Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 17, 2017	2017_482640_0018	023938-17	Resident Quality Inspection

Licensee/Titulaire de permis

KING NURSING HOME LIMITED
49 Sterne Street Bolton ON L7E 1B9

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

KING NURSING HOME
49 Sterne Street Bolton ON L7E 1B9

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

HEATHER PRESTON (640), KATHLEEN MILLAR (527), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 16, 17, 18, 19, 20, 23 and 24, 2017.

During the course of the inspection the following complaint inspections were conducted;
Intake # 007036-17 related to hospitalization and
Intake #023301-17 related to personal support services, continence care and bowel management, reporting and complaints, responsive behaviours, housekeeping, medication and staffing

The following Critical Incident System inspection was conducted;
Intake #034299-16 related to sexual abuse resident to resident
Intake #021365-17 related to responsive behaviours
Intake #011600-17 related to responsive behaviours and
Intake #016512-17 related to responsive behaviours

During the course of the inspection, the inspector(s): toured the home, observed the provision of care and services, interviewed residents, families and staff, reviewed relevant documents including but not limited to: clinical records, policies and procedures and meeting minutes.

During the course of the inspection, the inspector(s) spoke with Residents, families, Resident Council member, Family Council member, Housekeeping aides, Personal Support Workers (PSW), Dietary Aides, Registered Practical Nurses (RPN), Registered Nurses (RN), Registered Dietitian (RD), Food Service Supervisor (FSS), Director of Family and Resident Services (DRFS), Environmental Services Supervisor (ESS), Direcor of Care (DOC) and the Administrator.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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, strategies were developed and implemented to respond to these behaviours, where possible.

1) Resident #018 had a history of responsive behaviours and had specified interventions in place effective on a specified date in October 2017.
Review of progress notes revealed on a specified date in October 2017, resident #018 was in their room and had a responsive behaviour.
On another specified date in October 2017, LTCH Inspector heard a scream. Resident #018 was observed in their room with resident #020. Resident #018 appeared in discomfort. Interview with PSW #131 reported resident #020 wandered into resident #018's room and demonstrated a responsive behaviour toward resident #012.
BSO staff #128 confirmed that on two identified dates in October 2017, strategies were not implemented to respond to resident #018's responsive behaviours.

2) Resident #020 had a history of responsive behaviours.
i) On a specified date in June 2017, resident #020 was found standing beside resident #018. Resident #020 had sustained an injury.
ii) On a specified date in July 2017, staff observed resident #018 cause an injury to resident #020.
iii) On a specified date in September 2017, an unwitnessed incident occurred where resident #020 sustained an injury. Resident #018 reported to staff that they had caused the injury.
Review of resident #020's plan of care revealed a specific intervention to prevent responsive behaviours.
Interview with BSO staff #128 confirmed strategies were not implemented related to the responsive behaviours. [s. 53. (4) (b)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #011's business office file revealed that their Substitute Decision Maker (SDM) provided authorization, effective on a specified date in February 2017, for the resident to receive specific service from a specialized nurse. The assessment included recommendations. Review of the resident's written plan of care did not include the recommendations.
RPN #111 reported and confirmed that the recommendations should be in the written plan of care. [s. 6. (1) (a)]

2. The licensee failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

During the Resident Quality Inspection (RQI), the Long Term Care Homes (LTCH)

Inspector observed resident #006 with multiple alterations in skin integrity.
According to the clinical record reviewed by the LTCH Inspector, RPN #105 documented a note in the progress notes for resident #006 describing the size and location of areas and directed staff with specified interventions.
PSW #006 told the LTCH Inspector they had not followed the interventions as per the nurse and informed the LTCH Inspector they were not aware of the new interventions.
The PSW showed the LTCH Inspector the plan of care for resident #006, and the new interventions were not included in the plan of care.
During an interview with the Assistant Director of Care (ADOC), they told the LTCH Inspector the expectation was the PSW intervention should be included in the PSW tasks for the day and be included in the written plan of care.
The ADOC confirmed that all staff who provided direct care to the resident were not kept aware of the contents of the resident's plan of care. [s. 6. (8)]

3. 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, (b) the resident's care needs changed or care set out in the plan was no longer necessary.

1) Resident #009 had a fall with injury on a specified date in September 2017. The resident was identified as high risk for falls. The resident subsequently had a significant change in condition.
The clinical record was reviewed and the risk for falls was not reviewed and revised on the plan of care when the resident had a fall in September 2017 and/or when the resident had a significant change in condition in October 2017. There were no falls prevention interventions identified in the plan of care for resident #009.
Review of the home's policy called "Falls Prevention", number VII-G-30.00, and last revised January 2015, directed staff to complete a falls risk assessment when a resident had a significant change in status, and upon completion of the fall risk assessment, update the care plan with the associated risk level and update interventions. RPN #114 was interviewed and informed the LTCH Inspector that resident #009 had no falls risk assessment completed since their change in status. The RPN told the LTCH Inspector they were expected to update the written plan of care after the resident fell in September 2017 and this was not done. The RPN also confirmed that the current written plan of care dated October 2017, was not revised when the resident had a significant change in condition.
RN #113 was interviewed and confirmed that the staff were expected to update the care plan when the resident had a significant change in condition and after they complete the detailed falls risk assessment.

The home failed to ensure that resident #009's plan of care was reviewed and revised when resident #009's care needs changed.

2) During the Resident Quality Inspection (RQI), the Long Term Care Homes (LTCH) Inspector observed resident #010 with two treatments in place.
RPN #123 and the LTCH Inspector reviewed the resident's written plan of care and there were no changes made to the plan of care to reflect the treatments. The RPN confirmed there were no updates regarding the treatment in the written plan of care.
During an interview with the Director of Care (DOC), the DOC confirmed the written plan of care had not been updated to reflect the treatment and it was to be reviewed and revised related to the change in care needs for resident #010.

3) Resident #012 had a decline in their condition in February 2017. They had increased responsive behaviours as a result and required more assistance from staff.
Interview with PSW #126 confirmed the resident had increase in their need for more assistance from staff.
Interview with RPNs #106 and #116 confirmed the increased behaviours and a decline in the resident's clinical condition. They also confirmed the resident required more assistance from staff.
Upon review of the written plan of care, the written plan of care was not revised to reflect the changes in the resident's care needs.
The home failed to ensure that resident #012's written plan of care was reviewed and revised when their care needs changed. [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.

Resident #002's plan of care identified they required total assistance with eating, a specified diet, and specific hydration requirement per day.
In October 2017, the resident experienced a weight loss.
Review of their fluid intake record for a specified time range revealed they had not meet their fluid requirement.
A care conference note in September 2017, indicated the resident met their fluid intake goal once over the observation period. The note stated a recommendation to continue with current dietary interventions and goal for the resident to meet their estimated daily nutrition and hydration needs.
Interview with PSW #116 and PSW #117 who confirmed the resident had experienced

recent significant weight loss. PSW #116 reported the resident's food and fluid intake had been poor for approximately one month.
Interviews with RPN #115 and RPN #110 revealed the home's process for assessing hydration was for registered staff to review residents fluid intake over a 72 hour look back period, assess for signs and symptoms of dehydration, document the assessment and refer to the RD when the resident presented symptoms of dehydration.
Review of the clinical record for a specified period of time in 2017 revealed assessments of the resident's hydration were not consistently completed when they did not meet their fluid requirement over a 72 hour period goal; which was confirmed in an interview with RPN #115.
Interview with the RD who confirmed they had not received a referral regarding the resident's hydration; nor had they assessed the resident's fluid intake.
The licensee failed to ensure the resident was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective related hydration. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure;
1) that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, and
2) the resident is assessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary, and
3) that the resident is 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 is no longer effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

As a result of a complaint, the Long Term Care Home (s) Inspector reviewed the staffing of the home for the period in 2017. The review was completed by the LTCH Inspector and the Office Manager.
The Office Manager confirmed that on a specified day shift there was no Registered Nurse (RN) in the building. An RN was on call. The Office Manager confirmed on the day and evening shift on another specified date in 2017 there was no RN in the building. The Director of Care (DOC) was on call for both shifts.
During an interview with the DOC, they confirmed there was no RN in the building on the three identified shifts. [s. 8. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Review of the resident #011's business file records and interview with the resident's SDM revealed the SDM agreed to pay for specific service from a specialized nurse, which, as per the agreement included assessment and inspection of the feet and operation of non-invasive procedures.
Review of the resident's clinical record revealed the specificservice from the specialized nurse was provided on an identified date in March and May 2017. Interview with the specialized nurse confirmed the date in May was the last date they provided care to the resident.
Review of documentation completed by PSW staff from June to October 2017 revealed specific care was not consistently provided by staff. Review of recent PSW documentation, identified they had documented that toe nails were trimmed. Interview with regular PSW #116 confirmed the resident refused to have their toenails cut, that the documentation was inaccurate and confirmed the home did not ensure that the resident received preventative and basic foot care services, including cutting of toenails. PSW #116 confirmed it was the home's expectation to provide basic foot care services, including cutting of toenails [s. 35. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receive preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

WN #5: 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 a resident who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

1) During Stage 1 of the Resident Quality Inspection (RQI), the Long Term Care Homes (LTCH) Inspector observed resident #006 with multiple skin integrity issues on an identified date in October 2017. Resident #006 told the LTCH Inspector the areas were painful.
During an interview with the ADOC, they informed the LTCH Inspector that on an identified date in October 2017, RPN #106 was directed to assess the areas and document a skin narrative note in the progress note section of the electronic documentation tool. The ADOC described they had not seen the assessment completed by end of day shift, then directed the evening RPN #105 to complete the assessment.
During the interview, the ADOC confirmed, that based on the home's policy Skin and Wound Care Management Protocol, policy #VII-G-10.80, last revised February 2015, which directed staff to complete a skin assessment when a resident exhibited altered

skin integrity. The ADOC confirmed the required skin assessment tool was the Skin Assessment found in the assessment tab in Point Click Care (PCC), the home's electronic documentation system. They confirmed this tool was the clinically appropriate assessment instrument specifically designed for skin and wound assessment.
The ADOC confirmed the home did not complete a skin assessment using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

2) During Stage 1 of the Resident Quality Inspection (RQI), the Long Term Care Homes (LTCH) Inspector observed resident #010 with two areas of skin integrity issues.
The resident did not recall when the skin integrity issues had occurred.
Policy Skin and Wound Care Management, policy #VII-G-10.80 and last revised July 2015, directed the registered staff to conduct a skin assessment when a resident exhibited altered skin integrity.
During an interview with RPN #123, they informed the LTCH Inspector, when there was an alteration to skin integrity; registered staff was to assess using the skin and wound assessment tool found under the assessment tab in Point Click Care (PCC).
The LTCH Inspector, the DOC and RPN #123 reviewed the clinical record of resident #010 and were unable to locate an assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident who exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds (ii) receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infections, as required.

During Stage 1 of the Resident Quality Inspection (RQI), the Long Term Care Homes (LTCH) Inspector observed resident #006 with multiple skin integrity issues and immediately notified the Assistant Director of Care (ADOC).
Resident #006 told the LTCH Inspector the areas were painful.
During an interview with the ADOC, they informed the LTCH Inspector that RPN #106 was directed to assess the areas and document a skin narrative note in the progress note section of the electronic documentation tool. The ADOC described they had not seen the assessment completed by end of day shift, then directed the evening RPN #105 to complete the assessment. RPN #105 documented a "skin narrative" note in the progress notes for resident #006 describing the size and location of skin integrity issues.
During the interview, the ADOC confirmed, that the home's policy Skin and Wound Care

Management Protocol, policy #VII-G-10.80, last revised February 2015, directed staff to provide immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection. The ADOC confirmed there was no treatment provided to the resident for pain or promote healing until the following morning.
Review of the clinical record by the LTCH Inspector did not identify that any immediate treatment was provided, there was no assessment for pain conducted and the available as necessary (prn) pain medication, was not administered in response to the resident's pain related to the skin integrity issues.
During an interview with RN #103, the Skin and Wound Lead for the home, they informed the LTCH Inspector it was an expectation that any alteration in skin integrity would be treated immediately, assess the resident for pain and document the actions taken.
The ADOC and RN #103, confirmed the home did not provide immediate treatment and intervention to reduce or relieve pain, promote healing, and prevent infection. [s. 50. (2) (b) (ii)]

3. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) was assessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During Stage 1 of the Resident Quality Inspection (RQI), the Long Term Care Homes (LTCH) Inspector observed resident #010 with skin integrity issues.
The resident did not recall when the alteration to skin integrity occurred.
Policy Skin and Wound Care Management, policy #VII-G-10.80 and last revised July 2015, directed the registered staff to initiate weekly skin assessment.
During an interview with RPN #123, they told the LTCH Inspector when a resident was identified as having altered skin integrity; registered staff were to edit the Treatment Administration Record (TAR) to include the required weekly skin assessments.
RPN #123 and the LTCH Inspector reviewed resident #010's clinical record. During the review, the RPN and the LTCH Inspector were unable to locate a weekly assessment of the identified areas during a two month period, there was no changes made to the TAR to include the weekly skin assessments.
During an interview with the Director of Care (DOC), the DOC confirmed there were no weekly skin assessments completed for resident #010's identified areas of skin integrity issues. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ;
1) that a resident who exhibits altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds (i) receive 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,
2) that a resident who exhibits altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds (ii) receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infections, as required, and
3) that a resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) is assessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

Observations of the two home areas on October 16, 17 and 18, 2017, identified offensive odours in three resident's bathroom and in two resident bedrooms. However, there were lingering offensive odours observed throughout the third floor hallways and lounge areas.
The home's policy called "Offensive Odours - Housekeeping", number XII-F-10.61, and revised January 2015, directed housekeeping staff schedule a deep clean of a resident's room if there were odour concerns. In addition, the furniture would be disinfected and deodorized by the unit and by the environmental services.
During the Resident Quality Inspection (RQI) family members for resident #011, #016 and #017 had informed LTCH Inspector that the home area smells of urine.
The Environmental Services Manager (ESM) was interviewed October 17, 2017. The ESM was unable to provide any audits of deep cleaning that was completed on the home area of resident rooms, bathrooms, mattresses, draperies, walls and/or furniture in the resident lounge areas.
The ESM confirmed that it was expected of staff to notify them of offensive odours and steps would be taken to identify and rectify the odours and schedule deep cleaning, as necessary.
The home did not ensure procedures were implemented for addressing incidents of lingering offensive odours. [s. 87. (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 to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with Long-Term Care Homes Act 2007, Chapter. 8., s. 11. (1) (a), the licensee is required to ensure there is an organized program of nutrition care and dietary serves for the home to meet the daily nutrition needs of the residents.
Ontario Regulation (O.Reg) 79/10 s.68 requires every licensee of a long-term care home ensure that the nutrition care and hydration programs include (e) a weight monitoring system to measure and record with respect to each resident (i) weight on admission and monthly thereafter.
Review of resident #007's clinical record revealed their medical diagnoses.
On an identified date in June 2017, they experienced significant weight change. On an identified date in June 2017, the RD assessed the weight change and documented the weight as a potential weight error, with direction to staff to notify them if the weight gain was confirmed in July 2017.
In July 2017, the resident was re-weighed and maintained the same weight value noted in the previous month. A referral was sent to the RD.
The RD assessed the July 2017 weight and documented a request for staff re-weigh the resident.
Review of the clinical record including progress notes and the weight record revealed the resident was not weighed again until an identified date in August 2017, at which time the resident experienced weight change from the documented June and July 2017 weight.
Interview with RPN #110 who confirmed the clinical record did not indicate a re-weigh was taken in July 2017 and did not identify a reason why the weight was not taken and/or recorded. Interview with the RD who reported the resident refused to be re-weighed in July 2017; however, confirmed the refusal should have been documented. [s. 30. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #011 had documentation in the plan of care that they had dentures.
On an identified date in October 2017, staff documented unlabelled dentures were found and the resident's family confirmed the unlabelled denture belonged to the resident. The same day, staff documented that the dentures were labelled, which was confirmed in an interview with RPN #111.
On an identified date in October 2017, an unlabelled denture was observed in the resident's washroom. PSW #116 confirmed the unlabelled personal item was resident #011's denture. RPN #111 reported the home's expectation was that personal items such as dentures be labelled and confirmed resident #011's denture was unlabelled. [s. 37. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident.

Resident #019 informed RPN #111 on an identified date in December 2016, that resident #012 had come into their room and touched them inappropriately.
The home immediately reported the alleged abuse to the Director via the Ministry of Health and Long Term Care (MOHLTC) Action Line. The home subsequently submitted the Critical Incident (CI) Report to the Director. On the CI report, the date and time of the critical incident was documented as occurring on an identified date in December 2016, when it should have been an earlier date in December 2016. Also, the date the CI report was submitted to the MOHLTC was several days late of the required reporting timelines.

Interview with the Executive Director and the Director of Care (DOC) confirmed the report was not made within 10 days of becoming aware of the alleged sexual abuse of resident #019. [s. 104. (2)]

WN #10: 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:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that additional training for direct care staff regarding the skin and wound care program was provided to all direct care staff.

During a review of the skin and wound care program by the Long - Term Care Homes (LTCH) Inspector, the Administrator confirmed that 92.3 percent (%) of all PSWs who provided direct care were provided education on Topical Application instruction and 87% of all registered staff who provided direct care were provided training regarding skin and wound care policy and program review during the 2016 calendar year. [s. 221. (1) 2.]

Issued on this 1st day of December, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HEATHER PRESTON (640), KATHLEEN MILLAR (527), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2017_482640_0018
Log No. / No de registre :	023938-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 17, 2017
Licensee / Titulaire de permis :	KING NURSING HOME LIMITED 49 Sterne Street, Bolton, ON, L7E-1B9
LTC Home / Foyer de SLD :	KING NURSING HOME 49 Sterne Street, Bolton, ON, L7E-1B9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janice King

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:
1. Ensure that resident #018 and resident #020 are reassessed regarding their responsive behaviours, including behavioural triggers, where possible.
2. Ensure that for each resident demonstrating responsive behaviours, including resident #018 and resident #020, strategies are developed and implemented to respond to these behaviours, where possible.

Grounds / Motifs :

1. The non-compliance was issued as a compliance order (CO) due to a severity level of minimal harm or potential for actual harm (2), a scope of pattern (2) and a compliance history in the last three years of "one or more unrelated noncompliance" (2).

The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

1) Resident #018 had a history of responsive behaviours and had specified

interventions in place effective on a specified date in October 2017.
Review of progress notes revealed on a specified date in October 2017, resident #018 was in their room and had a responsive behaviour.
On another specified date in October 2017, LTCH Inspector heard a scream. Resident #018 was observed in their room with resident #020. Resident #018 appeared in discomfort. Interview with PSW #131 reported resident #020 wandered into resident #018's room and demonstrated a responsive behaviour toward resident #012.
BSO staff #128 confirmed that on two identified dates in October 2017, strategies were not implemented to respond to resident #018's responsive behaviours.

2) Resident #020 had a history of responsive behaviours.
i) On a specified date in June 2017, resident #020 was found standing beside resident #018. Resident #020 had sustained an injury.
ii) On a specified date in July 2017, staff observed resident #018 cause an injury to resident #020.
iii) On a specified date in September 2017, an unwitnessed incident occurred where resident #020 sustained an injury. Resident #018 reported to staff that they had caused the injury.
Review of resident #020's plan of care revealed a specific intervention to prevent responsive behaviours.
Interview with BSO staff #128 confirmed strategies were not implemented related to the responsive behaviours. [s. 53. (4) (b)] (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

The written request for review must be served personally, by registered mail, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 17th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

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Name of Inspector / Nom de l'inspecteur : Heather Preston

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