional ten times over the following two weeks.
iv. No mobility assessment was completed until an identified date in August 2016, at which time the resident was assessed to require the transfer device as noted by registered staff in July 2016, for all transfers due to safety.

Registered staff #122 and registered staff #124 stated PSW staff felt unsafe at times using the originally specified transfer device. Interview with the Physiotherapist (PT) confirmed that they did not receive a referral to assess the resident until a identified date in August 2016, and determined the resident was unsafe to use the originally specified transfer device. Interview with registered staff #122 and registered staff #100 confirmed that the mobility assessment was not completed when the resident was readmitted until after they were changed to use a different transfer device in August 2016. [s. 36.]

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 and ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all menu items were prepared according to the planned menu.

A) On August 16, 2016, pureed shepherd's pie, cream-style corn and lima beans were on the planned menu for lunch. During meal service in the Creekside dining room, the identified pureed items appeared to spread into other items on the plate and were less than pudding thick. Dietary staff #145 reported puree menu items were not always consistently thick enough. Review of the home's recipes for the menu items which indicated the items were to be blended to a puddling-like consistency.

B) On August 30, 2016, pureed lamb chop roast was on the planned menu for lunch. During meal service the Creekside dining room, the item was sampled and found to have sharp, rough pieces and did not clear from the throat immediately. Dietary staff #147 reported that the recipe directed staff to puree the regular texture lamb chop roast; however, to achieve a better consistency, the home had used a minced lamb product, then added spices to marinate; and confirmed the original recipe was not followed. Interview with dietary staff #147 and the Food Service Manager (FSM) who determined the rough pieces were likely dried rosemary which would be difficult to puree to a smooth consistency.

The FSM confirmed recipes for all puree menu items required preparation to a smooth, pudding-like consistency and were not to spread on the plate or contain sharp pieces. [s. 72. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that at minimum, all menu items are prepared according to the planned menu, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) On an identified date in December 2015, resident #062 fell and sustained an injury. Review of the eMAR identified they were administered an increase in their pain medication after sustaining the injury. Review of their plan of care revealed that a pain assessment was completed on an identified date in January 2016; however, was not completed after the resident sustained the injury when they required an increase in pain medication. Interview with registered staff #100 stated the pain assessment should of been completed when the resident was administered more pain medication and confirmed that the pain assessment using a clinically appropriate assessment instrument was not completed until over ten days after sustaining an injury. [s. 52. (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 and ensuring that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #10: 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. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

On an identified date in August 2016, resident #042 and #045 were observed having a verbal altercation and resident #042 was agitated. Verbal and physical aggression were observed. No staff were present during the altercation. Resident #042 continued to be agitated and yelled at co-residents. A registered staff overheard the interaction and came out of the nursing station to intervene.

Review of resident #042's plan of care identified they were at risk for harming co-residents and a specified monitoring intervention was put in place three times a week. Other interventions to minimize the risk to the resident were implemented. Interviews with staff and observations throughout the course of the inspection also identified that an extra PSW staff was present who provided specified behavioural support for resident #046; however, their role also instructed to survey all residents when on the unit to minimize the interactions and severity with a focus on specific residents, including resident #042. Registered staff #158 also reported resident #042 had a recent increase in behaviours due to a diagnosis.

On the identified date in August 2016, no staff had been monitoring over 10 residents seated in the common area. As a result, an altercation occurred between resident #042 and #045. Furthermore, some of the specific residents, who the home had identified as high risk for altercations, were in the common area unsupervised. Interview with registered staff #158 confirmed that PSW #159 was off the unit with resident #046 and two PSWs had gone for break, leaving the floor minimally staffed. By leaving resident #042 unsupervised when a pattern of increased in agitation was identified, interventions were not implemented to minimize the risk of harm to residents. The home staff were unaware the physical altercation had occurred until the LTC Homes Inspector notified registered staff #158. [s. 54. (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 and ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

On an identified date in August 2016, resident #047 was observed with a device applied. Interview with the resident revealed that they were unable to consistently release the device. Interview with PTA #136 identified that the device was placed on the resident as a safety measure; however, review of the plan of care did not include any indication that the resident was assessed to require the device. Interview with registered staff #135 confirmed that the resident was not assessed to require the device and it should have not been applied. [s. 33. (3)]

2. The licensee failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if alternatives to the use of a PASD had been considered and tried where appropriate, but would not be, or had not been, effective to assist the resident with the routine activity of living.

On multiple days during the inspection, resident #001 was observed with a device applied. Registered staff #122 and PSW #126 stated the resident required the device for positioning, comfort and assistance. Review of the plan of care indicated they used the device as a PASD; however, there was no documentation to indicate that alternatives for the use of the device as a PASD had been tried. Interview with registered staff #126 stated the resident required a device for positioning and comfort and confirmed that alternatives for the use of the PASD were not tried. [s. 33. (4) 1.]

3. The licensee failed to ensure that that the use of a PASD under subsection(3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority that consent.

On multiple days during the course of the inspection, resident #001 was observed using a device. Review of their plan of care identified the device was used as a PASD and was required to provide comfort, support and independence; however, there was no documented consent. Interview with registered staff #122 stated the resident used the device for positioning and confirmed that there was no documented consent for its use as a PASD. [s. 33. (4) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living and the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

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

**s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's dining and snack service, included, at a minimum, review of meal and snack times by the Residents' Council.

Interview with the Manager of Recreation and Volunteer Services confirmed that meal and snack times were not approved by the Resident's Council and rather, reviewed and approved at Resident Food Committee meetings, which occurred at a different time of the month. [s. 73. (1) 2.]

2. The licensee has failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

On August 16, 2016, during lunch in the Creekside dining room, residents were served dessert before they finished their main meal, including residents who were unable to eat without assistance by staff. Dietary staff #146 confirmed residents were served dessert before their main course was completed and that staff were expected to serve course by

course. [s. 73. (1) 8.]

3. The licensee has failed to ensure that proper techniques were used to assist residents with eating.

Resident #025's plan of care stated they required total assistance for eating related to their condition and history.

On an identified date in August 2016, during lunch, registered staff #151 was observed standing while providing total assistance to the resident with eating. Registered staff #151 confirmed they should not have been standing while assisting the resident. [s. 73. (1) 10.]

4. The licensee has failed to ensure that staff members assisted only one or two residents at the same time who required total assistance with eating or drinking.

A) On an identified date in August 2016, during lunch, PSW #150 was observed providing simultaneous assistance to resident #027 and resident #028 who both required total assistance, as well as limited to extensive assistance to resident #029. PSW #150 confirmed they were the only staff present to assist the three residents during the meal.

B) On an identified date in August 2016, during lunch, registered staff #151 was observed providing simultaneous total assistance with eating to resident #024, resident #025 and resident #026. PSW #152 also reported there was not always sufficient staff to assist residents in the home area during the meal. The FSM confirmed staff were not to assist more than two residents at the same time who required total assistance with eating or drinking. [s. 73. (2) (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 and ensuring that the home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were be kept closed and locked when they were not being supervised by staff.

Throughout the course of the inspection, a door on the ground floor adjacent to Spruceview home area was closed but unlocked. The door lead to a non-residential area where a garbage chute was located as well as bins of garbage. The door was equipped with a key pad lock but did not activate when the door was closed. Interview with laundry staff #155 confirmed that the door should have been locked when closed. [s. 9. (1) 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 and ensuring that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) 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. 229 (2).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept relating to each evaluation under clause (d) that included 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.

Interview with the ED who confirmed they were unable to produce a written record of the home's annual evaluation of their infection prevention and control (IPAC) program. [s. 229. (2) (e)]

2. The licensee failed to ensure that the designate staff member to co-ordinate the IPAC program had education and experience in infection prevention and control practices, including: infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management.

During the course of the inspection, non-compliance was issued related to the staff participating in the IPAC program, as identified in this report; as well as, surveillance of resident's with symptoms of infection. The current DON, who entered in the role effective July 1, 2016, was the designated staff member lead of the IPAC program. It was confirmed in an interview with the DON and ED that the current DON had not yet had an opportunity to acquire additional education related to IPAC including, but not limited to: infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management. [s. 229. (3)]

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

The home's policy, "Labeling Resident's Personal Items", last revised January 2014, directed staff to ensure personal toiletry items, such as combs, hairbrushes, toothbrushes, denture cups, roll on deodorants, were labelled on admission and whenever items were replaced.

A) On August 16, 2016, the following personal items were observed to be used and not labelled:
i. On Creekside home area, the tub room contained a used razor and toothbrush in a cupboard.
ii. On Creekside home area, the shower room contained a used razor on a chair.
ii. On Oakwood home area, the tub room contained one roll on deodorant.

B) On August 16 and 25, 2016, an unlabelled denture cup was observed in the shared bathroom of resident #011.

C) On August 30, 2016, the following personal items were observed to be used and not

labelled:
i. On Orchardview home area, the tub room contained one used bar of soap.
ii. On Oakwood home area, the tub room contained one roll-on deodorant by the bathroom sink.
iii. On Gateside home area, the shower room contained two hair brushes, two roll-on deodorants and one bar of soap.
iv. On Rose Garden home area, the tub room contained two nail clippers and two roll-on deodorants.
v. On Spruceview home area, the tub room contained one unlabelled brush.
vi. On Creekview home area, the tub room contained one unlabelled brush.

Interview with PSW #109 and PSW #106 confirmed that the residents' personal items were to be labelled and not shared among residents. [s. 229. (4)]

4. The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and the symptoms were recorded and immediate action was taken as required.

A) On an identified date in March 2016, resident #012 began displaying symptoms of a specific infection. In April 2016, treatment was ordered. During an identified period in March and April 2016, registered staff did not consistently monitor and record the resident's symptoms, which persisted over a week. After a specified date in April 2016, one day after the treatment was ordered for the second time, there was no monitoring or recording of symptoms, related to the infection, as confirmed by registered staff #100.

B) On an identified date in January 2016, resident #013 began displaying symptoms of a specific infection, and treatment was initiated the following day. Review of the plan of care did not include consistent monitoring and recording of symptoms every shift. Interview with registered staff #100 and registered staff #133 confirmed that the staff did not monitor and record symptoms every shift while the resident was symptomatic and being treated for a specific infection. [s. 229. (5)]

5. The licensee failed to ensure that the information that was gathered on every shift about the residents' infections, were analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

Throughout the course of the inspection, non-compliance was issued within relation to staff monitoring and recording symptoms of two residents with upper respiratory tract infections. As of July 2016, the DON who was the IPAC program lead revealed that they did the home did not gather information from every shift about residents' infection and the information was not analyzed daily or monthly, as they were new to the role and did not yet have the opportunity to receive training on infection prevention and control. [s. 229. (6)]

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 and ensuring that all staff participate in the implementation of the Infection prevention and control program; that on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and the symptoms are recorded and that immediate action is taken as required; and, that the information gathered under subsection (5) of O. Reg 229 is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

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

The home's program, "Continence Care and Bowel Management Program", revised July 2015, directed registered nursing staff and interdisciplinary team to:
i. Conduct a bowel and bladder assessment using the Bladder and Bowel Continence Assessment on admission, quarterly and after any change in condition that may affect bladder or bowel continence.
ii. Assess for casual factors, patterns, types of incontinence, potential to restore function, and type and frequency of physical assistance necessary to facilitate toileting.
iii. Complete voiding and bowel monitoring records for a seven day period to identify patterns and trends.

A) Review resident #010's clinical health record did not include quarterly Bladder and Bowel Continence Assessments of their continence to identify frequency of physical assistance necessary to facilitate toileting nor an individualized plan to ensure the resident remained clean, dry and odour free. Interview with registered staff #101 and

registered staff #124 confirmed that the home did not complete quarterly Bladder and Bowel Continence Assessments, as required by the home's policy.

B) Review resident #004's plan of care identified that a bladder and bowel continence assessment was not completed quarterly. Registered staff #101 stated a bowel and bladder assessment was on admission; however was not completed quarterly as required by the home's policy.

C) Review of resident #006's plan of care did not include a completed bladder and bowel continence assessment on admission or quarterly, nor were voiding and bowel monitoring records completed. Interview with registered staff #124 confirmed that resident #006 did not receive an assessment using the clinically appropriate assessment tools outlined in the home's policy. [s. 51. (2) (a)]

2. The licensee has failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented.

A) Resident #010's MDS assessment from May 2016, identified they were experiencing episodes of incontinence and required assistance for toileting. Review of their plan of care did not include an individualized program of continence care. Interviews with PSW #129 and PSW #131 revealed they were implementing different interventions for continence care. Interview with registered staff #124 confirmed that the resident's plan of care did not include an individualized program of continence care, specifically, interventions to direct staff to manage their continence. [s. 51. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy, "Zero Tolerance of Abuse and Neglect, AM-02-01-08", dated August 11, 2015, identified actions to be taken by the home in the case of an alleged incident of resident abuse which included:
i. The home will immediately investigate reports by staff and Board Members under this policy, and third party reports of abuse or neglect, in accordance with the investigation procedures in Part B: Part Two: Reporting and Notification.
ii. Ensure safety of staff and resident(s) involved and all other residents under his/her care.
iii. Conduct a head to toe assessment on the alleged victim and document findings if physical abuse is suspected.

iv. Notify the resident of the results of the investigation immediately upon the completion of the investigation.
v. Report to the MOHLTC Director the results of every investigation the home conducts under this policy.
vi. The timeline within which the home must submit the report within 10 days that includes, but is not limited to, the results of the investigation and any action the home takes in response to any incident of resident abuse or neglect.

On an identified date in August 2016, concerns regarding the conduct of PSW #138, PSW #170 and PSW #171 when providing care to resident #009 were brought to the attention of LTC Homes Inspector #585. LTC Homes Inspector #585 reported the details of the resident's concerns to registered staff #100 and the Executive Director (ED). After the home received the information, they submitted a critical incident system (CIS) report immediately to the Ministry of Health and Long-Term Care regarding allegations of staff-to-resident abuse.

Review of the home's investigation notes revealed the resident was not interviewed immediately. Interview with registered staff #100 confirmed the resident was not interviewed immediately and that a head to toe assessment was not completed, as per policy.

On identified dates in August 2016, LTC Homes Inspector #585 conducted interviews with PSW #170 and PSW #171, who reported that they worked with the resident prior to being interviewed by the home; which was confirmed by the DON. Review of the staff schedule also indicated PSW #138 worked on the resident's home area prior to being interviewed by the home.

On an identified date in September 2016, the DON reported in an interview that home completed the investigation on an identified date in August 2016, and that allegations were not substantiated; however, confirmed the home had not followed-up with the resident regarding the results of the investigation; nor had they reported the results of the investigation and any actions taken in response to the incident to the Director within 10 days. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the written policy in place to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee of failed to ensure that with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation, a written record was kept relating to each evaluation under paragraph 3 that included 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.

Interview with the ED who was unable to produce a written record of the home's annual evaluation of their pain management and skin and wound programs. [s. 30. (1) 4.]

WN #18: The Licensee has failed to comply with LTCHA, 2007, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee failed to review the assessments and information and approve the applicant's admission to the home unless:
(a) the home lacked the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements; or
(c) circumstances existed which were provided for in the regulations as being a ground for withholding approval.

In 2016, identified individual #049 was denied admission to the Long-Term Care Home. Correspondence addressed to the individual's SDM identified that based on the individual's profile, they may require a secure area. It was confirmed by the Manager of Resident Services and the ED that the secure area in the home was for a specific gender only.

i. Review of the home's 2016 to 2019 Long-Term Care Home Service Accountability Agreement (LSAA), detailed the home had four female only units (including a secured area) and two mixed male and female units.
ii. Article 14-4 of the LSAA identified that the home is to comply with The Act. "14-4. The Act. For greater clarity, nothing in this Agreement supplants or otherwise excuses the health service provider (HSP) from the fulfillment of any requirements of the Act. The HSP's obligations in respect of Local Health System Integration Act (LHSIA) and this Agreement are separate and distinct from the HSP's obligations under the Act.", as confirmed on August 29, 2016, in interview with an Advisor of Quality and Risk Management at the Local Integrated Health Network (LHIN).

In a specified month in 2016, individual #049 was refused admission, however, not based on the circumstances in s. 44 of the Act. [s. 44. (7)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A) Resident #020's plan of care identified they had a history of responsive behaviours to staff and residents. On a specified date in May 2016, resident #022 reportedly sustained an injury after resident #020 demonstrated a responsive behaviour. On a specified date in June 2016, resident #020 was physically responsive toward resident #021 which resulted in injury to resident #021.

Following the incident in May 2016, the physician's orders included a plan to observe resident #020. Review of the Patient Observation Record (POR), used to document the resident's behaviour every 30 minutes, revealed that their behaviours were not consistently documented during a specified period in May and June 2016. PSW #143 reported the record was to be completed on all shifts. Registered staff #142 confirmed the record was not completed as part of actions taken to meet the needs of the resident with responsive behaviours.

B) Resident #064's plan of care identified that they demonstrated responsive behaviours. Interview with registered staff #103 and PSW #160 reported that the resident exhibited responsive behaviours and had multiple interventions in place to respond to them; however, registered staff #103 confirmed that the written plan of care did not include the interventions and resident #004's responses to the interventions were not documented. [s. 53. (4) (c)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle was reviewed by the Residents' Council of the home.

Interview with the Manager of Recreation and Volunteer Services confirmed that the home's menu cycles were not approved by the Resident's Council and rather, reviewed and approved at Resident Food Committee meetings, which occurred at a different time of the month. [s. 71. (1) (f)]

2. The licensee has failed to ensure that planned menu items were offered at each meal and snack.

On August 16, 2016, regular texture bread was not offered on Spruce View home area for lunch. On August 30, 2016, regular texture bread was not offered on Creekside home area for lunch. Interview with dietary staff #107 and dietary staff #145 reported they offered food based on what was on show plates; however, bread was available in the kitchenette. Dietary staff #147 and the FSM confirmed bread was on the planned menu should have been offered at both meals.

On August 18 and 30, 2016, assorted juices were posted on the daily menu for lunch; however, on both days it did not appear that residents were offered choice in fluid. Interview with dietary staff #107 and dietary staff #145 confirmed residents were not always offered choice in fluids. The FSM confirmed a variety of beverages were available and should have been offered to residents capable of making a choice. [s. 71. (4)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas of any other areas provided for in the regulations, at times or at intervals provided for in the regulations.

Subsection 221. (2) 1. of Ontario Regulation 79/10 defined intervals for the purpose of subsection 76 (7) of the Act to be completed at annual intervals.

Interview with the ED who reported pain education was not provided to the staff in the home in 2015 and would be provided later in 2016. [s. 76. (7) 6.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of laundry services, procedures were implemented to report and locate residents' lost clothing and personal items.

Interview with the Administrative Assistant (AA) who reported that the home's process to report lost clothing conducted through completion of a Compliments, Complaints and Opportunities for Improvement (CCO) form.

i. Resident #009 reported they were missing multiple clothing items. Interview with PSW #116 reported they were aware of the missing items and reported it to a registered staff. The AA confirmed no CCO form was submitted.
ii. Resident #007 reported they were missing a clothing item. Interview with registered staff #123 confirmed they were aware of the missing item; however, they had not submitted a CCO form. The AA confirmed they had not received a CCO form.

The ED confirmed the home's processes to locate lost clothing and personal items was not implemented. [s. 89. (1) (a) (iv)]

WN #23: 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 failed to ensure that a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented, was promptly prepared.

Interview with the ED who confirmed they were unable to produce a written record of the home's annual evaluation of their policy to promote zero tolerance of abuse and neglect of residents. [s. 99. (e)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis.

Information provided by the home indicated that the monthly analysis of restraints was not completed in January and July 2016, and this was confirmed by registered staff #161. [s. 113. (a)]

2. The licensee failed to ensure that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis; that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared.

Interview with the ED who confirmed they were unable to produce a written record of the home's annual evaluation of their minimizing of restraints policy. [s. 113. (e)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

On August 24, 2016, during lunch service, registered staff #134 was observed administering medications to residents in a dining room. The medication cart was stored outside of the dining room, which was left unlocked each time registered staff #134 left the cart to administer medications. When registered staff #134 left the cart unattended to administer medication to a resident at the far end of the dining room, a cognitively impaired resident wandered past the cart. At the same time, LTC Homes Inspector #528 approached the cart and was able to open drawers without registered staff #134 being aware. When registered staff #134 returned to the cart, they confirmed the cart was to be locked when unattended.

2. The licensee has failed to ensure that drugs were stored in an area or a medication cart that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

On August 19, 2016, the medication room on Orchard View home area was observed and one container of Potassium Chloride was noted to be in the storage cupboard. The date on the container of expiry read May 2016, and on further inspection was noted to be opened and used. Interview with registered staff #124 confirmed the medication was expired and should have been discarded. [s. 129. (1) (a)]

WN #26: 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:
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).

Findings/Faits saillants :

1. The licensee failed to ensure that training was provided for all staff who applied physical devices or who monitored residents restrained by a physical device including: application, use and potential dangers of these devices.

A) On February 8, 2016, the home was issued a compliance order (CO) to provide education to all staff regarding the application of the physical device according to manufacturer's guidelines and be completed by March 11, 2016. Information provided by the home indicated that 69 of 188 staff who provided direct care to the residents did not receive training in the application of the physical device according to manufacturer's guidelines and this was confirmed by registered staff # 161.

B) Information provided by the DON regarding the content of the home's annual training provided to staff in 2016 who applied physical devices or who monitored residents restrained by a physical device did not include information regarding the application and potential dangers of the devices. [s. 221. (1) 5.]

Issued on this 7th day of October, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LEAH CURLE (585), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581)
Inspection No. / No de l'inspection :	2016_343585_0013
Log No. / Registre no:	024795-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 23, 2016
Licensee / Titulaire de permis :	IDLEWYLD MANOR 449 SANATORIUM ROAD, HAMILTON, ON, L9C-2A7
LTC Home / Foyer de SLD :	IDLEWYLD MANOR 449 SANATORIUM ROAD, HAMILTON, ON, L9C-2A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Maureen Goodram

To IDLEWYLD MANOR, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that all residents are reassessed and their plan of care reviewed and revised at any other time when care set out in the plan has not been effective related to individual fluid intake and hydration status.

The plan shall include, but is not limited to:

1. The development and implementation of a system to support, monitor and evaluate staff compliance to ensure the resident is reassessed and plan of care reviewed and revised when the care set out has not been effective related to fluid intake and hydration; and,
2. An education plan to ensure that all staff are re-educated on their roles and responsibilities regarding resident hydration.

The plan is to be submitted to leah.curle@ontario.ca by November 15, 2016.

Grounds / Motifs :

1. This non-compliance had a severity of "minimum harm/potential for actual harm/risk", with a scope "widespread" and an ongoing history of non-compliance.

2. The licensee failed to ensure that the resident was reassessed and the plan of

care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

A) Resident #004's plan of care identified they were at nutrition risk and had an individual daily fluid requirement, as confirmed by the Registered Dietitian (RD). Review of their fluid intake look back report from a period between June to August 2016, revealed they did not meet their fluid requirement on 61 out of 63 days.

i. In June 2016, a monthly progress note completed by registered nursing staff did not include an assessment of whether their hydration goals were met as per their plan of care.
ii. In June 2016, the RD noted in an annual nutrition assessment that the resident was not meeting their daily calculated fluid requirement and did not implement a hydration strategy.
iii. The resident's plan of care indicated they had a specific hydration intervention to receive 250 mL of water at meals; however, the RD confirmed it was not a hydration intervention as it was standard practice that all residents be offered 250 mL of water at meals.
iv. Interview with PSW #105 and PSW #110 reported the resident had poor fluid intake.
v. Registered staff #119 reported referrals to the RD were made based on clinical judgement, that the home had no specific criteria for placing referrals and was unaware of residents having specific fluid goals.

The RD reported they did not receive a referral to assess the resident's hydration status since May 2016, and confirmed the resident was not reassessed nor was their plan of care reviewed and revised at when care set out in the plan had been ineffective.

B) Resident #006's plan of care identified they were at nutrition risk and had an individual daily fluid requirement, as confirmed by the RD. Review of their fluid intake look back report from a period between June to August 2016, revealed they did not meet their requirement on 61 out of 63 days.

i. On an identified date in February 2016, the RD documented in a progress note that the resident was not meeting their fluid requirement and would continue to monitor; however, at the time of the inspection, the RD confirmed they had not reassessed the resident regarding their hydration status.

ii. On an identified date in April 2016, an assistant food service manager (AFSM) documented the resident was not meeting their daily fluid requirement and did not implement a hydration intervention.
iii. On an identified date in June 2016, a monthly progress note competed by registered nursing staff stated the resident usually consumed foods and fluids well; however, PSW documentation indicated the resident was not meeting their hydration requirement.
iv. On an identified date in July 2016, a monthly progress note stated the resident's intake was well; however, PSW documentation indicated the resident was not meeting their hydration requirement.
v. On an identified date in August 2016, an AFSM noted in a quarterly nutrition assessment that the resident was not meeting their daily calculated fluid requirement and implemented an intervention to receive 250 mL of water at meals.
vi. Interview with PSW #108 and PSW #109 reported the resident did not always consume fluids at nourishment.

The RD reported no individualized hydration intervention had been implemented for the resident as water at meals was provided to all residents. The RD confirmed the resident was not reassessed when the care set out in their plan of care had not been effective.

C) Resident #005's plan of care identified they were at nutrition risk and had an individual fluid requirement per day, as confirmed by the RD. Review of their fluid intake look back report from a period in July and August 2016, revealed they did not meet their fluid requirement on 16 out of 26 days, which included a period of 11 consecutive days. Interview with PSW #105 and PSW #110 reported the resident's fluid intake fluctuated. Review of the home's documentation revealed the resident's hydration status was last assessed on a identified date in July 2016, where registered staff documented that the resident drank well; however, no reassessment was completed when the resident was not meeting their fluid requirement, as confirmed by the RD. [s. 6. (10) (c)] (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_240506_0030, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act, staff apply the physical device in accordance with any manufacturer's instructions.

The plan shall include, but is not limited to:

1. How the home will ensure that for all residents who use a physical device; staff will apply the physical device in accordance with any manufacturer's instructions.

2. A collaborative system is developed and implemented to ensure there is a process to monitor, follow-up and evaluate that all physical devices are used appropriately.

3. All staff who apply physical devices or who monitor residents restrained by a physical device receive training on the application, use and potential dangers of these devices; that where a resident is being restrained by a physical device under section 31 of the Act that the resident is released from the physical device and repositioned at least once every two hours; and every use of a physical device to restrain a resident under section 31 of the Act is documented, including, every release of the device and all repositioning and the removal or discontinuance of the device, including time of removal or discontinuance.

The plan will be submitted to dianne.barsevich@ontario.ca by November 15, 2016.

Grounds / Motifs :

1. Previously issued as a written notification (WN) in September 2014 and a compliance order (CO) in January 2016.

2. The non-compliance was identified to have a severity of minimum harm and/or potential for actual harm, with a scope of isolated.

3. The licensee failed to ensure that the physical device was applied in accordance with the manufacturer's instructions.

On an identified date in August 2016, resident #005 was observed with a physical device applied more than four finger widths from their body. Interview with registered staff #123 confirmed the physical device was too loose, was a restraint and not applied according to manufacturer's guidelines. The physical device was adjusted to two finger widths from their body by Shoppers Home Health service provider who stated that the manufacturer's guidelines was two finger widths from their body.

4. The licensee failed to ensure that training was provided for all staff who applied physical devices or who monitored residents restrained by a physical device including: application, use and potential dangers of these devices.

i. On February 8, 2016, the home was issued a compliance order to provide education to all staff regarding the application of the physical device according to manufacturer's guidelines and be completed by March 11, 2016. Information provided by the home indicated that 69 of 188 staff who provided direct care to the residents did not receive training in the application of the physical device according to manufacturer's guidelines and this was confirmed by registered staff #161.

ii. Information provided by the DON regarding the content of the home's annual training provided to staff in 2016 who applied physical devices or who monitored residents restrained by a physical device did not include information regarding the application and potential dangers of the devices. [s. 110. (1) 1.] (581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2016

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, 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 23rd day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Leah Curle

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