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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Inspection de soins de longue durée

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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
Jun 13, 2018	2018_544527_0005	004036-18	Resident Quality Inspection

Licensee/Titulaire de permis

2063415 Ontario Limited as General Partner of 2063415 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Maple Grove Care Community
215 Sunny Meadow Boulevard BRAMPTON ON L6R 3B5

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

KATHLEEN MILLAR (527), DARIA TRZOS (561), JESSICA PALADINO (586), KELLY HAYES (583)

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): February 26, 27 and 28, March 1, 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27 and 28, 2018

The following Complaints and Critical Incidents were inspected concurrently with the Resident Quality Inspection (RQI):

Complaints:
013920-17, related to alleged physical abuse and staffing shortages;

021415-17, related to personal care concerns;
021745-17, related to dining and snack services and staffing shortages;
022782-17, related to plan of care and alleged retaliation;
022818-17, related to supply of linens and non- functional bath tub;
023124-17, related to plan of care and improper care;
023225-17, related to staffing shortages and Residents' Bill of Rights;
024304-17, related to plan of care and admission concerns;
024592-17, related to Residents' Bill of Rights and feeding concerns;
025072-17, related to staffing shortages and attempted suicide;
025475-17, related to plan of care and assessments;
027493-17, related to continence care, hydration and staffing shortages;
029461-17, related to nutrition concerns;
003034-18, related to plan of care;
003687-18, related to refusal of admission; and
005224-18, related to personal and oral care, bed rails and recreation activities.

Critical Incidents:
008916-17, related to a fall;
010866-17, related to an injury of unknown cause;
011464-17, related to resident to resident abuse;
015954-17, related to resident to resident abuse;
017463-17, related to alleged staff to resident abuse;
023471-17, related to resident to resident abuse;
026496-17, related to improper/incompetent treatment;
028853-17, related to a fall;
002591-18, related to alleged staff to resident abuse;
004832-18, related to alleged staff to resident abuse;
005020-18, related to alleged staff to resident abuse;
006930-18, related to a fall; and
006935-18, related to a fall.

The following onsite Inquiries were completed concurrently with the RQI:
009717-17, related to resident to resident abuse;
022084-17, related to resident to resident abuse;
021629-17, related to dining and personal care concerns;
022352-17, related to resident to resident abuse;
027032-17, related to alleged staff to resident abuse;
000435-18, related to broken medication ampoules;

002410-18, related to alleged staff to resident abuse;
002448-18, related to resident to resident abuse;
006930-18, related to a fall; and
002405-18, related to feeding concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), the Resident Relations Manager/Social Worker, the Director of Dietary Services, the Director of Programs, The Environmental Services Manager, the Resident Assessment Instrument (RAI) Coordinator, the Behavioural Support Ontario (BSO) Registered Practical Nurse (RPN), the Scheduling Clerk, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Registered Dietitian (RD), Physiotherapist (PT), physiotherapy aides (PTA), maintenance staff, housekeeping aides, laundry aides, dietary aides, the Residents' Council President, the Family Council President, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Critical Incident Response
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **27 WN(s)**
- **17 VPC(s)**
- **4 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 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. (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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

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, and clear directions to staff and others who provide direct care to the resident.

A) During an interview with resident #013's family member it was shared that the resident was supposed to have oral care twice per day. The plan of care was reviewed and directed staff specifically how to provide oral care. A sign was observed posted in the

resident's room, which directed staff specifically how to provide oral care.

Resident #013 was a nutritional risk and required assistance for oral care. The nutrition plan of care identified the resident was not to have thin fluids.

During an interview with front line staff in March 2018, they were unclear as to what oral care was to be provided to resident #013. Staff shared there was not clear direction related to the resident's oral care. In an interview with the DOC, it was acknowledged that the plan of care did not provide clear direction to the staff who provided oral care to resident #013.

This area of non-compliance was identified during a Complaint Inspection, log #021745-17, conducted concurrently during the RQI. (583)

B) Resident #032 had expressed a concern to LTCH Inspector #561 during this inspection that the PSW staff were not providing care, as requested.

Interview with the RN #128 and RPN #129 indicated that they were aware of this resident's preference and had discussed with the Director of Care (DOC). The DOC was interviewed and stated that this was part of resident #032's care, the staff were supposed to provide this care to the resident and that they had a meeting with the PSWs on the unit informing them that they were required to provide this care.
Interviewed the resident in March 2018, and they stated that the care was still not being provided.

The written plan of care was reviewed for resident #032 and this intervention was not included as part of the resident's planned care.

The licensee failed to ensure the written plan of care set out the planned care for resident #032, and clear directions to staff and others who provided direct care to the resident.

This area of non-compliance was identified during a Complaint Inspection, log #024225-17, conducted concurrently during this RQI.

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

A) Resident #017 was diagnosed with an injury in May 2017. The resident's clinical record, the home's investigative notes and communication books were reviewed and identified the resident had a change in status prior to the diagnosis. Based on the investigative notes the PSWs were reporting changes in the resident's status to the registered staff; however the registered staff did not notify the physician and/or the nurse practitioner (NP) to assess the resident until later. When the NP assessed the resident, they ordered a diagnostic test. The order was faxed to the service provider, which was three days after the resident's status changed, and the diagnostic test was not performed until four days after it was ordered by the NP. Once the home was notified of the abnormal results, the resident was transferred to the hospital for treatment.

Interview with the Physiotherapist (PT) confirmed that it was after the NP's assessments that they received a referral to assess the resident and changed their transfer status. The PT stated that they did not receive a referral when the resident's transfer and mobility status had changed and they should have been re-assessed.
The DOC was interviewed and stated that when the staff identified the change in status the registered staff were expected to contact the physician or NP, and to make a referral to the PT to re-assess the resident's transfer and mobility needs.

The licensee failed to collaborate with other staff in the different aspects of care related to the resident #017's injury, therefore the care was not integrated and consistent and complemented each other.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection #2911-000013-17, log #010866-17, conducted concurrently during the RQI.

3. The licensee failed to ensure that the substitute decision maker (SDM), if any, and the designate of the resident/SDM had been given an opportunity to participate fully in the development and implementation of the plan of care.

A Complaint was submitted to the Director in September 2017, indicating that the Substitute Decision-Maker (SDM) of resident #022 was not notified when the resident's condition had changed. They stated during an interview with LTCH Inspector #561, that the resident had a change in condition and they were not made aware of this. The SDM stated that staff knew that they requested to be called at any time when there was a change in condition.

The written plan of care was reviewed and directed staff to contact the SDM with any changes in care and regarding any incidents. The SDM acknowledged this may lead to multiple calls per day and they had consented to this. The written plan of care also directed staff to leave a voicemail if the SDM was unavailable. There was no evidence indicating the staff had notified the SDM of the resident's change in condition.

The DOC was interviewed and acknowledged that staff were expected to notify the SDM of any changes in the resident's health condition.

The home failed to ensure that the SDM for resident #022 had been provided an opportunity to participate fully in the development and implementation of the plan of care.

This area of non-compliance was identified during the Complaint Inspections, log #022782-17 and #024304-17, conducted concurrently during this RQI.

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

A) Resident #010 had a fall in January 2018, was injured and then transferred to the hospital. The resident was assessed prior to the fall as a moderate risk for falls.

The clinical record was reviewed and indicated on the written plan of care that the resident was to have specific interventions to reduce the risk for falls.

The resident was observed on three specific dates in March 2018, and the fall prevention interventions were not implemented, as required.

RPN #110 and PSW #112 indicated what the specific falls prevention interventions were for the resident; however they were not implemented.

The licensee failed to ensure the falls prevention interventions were implemented for resident #010, as specified in the plan of care.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection #2911-000005-18, log #006935-18, conducted concurrently during the RQI.

B) In March 2018, Long Term Care Home (LTCH) Inspector #583 heard a staff member providing direction to resident #038, behind a closed door in a loud tone. LTCH Inspector

#583 approached the resident's room and resident #038 was brought out by PSW #148 and #149. The LTCH Inspector interviewed the resident asking how they were feeling and how the care was that they received. The resident was non-responsive and was not distressed.

A review of resident #038's plan of care directed staff to approach the resident in a certain way to avoid triggering responsive behaviours.

In an investigation completed by the home, which included interviews with PSW's #148 and #149, it was confirmed that the resident was experiencing responsive behaviours during care.

In an interview with the ED in March 2018, they acknowledged that resident #038's plan of care directed staff to use a specific approach with the resident. The care set out in the plan of care was not provided to the resident as specified in the plan. (583)

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #005020-18, conducted concurrently during the RQI.

C) Resident #016 had a fall in December 2017, was transferred to the hospital and diagnosed with an injury. The resident was assessed prior to the fall as a moderate risk for falls.

The clinical record was reviewed and indicated on the written plan of care that the resident was to have specific falls prevention interventions implemented.

The resident was observed in March 2018, and the falls prevention interventions were not implemented.

RPN #106 was interviewed and indicated what the falls prevention interventions were for the resident; however they were not implemented. The RPN acknowledged that the staff did not follow the falls preventions interventions outlined in the written plan of care for resident #010.

The licensee failed to ensure that the specific falls interventions were implemented for resident #010, as specified in the plan. (527)

This area of non-compliance was identified during a Critical Incident System (CIS)

Inspection #2911-000035-17, log #028853-17, conducted concurrently during the RQI.

D) Resident #023 was assessed as exhibiting a specific behaviours. The clinical record was reviewed and the plan of care identified the interventions to manage these behaviours.

The resident was observed on three dates in March 2018, and the interventions were not implemented.

PSW #156 was interviewed and acknowledged what the interventions were to manage the resident's behaviours; however they were not implemented.

The licensee failed to ensure that the care for managing resident #023's behaviour was provided as specified in the plan. (527)

This area of non-compliance was identified during the Complaint Inspections, log #024124-17 and #025475-17, conducted concurrently during this RQI.

E) The plan of care for resident #013 identified that their specific medical clothing was not to go down to the laundry department as they needed to be hand washed.

In an interview with Housekeeping and Laundry Services Manager in March 2018, it was shared that two items of resident #013’s medical clothing was sent down to the laundry department and washed. One piece of clothing was located and the other was missing. A missing item and clothing form was posted in the laundry department, but the medical clothing had not been located.

In an interview with PSW #163, they said that resident #013’s medical clothing was put in the laundry basket by staff by mistake and sent to laundry. Resident #013's room was observed and one piece of the medical clothing was found, the resident was wearing one and one of the three remained missing. It was acknowledged by staff that resident #013’s care of their medical clothing was not followed as specified in the resident’s plan of care. (583)

This area of non-compliance was identified during a Complaint Inspection, log #005224-18, conducted concurrently during the RQI.

F) Resident #011 had a written plan of care indicating that resident had a persistent

condition. The plan of care indicated that they had a specific device that was to be monitored and the output documented.

The clinical record was reviewed and there was no evidence that the output was recorded by staff on any shifts. The POC was reviewed for the months of January and February 2018, and the staff did not document the resident's output on any of the days during those months. The progress notes were reviewed and only on one shift in February 2018, the registered staff documented the output.

PSW #102 indicated that they monitor residents' who have specific devices for output on every shift and document in POC the amount. RPN #126 was interviewed and acknowledged that the output needed to be monitored and documented in the progress notes on every shift.

The licensee's policy, number VII-D-10.30, and revised September 2016, indicated that the PSW will empty the specific device each shift and record the output on the PSW flow sheet / electronic documentation.

The DOC was interviewed and stated that the output was expected to be monitored by PSWs and documented in POC.

This area of non-compliance was identified during a Complaint Inspection log #021415-17, conducted concurrently during this RQI.

G) Resident #022 had a plan of care indicating that staff were to remove a piece of the resident's mobility device, so that they could self-propel. In addition, program staff were to invite and porter the resident to and from group activities.

(i) The resident's SDM was interviewed and stated that the resident was not able to fully self-propel; however many times the staff did not follow the directions related to the resident's mobility device, which prevented the resident from being able to propel.

The resident was observed several times in March 2018. The housekeeping staff pushed the resident from the dining room back to the activity room and left the mobility device in a locked position. They did not follow the directions on the plan of care, which prevented the resident from being able to self-propel.

PSW #158 was interviewed and they stated that the housekeeping staff might not have

been aware of the directions on the written plan of care related to the resident's mobility device.The DOC was interviewed and stated that staff should have followed the written plan of care for resident #022.

(ii) The plan of care for resident #022, also indicated the resident attended mostly group activities and program staff were to invite and porter the resident to and from group activities.

Resident #022's family members were interviewed and stated that many times the resident was not included in activities because of their cognitive impairment.

In March 2018, the resident was observed and was excluded from a group activity provided by the Physiotherapy Assistant (PTA) in the activity room.

The PTA was interviewed and they stated that this group activity was on a referral basis and only residents who were candidates for this activity were included.
The DOC was interviewed and they acknowledged that this group activity was provided for any resident in the home and anyone could attend. The resident should not have been excluded from participating in the group activity. (561)

The licensee failed to ensure that the care for resident #022, was provided as specified in the plan.

This area of non-compliance was identified during the Complaint Inspections, log #022782-17 and #024304-17, conducted concurrently during this RQI.

H) Resident #001's physician ordered a specific test to be collected in February, July, October and November 2017, as well as in February 2018. The specific sample for the test was not collected and the resident had no procedures performed to ensure the sample was obtained.

The clinical record was reviewed, which confirmed the physician's orders for the specific test and the procedure to be performed, if staff were unable to collect the sample; however there was no documentation in the progress notes that the physician was notified within 24 to 48 hours that the test and/or the procedure was performed.

RPN #109 was interviewed and indicated that they obtain an order from the physician for a specific test, they will try to collect the sample and if they were unable to collect the

sample within 24 hours, they would call the physician for an order for a specific procedure to obtain the sample. If this was not effective, they would notify the physician. RPN #161 was interviewed and also acknowledged this process for the specific test.

The DOC and ADOC were interviewed and they both indicated that registered staff were expected to contact the physician if they had concerns that the resident may be experiencing new behaviours or an increase in behaviours for an order to collect a sample for a specific test. If the registered staff were unable to collect the sample within 24 hours and they didn't have a physician's order for another procedure to obtain the sample, they were expected to contact the physician again. If this procedure also failed to obtain the sample, registered staff were expected to notify the physician. (527)

The licensee failed to ensure that resident #001 received the care as specified in the plan of care.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection #2911-000017-17, log #015954-17, conducted concurrently during the RQI.

I) Resident #019's physician had ordered a specific test and a sample was to be collected in March, April, and November 2017. The physician also ordered another sample to be collected in August 2017; however the sample was not collected until six days later. The samples for the specific test were not collected as ordered by the physician and the resident did not have any additional procedures to obtain the sample.

The clinical record was reviewed, which confirmed the physician's order for the specific test and the procedure to collect the sample; however there was no documentation in the progress notes that the physician was notified within 24 to 48 hours that the test and/or the procedure was performed.

RPN #109 was interviewed and indicated that they would obtain an order from the physician for specific test, they will try to collect the sample and if they were unable to collect the sample within 24 hours, they would call the physician for an order for a procedure to collect the sample. If this was not effective, they would notify the physician. RPN #161 was interviewed and also acknowledged this process for obtaining a sample for the specific test.

The ADOC was interviewed and confirmed that staff were expected to collect the sample as ordered by the physician and if they were not able to within 24 hours, the registered

staff were expected to obtain an order from the physician for a procedure to obtain the sample. The ADOC indicated that if the registered staff continued to have difficulty obtaining the sample, they were expected to contact the physician.

The licensee failed to provide resident #019 with the care that was specified in the plan.

This area of non-compliance was identified during the Critical Incident System (CIS) Inspections #2911-000017-17, log #015954-17, and CIS #2911-000014-17, log #011464 -17, conducted concurrently during the RQI.

J) Resident #033's physician had ordered a specific test and the sample was to be collected in October 2017 and January 2018. The samples were not collected as ordered and the resident had no other procedures to obtain the sample.

The clinical record was reviewed, which confirmed the physician's orders for the specific test and the procedure to obtain the sample; however there was no documentation in the progress notes that the physician was notified within 24 to 48 hours that the test and/or the procedure was performed.

RPN #109 was interviewed and indicated that they would obtain an order from the physician for a specific test, they would try to collect the sample and if they were unable to collect the sample within 24 hours, they would call the physician for an order for a procedure to obtain the sample. If this was not effective, they would notify the physician. RPN #161 was interviewed and also acknowledged this process for the specific test.

The ADOC was interviewed related to the sample collection for resident #033. The ADOC acknowledged that when the resident was admitted, the physician ordered the specific test in October 2017, and then again in January 2018. The physician also ordered a specific procedure to be performed, if needed; however the samples were not collected by staff. The ADOC acknowledged that staff were expected to collect the samples as ordered by the physician and if they were not able to, then perform a procedure to obtain the sample. If this was not feasible for the resident, then staff were expected to contact the physician within 24 hours to notify them of the difficulties obtaining the samples and this did not occur.

The licensee failed to ensure that the care set out in the plan of care for resident #033, was provided to the resident as specified in the plan.

K) A Complaint was reported to the Director indicating that registered staff failed to apply treatment as per the physician's order for resident #022, when they sustained altered skin integrity in September 2017.

The clinical record was reviewed and the written plan of care indicated the resident was at risk for altered skin integrity. The staff were to use a specific treatment as per the SDM's request and apply, as per the physician's order. The Treatment Administration Record (TAR) was reviewed, which confirmed the SDM's request and the physician's order.

The home investigated the complaint and found that the registered staff who provided treatment did not follow the physician's order. The home's investigation notes indicated that during the interview with the registered staff, they stated that they applied the treatment, which was not according to the physician's order. The DOC was interviewed and acknowledged that the treatment was not provided as per the physician's order.

This area of non-compliance was identified during the Complaint Inspections, log #022782-17 and #024304-17, conducted concurrently during this RQI.

The licensee failed to ensure that the care set out in the plan of care for resident #001, #010, #011, #013, #016, #019, #022, #023, #033 and #038 was provided to the resident as specified in the plan.

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

A) During an interview with resident #013's family member it was shared that the resident was supposed to be served specific foods and amounts of food at all meals to meet their nutritional requirements. It was also shared that on multiple occasions they observed the resident did not receive the specific foods and amounts of food.

A review of the plan of care identified the Registered Dietitian (RD) changed the interventions in October 2017. In an interview with the RD it was shared that the resident ate well and required a specific amount of food at all meals to meet their nutrition requirements and that the resident could no longer state their preference to staff anymore.

In March 2017, the binder located in the servery was reviewed that provided direction to

the Dietary Aids (DA) on what resident's diets, special needs and preferences were. The "RD/FSM/Nursing Communication Tool", located in the binder directed the DA's to provide the resident a specific amount of food, if they requested.

In an interview with the Director of Dietary Services (DDS) , they acknowledged that the communication tool was not revised in October 2017, when resident #013's nutrition plan of care changed. (583)

This area of non-compliance was identified during a Complaint Inspection, log #021745-17, conducted concurrently during the RQI.

B) Resident #023 was assessed by the RD as a moderate nutritional risk. The nutritional plan of care was reviewed, which identified the resident required constant reminders to drink fluids and the resident's intake and output was to be monitored.

The written plan of care was reviewed and indicated the SDM requested specific assistance and planned care was twice daily and whenever necessary.

In October 2017, the resident was transferred to the hospital. Subsequently, the Speech Language Pathologist (SLP) assessed the resident and made specific recommendations.

Resident #023 was observed on three occasions in March 2018, and the resident did not receive planned care after meals and staff were not observed implementing the SLP's recommendations.

RN #107 and PSW #154 were interviewed. Neither of the staff were aware of the SLP's recommendations, which were located in the resident's clinical record.

This area of non-compliance was identified during the Complaint Inspection, log #024124 -17 and #025475-17, conducted concurrently during this RQI.

The licensee failed to ensure that resident #013 and #023 were reassessed and the plan of care reviewed and revised when the resident's care needs changed and/or when the care set out in the plan was no longer necessary.

6. The licensee failed to ensure when a resident was reassessed and the plan of care reviewed and revised that, (b) if the plan of care was being revised because care set out in the plan had not been effective, the licensee shall ensure that different approaches

were considered in the revision of the plan of care.

Resident #023 was assessed for continence. The plan of care was reviewed and identified that the resident had specific care and interventions.

The interventions were in place since the resident was admitted for over a year since admission in 2017; however the resident would follow their own routines.

PSW #156 was interviewed and confirmed that the current interventions were effective some of the time and they were not aware if different approaches were considered for resident #023. RN #107 was interviewed and was not aware if the care approaches were effective or not. The RN indicated there had been no change since the resident was admitted early in 2017. The RN was not aware if different approaches were considered when the written plan of care was revised.

The licensee failed to ensure that when resident #023's care was reassessed and the plan of care was being revised because some of the interventions were not effective, that different approaches should have been considered in the revision of the plan of care.

This area of non-compliance was identified during the Complaint Inspections, log #024124-17 and #025475-17, conducted concurrently during this RQI.

Additional Required Actions:

CO # - 001, 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 to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that, (a) procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A) The responsive behaviour procedures and interventions developed and implemented to assist resident #019, and to minimize the risk of altercations and potentially harmful interactions between and among residents was not effective. Although, the altercations between resident #019 and co-residents in two consecutive months in 2017, were witnessed by staff, the responsive behaviour interventions were not implemented and the staff did not intervene immediately to prevent altercations.

As a result of the two altercations with resident #001 and #018, resident #019 sustained an injury, which required the resident to be transferred to the hospital for treatment.

The clinical record was reviewed and the interactions among residents were observed on several occasions in March 2018.

RPN # 110 and PSW #112 were interviewed and acknowledged the resident had aggressive behaviours and interventions were not always effective when the resident's

behaviours were escalating. RPN #110 confirmed that both incidents in 2017, were witnessed by staff and the staff member was unable to answer why the staff did not intervene sooner when both residents in each incident had increased responsive behaviours, which resulted in the altercations.

This area of non-compliance was identified during the Critical Incident System (CIS) Inspections #2911-000017-17, log #015954-17, and CIS #2911-000014-17, log #011464 -17, conducted concurrently during the RQI.

B) The responsive behaviour interventions that were developed and implemented to assist resident #018, and to minimize the risk of altercations and potentially harmful interactions among residents were not effective. Although, the incidents in two different months in 2017, were witnessed by staff, the responsive behaviour interventions were not implemented and the staff did not intervene immediately to prevent the altercations with resident #019 and #035. As a result of the altercation with resident #019, they sustained an injury and required transfer to the hospital for treatment.

The interactions among residents were observed on three occasions in March 2018. The resident's interventions were effective when the Behavioural Support Officer (BSO) redirected the resident.

RPN #110 and PSW #112 were interviewed and acknowledged the resident had responsive behaviours. The staff indicated that the interventions were not always effective when the resident's behaviours were escalating. RPN #110 confirmed that both incidents in 2017, were witnessed by staff and they were unable to answer why the staff did not intervene sooner when both residents in each incident had increased responsive behaviours, which resulted in altercations.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection #2911-000017-17, log #015954-17, conducted concurrently during the RQI.

The licensee failed to implement responsive behaviour interventions to assist the resident who was at risk of harm as a result of the resident’s behaviours and to minimize the risk of altercations and harmful interactions between resident #001, #018, #019 and #035.

Additional Required Actions:

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

WN #3: 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.

A) The manufacturer's instructions for the Alenti ArjoHuntleigh, June 2012, indicated that the safety belt must be used at all times on the tub lift chairs. Furthermore, it indicated that the safety belt when not in use was to be attached to the belt clip on the hand rest-handle arm.

During the initial tour of the home in February 2018, LTCH Inspector #561 observed that the Alenti tub lifts in all five home areas had no safety belts attached to the lifts in the tub rooms. In two of the home areas, the safety belt could not be found in the tub rooms.

Interview with PSW #101 and PSW #105, revealed that they used the tub lifts while bathing residents without using the safety belts. Both of the PSWs indicated that the arm rests on the lift were enough to ensure that residents were safe. PSW #101 indicated that they had never seen a safety belt with the tub lift. The DOC was interviewed and acknowledged that the safety belts were required to be used while residents were bathed using the Alenti tub lift.

The licensee failed to ensure that staff used the Alenti tub lifts according to the manufacturer's instructions.

B) Resident #011 had a plan of care indicating that they had altered skin integrity. The resident had a specific intervention, which allowed the staff to select the function to assist with the resident's positioning. The written plan of care indicated the resident was to be

repositioned every two hours.

Interview with PSW #127 and RPN #108 indicated the resident was expected to be repositioned every two hours; however the resident was not always compliant.

Observations were made over several days and the resident was observed in bed most of the time. The resident had a specific intervention for positioning and when LTCH Inspector #561 asked the resident if the function was ever set at rotating, they said no.

The wound care nurse was interviewed and stated that the resident had a specific intervention implemented and they were also being turned and repositioned while in bed every two hours.

The manufacturer's instructions for the specific intervention indicated that there were two settings on the device that could be implemented.

The DOC was interviewed regarding the functionality of this intervention and they stated that they were not aware that it had these settings. The DOC indicated that they never tried this option and for this resident it might be beneficial.

The licensee failed to ensure that the specific device was being used in accordance with the manufacturer's instructions to assist with management of resident #011's altered skin integrity.

This area of non-compliance was identified during a Complaint Inspection, log #021415-17, conducted concurrently during the RQI.

Additional Required Actions:

CO # - 004 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 to ensure 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 #4: 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 the any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including a skin and wound care program, programs were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments. O. Reg. 79/10, s.48

The licensee's policy titled “Skin and Wound Care Management Protocol", number VII-G-10.80, and revised January 2015, indicated that the home will identify a nurse who had knowledge and skills in skin and wound care as a Skin & Wound Care Coordinator and will conduct weekly wound and skin care rounds with the RN/RPN in the resident home area assessing specific types of altered skin integrity with other etiologies. The home also utilized a Skin and Wound Care Tip Sheet for registered staff that described the steps they needed to take when a resident had new or an existing area of altered skin integrity. The tip sheet indicated that when a resident sustained a new area of altered skin integrity, the registered staff were expected to complete a weekly skin assessment tool after assessing the area, complete a pain assessment, update the care plan, update the Treatment Administration Record (TAR) based on the protocol, send an RD referral, send an Ulcer Referral Form, notify the POA, and communicate the new area of altered skin integrity to all shifts.

A) Resident #020's clinical record was reviewed and indicated the resident sustained altered skin integrity in November 2017. The clinical records indicated that the referral to the Wound Care Nurse was not completed when the resident sustained altered skin integrity.

The Wound Care Nurse was interviewed and stated the staff were expected to complete a referral for specific altered skin integrity. The Wound Care Nurse also stated that the staff did not complete a referral for this resident when they sustained altered skin integrity. The Wound Care Nurse received a referral in December 2017, and assessed the resident at that time. The resident’s altered skin integrity had deteriorated by the time of the referral. The physician ordered specific tests in December 2017, and the results confirmed an additional diagnosis; however, the resident was already transferred to the hospital.

The DOC was interviewed and stated that the registered staff were expected to have completed the referral to the Wound Care Nurse.

The licensee failed to ensure that the home’s Skin and Wound Care Management Protocol as it related to resident #022, was complied with.

This area of non-compliance was identified during a Complaint Inspection, log #013920-17, and a Critical Incident System (CIS) Inspection #2911-000030-17, log #026496-17, conducted concurrently during this RQI.

B) Resident #011’s clinical record was reviewed and indicated that resident was transferred to the hospital and when they returned to the home, they had altered skin integrity. The clinical records were reviewed and revealed that the referral to the Wound Care Nurse was not completed when the resident returned from the hospital.

The Wound Care Nurse was interviewed and stated that they assessed the resident in January 2018, the Enterostomal Therapy Nurse assessed the resident in February 2018, and changed the resident's treatment. The Wound Care Nurse stated that they thought the staff sent a referral when they first assessed the resident after readmission, but they were wrong. RPN #108 was interviewed and stated that it was an expectation in the home that residents were referred to the wound care nurse for specific types of altered skin integrity. The DOC was interviewed and stated that resident #011 should have been referred to the wound care nurse when they were first assessed to have specific types of altered skin integrity.

The licensee failed to ensure that the home's Skin and Wound Care Management Protocol was complied with as it related to the care of resident #011. (561)

C) The home's policy titled, "Expiry and Dating of Medications", number 5-1, and last reviewed February 2017, directed the registered staff to remove any expired medications and order a replacement if necessary.

In March 2018, LTCH Inspector #527 observed the government stock and found a number of medications expired.

The DOC was interviewed and acknowledged the registered staff were expected to comply with the home's medication policies and procedures. The DOC also acknowledged that registered staff were expected to remove the expired medications and re-order replacements, if needed.

The licensee failed to ensure that the medication policy and procedure related to expired medications was complied with by registered staff. (527)

D) Resident #017 was complaining of new pain and had a specific test performed in May 2017, which confirmed an injury.

The licensee's policy titled "Pain & Symptom Management", number VII-G-30.10, and revised June 2017, as well as the "Pain and Symptom Management Tip Sheet", directed staff to initiate the 24 hour pain monitoring tool for 72 hours (3 days), to review daily and inform the Medical Doctor (MD) or Nurse Practitioner (NP) of new or increased pain. In addition, the policy directed registered staff to complete a pain assessment for pain scores of two (2) or more.

The resident's clinical record was reviewed, which confirmed the 24 hour pain monitoring tool was not initiated for 72 hours. The resident's pain score was assessed in May 2017, and pain assessments were not completed. The MD/NP was not notified of the new onset of pain.

RPN #108 and #110 were interviewed and acknowledged that when a resident had new pain that they were expected to initiate the 24 hour pain monitoring tool for 72 hours (3 days), to review daily and inform the Medical Doctor (MD) or Nurse Practitioner (NP) of new or increased pain. The RPNs also acknowledged that based on their policy for pain

management, if a resident had a pain score greater than two (2), they were expected to initiate a pain assessment. The DOC was interviewed and acknowledged the expectations as stated by the RPNs.

The license failed to ensure the pain and symptom management policy and tip sheet were complied with in regards to resident #017. (527)

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection #2911-000013-17, log #010866-17, conducted concurrently during the RQI.

E) The Ontario Regulation 79/10, s. 136(2) indicated that the licensee was required to ensure that drugs were destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The licensee's policy titled "Drug Destruction and Disposal", number 5-4, and dated February 2017, indicated that medications for destruction/disposal were to be removed from all medication storage areas and retained in a locked area in the medication room, in the designated container in a locked area within the home, which was only accessible by nursing staff.

In February 2018, LTCH Inspector #561 found a specific type of medication in the home in an open box on the floor with other waste products.

RPN #100 was interviewed and indicated that this medication was supposed to be disposed of as per the home's Drug Destruction and Disposal policy.

The licensee failed to ensure that their Drug Destruction and Disposal policy was complied with.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure the food production system must, at a minimum, provide for, (d) preparation of all menu items according to the planned menu.

A) An observation of resident #013 was completed in March 2018. Resident #013's plan of care identified they were a nutritional risk and required a specific type of fluids. The nourishment list was reviewed and identified that staff were to provide resident #013 specific types of snacks and fluids.

PSW #130 was observed adding additional thickener to a pre-thickened fluid. The label on the lid was then observed with the staff member and the LTCH Inspector and it was identified that staff were supposed to shake the beverage before serving and the thickener was not to be added as it was already prepared to the correct consistency in the kitchen. PSW #104 was also observed taking a mug and made resident #013 a beverage by adding thickener to the beverage. It was noted that there was no measuring spoon located on the snack cart with the thickener and neither staff referred to the usage guide for thickening attached to the cart.

As per the recipe, the beverage required a specific amount of thickener and the resident was provided with less, therefore, the beverage was inconsistent and runny. It was also observed that the recipe attached to the snack cart did not provide instructions on how to prepare a specific volume of the same beverage.

B) An observation was completed in March 2018. PSW #158 went to the servery and was provided a container of thickener from the Dietary Aide (DA). The PSW requested a spoon and was provided a metal teaspoon and thickened resident #055's beverage. The beverage was observed to be inconsistent and watery.

The diet list identified resident #065 was ordered specific type of fluids. LTCH Inspector #583 asked the two DA's if they had a recipe available for staff to thicken fluids. Neither staff could locate the usage guide and they did not know how much thickener was required to be added to resident #055's beverage in order to make it the consistency required.

The DSS came to the servery and the recipe was located. It confirmed the PSW staff were not provided with the proper tools or recipe to prepare the specific beverage for resident #065 and the resident was not provided with fluids that were a safe consistency. (583)

This area of non-compliance was identified during a Complaint Inspection, log #021745-17, conducted concurrently during the RQI.

C) In March 2018, a Speech Language Pathologist (SLP) completed an assessment. The documented assessment identified a specific beverage provided to the resident was not the required consistency. It was described that the beverage was a thicker consistency at the beginning of the meal service and changed to a thin consistency by the end of the service.

The SLP said the resident still required a specific fluid consistency and specific textured diet and made a recommendation that the home ensure all fluids provided to resident #013 were a specific consistency as there was risk for aspiration.

In an interview with the RD in March 2018, they acknowledged that the current recipes used to thicken the beverage had been inconsistent. It was also acknowledged that resident #013 was not provided with fluids that were a safe consistency. (583)

D) The planned menu for resident #023 required the resident to receive a food specifically prepared at a certain meal service.

The resident's clinical record was reviewed, which identified the resident returned from the hospital with a specific diagnosis. The resident subsequently had an assessment by the SLP and recommendations were made.

Resident #023 was observed at a specific meal on three occasions in March 2018. On the first and second observation, the resident did not receive the planned menu item, then on third observation the resident received the specific food, but it was not prepared as required.

RN #107 and PSW #154 were interviewed and neither were aware the resident was to receive a food specifically prepared.

The licensee failed to ensure that resident #023 was provided with food that was safe, adequate in quantity, nutritious and varied.

This area of non-compliance was identified during the Complaint Inspections, log #024124-17 and #025475-17, conducted concurrently during this RQI.

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 residents were provided with food and fluids that are safe, adequate in quantity, nutritious and varied, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the residents' equipment were kept clean and sanitary.

Resident #005's, #011's, #013's and #042's mobility devices were observed. The residents' mobility devices remained soiled throughout the inspection.

(i) Resident #005 was interviewed in March 2018, and indicated that the mobility devices were being cleaned approximately twice a month or sometimes less than that. They indicated that they had their family clean their mobility device.

(ii) Resident #042's mobility device was observed soiled on a specific date in March 2018. The schedule obtained from the PSW assignment binder for the cleaning indicated that the mobility device was on the schedule to be cleaned on a specific date in March 2018. LTCH Inspector #561 observed the mobility device after the date it was scheduled for cleaning and it remained soiled. The Point of Care (POC) notes were reviewed and the staff did not sign that they had cleaned the mobility device on the scheduled date.

(iii) Resident #011's and #013's mobility devices were observed on several occasions in March 2018, and they were soiled. The POC documentation for resident #011 was reviewed for March 2018, and the staff failed to document that the mobility device was cleaned on any of the scheduled days over several weeks in March 2018. The POC for resident #013 was reviewed and indicated that the PSWs signed that the mobility device was cleaned twice in March 2018.

RPN #106 was interviewed and acknowledged that there was a schedule for PSWs on the evening shift to clean residents' mobility devices; however, they did not notice if they were being cleaned. The ADOC was interviewed and indicated that it was an expectation that PSW staff on the evening shift were to clean residents' mobility devices once a week according to the schedule in POC.

The licensee's policy titled "Equipment Maintenance and Cleaning – Nursing and Resident Care", number VII-H-10.3, and revised March 2017, did not include a schedule for cleaning of mobility devices.

The licensee failed to ensure that the residents' equipment were kept clean and sanitary.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, (a) the home, furnishings and equipment were kept clean and sanitary, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In July 2017, the home became aware of an incident of alleged staff to resident abuse, when care was provided to resident #021 by a PSW. The ADOC became aware of the incident when resident #021's family shared their concerns with the ADOC.

During the home's investigation it was identified that resident #021, reported an incident of abuse to PSW #144.

RPN #162, acknowledged they were aware of the incident and had not reported it to management in the home or the RN on duty.

In July 2017, interviews were completed with resident #021, the resident's family, PSW #144 and RPN #162. The resident shared that when a PSW came in to their room at the beginning of their shift to provide care, the resident tried to communicate that care wasn't required. They tried to share with the PSW that PSW #144 had recently provided the same care. Resident #021 shared that staff continued to provide the care and alleged the

PSW physically assaulted them.

The plan of care was reviewed and it indicated that resident #021 was not cognitively impaired, could communicate care needs and did not have any history of responsive behaviours.

The staff schedule was reviewed and identified that PSW #160 and #159 worked on the resident's unit on the specific shift and date in July 2017. Upon further review of the worked schedule, it was identified that PSW #160 was taken off their scheduled shifts until the investigation was completed, but that PSW #159 continued to be scheduled to work on resident #021's unit the following shift after the incident.

The licensee's policy titled "Prevention of Abuse and Neglect of a Resident", number #VII-G-10.00, and revised January 2015, was reviewed and directed staff to complete the following:

i) All employees were required to immediately report any suspected or known incident of abuse or neglect to the ED or designate in charge of the home.

ii) Remove the abuser from the resident. Determine if the employee should be sent home with pay, pending investigation of the incident.

In an interview with the DOC, they acknowledged both the PSW and RPN should have immediately informed the Administrator, designate in charge or charge nurse in the home when they became aware of the incident. The DOC acknowledged that PSW #159 should not have been scheduled to work on resident #021's unit, as the PSWs had not been interviewed and the investigation was still pending. It was acknowledged that the licensee's written policy in place to promote zero tolerance of abuse and neglect of residents was not complied with. (583)

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection #2911-000019-17, log #017463-17, conducted concurrently during the RQI.

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 there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) The bathing schedule for a specific unit was reviewed and it was identified that five residents were scheduled for bathing on a specific date in March 2018.

A review of the Point of Care (POC) documentation revealed that resident #050 received a specific type of bath, and resident #051 and resident #023 were not bathed. The documentation indicated that the three residents' bathing was not provided on an alternative date and that they did not have a minimum of two showers that week as per their preference. The plan of care was reviewed and identified that a shower was the method of their choice for all three residents.

In an interview with PSW #150, it was identified that the three residents were not showered. The shift was short one scheduled PSW who was replaced with a PSW who was not able to complete the task of bathing. (583)

B) An observation was completed on another unit in March 2018. The bathing schedule identified resident #021 and #053 were scheduled for a shower on a specific shift and the PSW job routine identified scheduled bathing was to be completed during a specific time period.

Resident #053 was observed in bed asleep and resident #021 was observed in bed awake with day clothing on. Neither resident was observed as being showered recently.

An interview was completed with PSW #145 and #146, after the observation and they acknowledged that resident #021 and #053 had not been showered. It was shared that they would complete their showers later that evening.

Resident #021's plan of care identified their preference was to go to bed at a specific time and resident #053's plan of care identified their preference time to go to bed in the evening. (583)

The licensee failed to ensure that resident #023, #050 and #051 were bathed, at a minimum, twice a week by the method of their choice and that resident #021 and #053's bathing preferences were not implemented.

C) Resident #023's bath/shower days were scheduled on specific days and at a certain time. The home conducted a care planning conference with the interdisciplinary team and the resident's substitute decision makers (SDMs) in March 2017. After the meeting, the SDM provided the home with a document with the meeting notes. In this document the SDM identified the resident's preference for their shower schedule and requested to not have their shower on a specific day and to move the time of their showers. The SDM also documented that they would prefer not for the resident to be showered on specific day as they may take them out.

The clinical record and the home's information for bathing residents were reviewed from February 2017 to March 2018. There was no change to the resident's shower schedule based on the preferences identified by the SDM in March 2017.

PSW #156 was interviewed and acknowledged the resident's shower days and time. The PSW was not aware that the resident had a preference to be showered at a specific time and not scheduled on a specific day. RN #107 was interviewed and they were not aware of the SDM's preference for showers, which was documented in the resident's hard copy

clinical record. The RN acknowledged that shower schedules were based on the resident's preference and they would negotiate the day and time for the shower with the resident and/or their SDM in order to accommodate.

The licensee failed to ensure that resident #023's preferences for showers were implemented as requested.

This area of non-compliance was identified during the Complaint Inspections, log #024124-17 and #025475-17, conducted concurrently during this RQI.

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 was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee failed to ensure that strategies developed were implemented to meet the needs of residents with compromised communication and verbalization skills of residents who cannot communicate in the language used in the home.

A review of resident #021's plan of care identified the resident had a language barrier. The resident spoke a specific language and the goal of the communication plan of care was that the resident would be able to make their needs known on a daily basis. Interventions identified that staff were to utilize a communication tool in the resident's language, which was located in the resident's room, use staff available in the home that speaks the resident's language or to use the family for translation.

In July 2017, the home became aware of an incident of alleged physical abuse when care was provided to resident #021 during a specific shift by a PSW.

During the investigation interviews completed by the DOC and ADOC and with use of a translator, resident #021 shared that when the PSW came in to their room at the beginning of their shift to provide care the resident tried to communicate that care wasn't required. They tried to share with the PSW that PSW #144 had recently provided the same care, but couldn't as there was a language barrier. Resident #021 shared that staff continued to provide the care and alleged an incident of abuse occurred.

The plan of care was reviewed and revealed that resident #021 was not cognitively impaired, could communicate care needs and did not have any history of responsive behaviours.

During an interview with resident #021 and with the DOC present, the resident shared the same incident with the LTCH Inspector. During the interview it was confirmed that the PSW who provided care failed to implement the communication strategies to allow resident #021 to make their care needs known. It was also acknowledged that specific communication strategies were not implemented at the time of the incident. It was acknowledged that resident #021's communication needs were not met. (583)

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection #2911-000019-17, log #017463-17 conducted concurrently during the RQI.

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 strategies were developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home, to be implemented voluntarily.

WN #10: 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and 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.

A) The clinical record was reviewed for resident #013, which identified they had altered skin integrity in March 2018 and received immediate treatment. The electronic record was reviewed, which revealed that the resident’s altered skin integrity had not been assessed at least weekly by registered staff.

RPN #108 was interviewed and stated that resident's with altered skin integrity were required to be assessed weekly by registered staff.

The licensee's policy titled “Skin and Wound Care Management Protocol", number VII-G-10.80, and revised January 2015, indicated that registered staff were to initiate a weekly skin assessment for residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

The ADOC was interviewed and stated that the altered skin integrity for resident #013 was not assessed weekly as expected.

B) The clinical record for resident #020 was reviewed and indicated that the resident sustained altered skin integrity in November 2017, and a family member also noticed additional areas of altered skin integrity. The skin assessment was completed of one area; however, there was no assessment completed for the other area.

The clinical records were reviewed and indicated that in December 2017, that areas of altered skin integrity had deteriorated.

RPN #108 was interviewed and stated that resident's with altered skin integrity required weekly assessments by registered staff.

The licensee's policy titled “Skin and Wound Care Management Protocol", number VII-G-10.80, and revised January 2015, directed the registered staff to initiate a weekly skin assessment for residents' exhibiting altered skin integrity, including skin breakdown, pressure ulcers, and skin tears or wounds.

The DOC was interviewed and stated that registered staff were expected to assess residents' on a weekly basis for any alteration in skin integrity and this was not done as expected.

The licensee failed to ensure that when resident #013 and #020 exhibited altered skin integrity that they had been reassessed at least weekly by registered staff.

This area of non-compliance was identified during a Complaint Inspection, log #013920-17, and a Critical Incident System (CIS) Inspection #2911-000030-17, log #026496-17, conducted concurrently during this RQI.

2. The licensee failed to ensure that equipment, supplies, devices and positioning aids were readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

Resident #020 sustained altered skin integrity, as documented in the progress notes.

The weekly assessment completed by registered staff for the altered skin integrity indicated that the resident required a specific piece of equipment. The clinical record review indicated that there was equipment available in the home and the resident did not receive one at that time. The progress note indicated when the equipment was provided to the resident. The progress note and the assessment of the areas of altered skin integrity identified that the areas had deteriorated.The physician also assessed the resident and suspected the areas of altered skin integrity had deteriorated and ordered a test.

The wound care nurse was interviewed and stated that the specific interventions was one that the home utilized as a prevention technique. The wound care nurse indicated that the equipment was subsequently provided to the resident; however did not recall the exact date of when.

The licensee's policy titled "Skin and Wound Care Management Protocol", number VII-G-10.80, and revised January 2015, indicated that the DOC was to ensure that equipment, supplies, devices and positioning aids were readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

The DOC was interviewed and stated that the specific equipment was not available in the home, but was provided to the resident once available.

The licensee failed to ensure that devices and positioning aids were readily available as required to relieve pressure and promote healing for resident #020.

This area of non-compliance was identified during a Complaint Inspection, log #013920-17, and a Critical Incident System (CIS) Inspection #2911-000030-17, log #026496-17, conducted concurrently during this RQI.

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, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #11: 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,
(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).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

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

A) Resident #028 had a plan of care indicating that they were incontinent and were placed on the nursing rehabilitation program, which indicated that they were on a scheduled routine.

The plan of care indicated the resident required assistance utilizing certain equipment. The assessment in March 2018, indicated that resident was to follow the scheduled routine.

In March 2018, the resident was interviewed by LTCH Inspector #561 and they shared that they had not received care since early that morning. The resident indicated that sometimes they had to wait a long time. The resident became teary and indicated that it was not right to be treated this way.

The RPN asked PSW #102 regarding the resident's scheduled routine and they stated that the resident's specific routine was followed for certain types of continence.They said that usually the resident called. The PSW asked the resident if they needed care and the resident told the PSW that they had not received care since the morning.

Interviewed the ADOC who was the lead for the continence care program and they stated that the resident was on the nursing rehabilitation program and scheduled routine. The staff were to ask the resident every two hours if they needed care, as required. If the resident did not need the specific care then they would document in POC that the resident was continent. They were also required to document if the resident refused care.

This area of non-compliance was identified during a Complaint Inspection, log #026068-17, conducted concurrently during this RQI.

B) Resident #022 was observed in March 2018, and the resident did not receive specific care and none of the staff approached the resident to check if the resident required care.

The resident’s written plan of care was reviewed and outlined the resident's interventions to be implemented for their specific type of care.

The assessment in October 2017, was reviewed and indicated that resident was using a specific device in bed for their care.

PSW #158 was interviewed and they were not aware that resident of the resident's interventions related to specific care required. During the interview, the PSW also stated that resident was not checked today because they had to assist another resident. The PSW indicated that the current written plan of care was not correct.

Interviewed PSW #146 on a different shift and they stated the resident was incontinent and wore a product. The resident was checked every two hours and if needed specific care would be provided. The PSW stated they cared for the resident in bed because of the type of assistance the resident required.

Interviewed the ADOC, who was the lead for the continence care program and they stated that the resident’s current written plan of care was not correct and had not been revised and updated with the current interventions. The registered staff were expected to revise the residents' care plan once they complete an assessment. The ADOC also stated that the latest assessment in October 2017, was not correct, as it indicated that resident used a specific device in bed and they did not.

This area of non-compliance was identified during the Complaint Inspections, log #022782-17 and #024304-17, conducted concurrently during this RQI.

The licensee failed to ensure that resident #028 and #022, had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that their plan was implemented.

2. The licensee failed to ensure that residents who required continence care products had sufficient changes to remain clean, dry and comfortable.

In March 2018, a visitor in the home placed a complaint with LTCH Inspectors' that resident #044 had not received specific care during the meal service. It was shared that resident #044 was not kept clean, dry and comfortable and that residents' and visitors smelled odours throughout the meal service.

During an investigation completed by the home it was confirmed that staff identified that resident #044 was incontinent at the beginning of the meal service and was not removed to receive specific care until approximately 45 minutes later.

Resident #044’s plan of care was reviewed and identified the specific care they required and they were high risk for altered skin integrity.

During the meal service PSW’s #104, #150, #151 and #152 were present. During interviews completed by the home it was identified that the registered staff #109 was not monitoring the meal service, as they were attending to other care issues. All PSWs

reported they were providing meal service duties and assistance to residents' during this time. It was confirmed that none of the PSWs notified the registered staff that they could not provide specific care and assistance required by resident #044.

In an interview with the Administrator, it was shared that it was the expectation that the registered staff should have been monitoring the meal service and that PSWs should have notified the registered staff about the care concerns related to resident #044. It was shared that resident #044 should have been removed from the meal service and provided with the care needed. It was confirmed that resident #044 did not have sufficient changes to remain clean, dry and comfortable. (583)

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection 2911-000006-18, log # 004832-18 and complaint Inspection log #005224-18, conducted concurrently during the RQI.

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, (b) each resident who was incontinent had 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 was implemented, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that a summary of the changes made, included the date that those changes were implemented.

The home's Responsive Behaviour Program annual evaluation was reviewed for 2016. The home had not completed their 2017 Responsive Behaviour Program annual program evaluation at the time of the inspection. The 2016 written evaluation did not include the date that the changes to the program were implemented.

The DOC was interviewed and acknowledged that the dates from their summary of changes to the Responsive Behaviour program for 2016, did not include the dates the changes were implemented.

The licensee failed to ensure that a summary of the changes made to the home's Responsive Behaviour Program included the date that those changes were implemented.

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

In March 2018, LTCH Inspector #583 heard a staff member providing direction to resident #038 in their room behind a closed door in a loud tone.

In an investigation completed by the home, which included interviews with PSW's #148 and #149, they confirmed that the resident exhibited specific responsive behaviour to care that staff needed to complete.

The clinical record was reviewed, which identified the resident's responsive behaviour to specific care on the behaviour monitoring task report generated from Point of Care (POC) over a two week period in March 2018. The written plan of care was reviewed and interventions to manage the resident's behaviours were identified. The progress notes were reviewed and there was no documentation found related to the actions taken by staff to respond to resident #038's identified behaviours on the specific date in March 2018, or the other times it was documented the resident demonstrated behaviours. There was also no documentation related to the resident's responses to the interventions implemented.

The plan of care and POC documentation was reviewed with the ADOC and they acknowledged that actions taken to respond to the needs of resident #038 and the resident's responses were not documented as the home required. (583)

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #005020-18, conducted concurrently during the RQI.

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, (c) a written record was kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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 planned menu items were offered and available at each meal and snack.

A) Resident #022 had a nutritional plan of care indicating that they were a nutritional risk and were also at risk for fluid deficit. The goal was for the resident to be free of symptoms of dehydration through the next review date and staff were to ensure that resident was provided fluid of choice.

The resident's SDM identified that the resident was not receiving the specific fluid, as per the resident's preference and they were concerned that they were not getting enough fluids during meals.

i) Resident #022 was observed in March 2018, and the preferred fluids were not provided to the resident as indicated on the planned menu.

LTCH Inspector #527 reviewed the nourishment list, a document that PSWs refer to when delivering snacks to residents, did not specify that the resident's preference for fluids at specific times.

PSW #158 was interviewed and stated that they were not aware that resident was required to get a specific fluid and it was not on the nourishment list. They also stated that they had never provided resident #022 with the specific preferred fluids.

The DSS was interviewed and acknowledged that the nourishment list did not include the resident's specific fluids they preferred. The RD was interviewed and acknowledged that the resident’s family requested at a meeting that staff provide the specific preferred fluids.

ii) Resident #022 was observed on another date in March 2018. The resident was observed to have one glass of fluids on their table.

PSW #146 was assisting the resident with feeding. There were no other fluids available on the table or offered to the resident. When the LTCH Inspector #561 asked the PSW if the resident was getting more fluids, it was then that the PSW proceeded to the servery area and obtained additional fluids for the resident.

The DSS acknowledged that the standard minimum fluid amount to be provided was greater than one glass of fluids.

The licensee failed to ensure the planned standard minimum fluids were available at a specific meal service and planned menu items were available at snack service for resident #022.

This area of non-compliance was identified during the Complaint Inspection, log #022782 -17 and #024304-17, conducted concurrently during this RQI.

B) Resident #023's clinical record was reviewed and the plan of care identified that the resident had special instructions, which included a food specifically prepared. The plan of care also identified the resident's dislikes and what fluids to avoid.

The resident was observed on several occasions in March 2018 and the following was observed:

(i) The resident did not receive the food specifically prepared and received fluids that were to be avoided. The Dietary Aide #153 was interviewed and indicated the resident didn't receive the specific food. The FSM acknowledged that the resident should have received the specific food at the meal service. PSW #101 was interviewed and was not

aware that the resident should have received food specifically prepared or the resident's dislikes for certain fluids.

(ii) On a specific date in March 2018, PSW #142 was observed serving resident #023 fluids that the resident was to avoid and disliked. When PSW #142 was interviewed, they showed the inspector the nourishment list attached to their snack cart and there was no likes or dislikes documented for this resident, therefore they were not aware the resident disliked the specific fluids.

The licensee failed to ensure that resident #023's planned menu items were offered and available at each meal and snack service.

This area of non-compliance was identified during the Complaint Inspection, log #024124 -17 and #025475-17, conducted concurrently during this RQI.

Additional Required Actions:

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

WN #14: 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: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. 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: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. 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).

Findings/Faits saillants :

1. The licensee failed to ensure that food was served at a temperature that was palatable to the residents.

A meal observation occurred on a specific date in March 2018. During the service resident #029's meal was placed on the table with a cover over it. RPN #140 was seated beside the resident, but was providing assistance to another resident. The food sat covered for approximately 13 minutes until RPN #140 was available to provide the assistance resident #029 required.

LTCH Inspector #583 requested to check the temperature of the meal prior to the staff feeding it to the resident and the food was cold. The home then provided the resident a new meal from the hot plate in the server. The resident was provided assistance to eat approximately an hour later than other residents and when RPN #140 was available to provide assistance.

The licensee's policy titled "Dining Tray Service", number VII-I-10.60, and revised September 2016, identified food was to be served at an adequate temperature, hot foods above 60 degrees Celsius. The Dietary Aide (DA) acknowledged that hot food was to be

served at a minimum of 60 degrees Celsius.

This area of non-compliance was identified during a Complaint Inspection, log #021745-17, conducted concurrently during the RQI.

2. The licensee failed to ensure that the home had a dining and snack service that included, at minimum, the following elements: 9. Provided residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A) Resident #022 had a nutritional plan of care indicating that they were a nutritional risk.

The nutritional plan of care identified that resident #022 was assessed by the Registered Dietitian (RD) to have fluids provided in an assistive device at meals.

The resident was observed on a specific date in March 2018. Fluids were provided to the resident in an assistive device and another type of fluid was served in a regular glass. The resident was also observed at another meal service in March 2018, and fluids were provided to the resident in a regular glass.

RPN #162 was interviewed and they acknowledged that the resident required an assistive device and brought one from the servery. Only one type of fluid was served in the assistive device.

The RD was interviewed and confirmed that the resident was to have fluids served in an assistive device. This was discussed with the family as well during one of the family meetings. The diet list located in the servery was reviewed by LTCH Inspector #583, and it was not updated to include this intervention. The DSS was interviewed and acknowledged that the diet list was not updated. (583)

This area of non-compliance was identified during the complaint inspections log numbers 022782-17 and 024304-17, conducted concurrently during this RQI.

B) During an observation of a meal service on one of the home areas in March 2018, resident #024 was observed at a specific time having difficulty feeding themselves. A number of residents remained in the dining room and one PSW staff remained in the dining room providing feeding assistance to a resident at a table on the opposite side of the room. The RPN was in the hall and the other two PSWs were providing resident care

outside the dining area.

The resident was unable to scoop the food with regular cutlery or lift their drink in a regular cup and reach their mouth. LTCH Inspector #583 spoke to the Dietary Aide (DA) who confirmed that resident #024 was supposed to have an assistive device for their fluids according to the diet list, which also identified the resident's special needs and preferences. Staff removed resident #024's main entrée and dessert was not offered.

A restorative feeding assessment completed in February 2018, identified resident #024 was not a candidate for the program as they were mostly dependent and required much assistance for their activities of daily living.

The DOC was interviewed and acknowledged that resident #024 was not provided with the assistive device they required for their fluids and staff did not provide the assistance the resident required during the meal service.

The licensee failed to ensure that resident #022 and #024 were provided with assistive devices and personal assistance required to drink as comfortably as possible. (561)

This area of non-compliance was identified during a Complaint Inspection, log #024592-17 and #025072-17, conducted concurrently during the RQI.

C) The meal service was observed in one of the home areas in March 2018. During the meal service resident #029, #059 and #060 had a family member/visitor present that provided them with feeding assistance. The family members/visitors finished feeding the main entree to the residents. At this time they began providing feeding assistance to other residents in the dining room that had not yet started to eat, as they required assistance or encouragement to eat. These residents had not yet been assisted by staff as there were no staff available that were not already providing feeding assistance to other residents. The family members/visitors provided both feeding assistance and encouragement with eating to residents and re-direction to residents with responsive behaviours. The family members/visitors volunteered to provide assistance to resident #038, #061, #045 and #062. RPN #110 was present during the meal service while the family members/visitors volunteered their time and assistance.

The "volunteer orientation on assisting in the dining room", training attendance sheets were reviewed. As there were volunteers in the home who provided mealtime assistance who had received "volunteer orientation on assisting in the dining room" training, per the

home's procedures. Upon review of the training records none of the three family members/visitors were volunteers in the home had been offered or received this training on mealtime assistance.

The ADOC was interviewed and acknowledged that resident #029, #059 and residents, were not provided the personal assistance and encouragement with eating that they required from staff. In an interview with the RD, it was identified that the residents were not provided with the personal assistance and encouragement required to safely eat and drink as the family members/visitors assisting other residents were not aware of these residents' nutritional risk, special dietary interventions or nutrition plans of care.

The licensee failed to ensure that resident #38, #045, #061 and #062 was provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

4. The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

An observation was completed at a meal service on a specific home area in March 2018.

A) Resident #056 was observed as not safely positioned in their mobility device and didn’t appear to have been repositioned prior to feeding. The resident was repositioned by the activation staff with the help of RPN #126. After the resident was repositioned staff were able to feed the resident safely. Resident #056’s nutrition plan of care identified they required feeding assistance by staff a were on a texture diet.

B) Resident #057 was observed as not safely positioned in their mobility device by RPN #106. In an interview with RPN #126, it was acknowledged the resident wasn’t safely positioned in an upright position. Resident #057’s nutrition plan of care identified they required feeding assistance by staff and were on a textured and fluids had to be a specific consistency.

C) Resident #058 was observed being fed by a staff member in a mobility device and not positioned properly. After LTCH inspector #583 observed the resident and spoke to RPN #126, the staff used a device to improve the resident’s position and achieve an upright more centred position. Resident #058’s nutrition plan of care identified they required feeding assistance by staff and were on a texture diet and fluids had to be a specific consistency.

The RD was interviewed and it was shared that the expectation for all residents, unless specified otherwise in their plan of care was that residents were fed in an upright position. Proper techniques including safe positioning were not provided for resident #056, #057 and #058. (583)

D) Resident #043's written plan of care indicated that they were a nutritional risk and required a texture diet. The plan of care also included the use of a mobility device, which was to be upright during meal times.

During the meal service on specific date in March 2018, resident #043 was observed being fed their texture diet by a PSW student and was not positioned upright.

RN #134 was interviewed and indicated that the resident was not at risk even though they were not positioned upright while being fed. Approximately 10 minutes later, the RN was observed readjusting the resident's mobility device to be upright while they finished their meal.

In an interview with the RD, they acknowledged that the resident was a nutritional risk and should have been positioned upright during the meal, as per their plan of care.

Resident #043 was not safely positioned while eating.

The licensee failed to ensure that proper techniques were used to assist resident #022, #043, #057 and #058 with eating, including safe positioning of residents who required assistance.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home had a dining and snack service that included, at a minimum, the following elements: 6. Food and fluids being served at a temperature that was both safe and palatable to the residents, and 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #15: 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 the procedures to report and locate residents' lost clothing and personal items was implemented.

During the resident and family interviews completed in February 2018, it was shared that clothing and personal items for residents #005, #010 and #012, had been lost in the past several months and had not been located. In all cases, it was shared that the residents' items were reported missing to staff in the home.

The licensee's policy titled "Missing Clothing and Items", number VII-C-10.12, and revised April 2016, identified the procedure the staff were to follow in an effort to locate residents' missing clothing and items. The policy directed PSW's to report the lost items by forwarding the "Missing Clothing and Items Form" to the environmental services department if the item was not found in the resident's home area.

The Environmental Services Manager (ESM) was to complete the following:

i) Track and trend missing clothing and items and forward it to the ED for review.
ii) Assist in the development of actions to minimize future occurrences.
iii) File a copy of the completed "Missing Clothing and Items Form".

During an observation of the units, it was identified that the "Missing Clothing and Items Form" was readily available to residents and families in the resident home areas. However, a filed copy of the form was not located for resident #005, #010, or #012's missing items and clothing. LTCH Inspector #583, reviewed the filed copies of the form for 2017 and 2018.

In an interview with the ESM and Laundry Manager, they acknowledged that the forms were not being filled out and at the time of the inspection only two forms could be located for this time period. The ESM also acknowledged that the home was not tracking and trending missing clothing and items, and actions could not be identified that were taken to minimize future occurrences. It was acknowledged that the process to report and locate residents' lost clothing and personal items was not implemented.

The licensee failed to ensure that the procedures to report and locate resident #005, #010 and #012's' lost clothing and personal items were implemented.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, (a) procedures were developed and implemented to ensure that, (iv) there was a process to report and locate residents' lost clothing and personal items, to be implemented voluntarily.

WN #16: 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 failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

A) On specific date in March 2018, LTCH Inspector #527 observed the medication cart on one of the home areas. There were residents' personal belongings and drugs stored together in the medication cart. The following items were observed:

- In the first drawer of the medication cart there was jewellery;
- In the second drawer, there were visual devices belonging to residents;
- In the third drawer, there were visual devices belonging to residents, jewellery and other

personal items; and
- In the fifth drawer there was a resident's jewellery, resident communication and visual devices and an electrical charger belonging to a resident.

RPN #112 was interviewed and said that they were to keep the resident's belongings in the medication cart, or they may get lost and that they had nowhere else to store them.

The DOC was interviewed and said the staff were informed to not keep resident belongings in the medication cart and to give them to the family to take home if the resident does not need them. The DOC acknowledged that resident belongings were not to be stored in the medication carts, which were to be used for drugs and drug-related supplies.

The licensee failed to ensure that drugs were stored in the medication cart that was used exclusively for drugs and drug-related supplies. (527)

B) In February 2018, LTCH Inspector #561 found a prescription cream for resident #040, on the resident's night table. Furthermore, the Inspector also observed a bottle of a solution left on the night table of resident #041 and another bottle of the same left in resident’s bathroom.

RPN #106 acknowledged that the bottles of the solution should have been stored in the treatment cart in the medication room. RPN #106 also acknowledged that prescription creams were to be kept in the treatment cart in the medication room unless a resident had an order for self-administration. The RPN acknowledged that resident #040 did not have an order for self-administration. The clinical records were reviewed and confirmed the same.

The licensee's policy titled “Medication Storage”, number 3-4, and dated February 2017, indicated that all medications were to be safely stored in accordance with applicable legislation, medications stored in a medication room must be locked at all times. Medication carts used to store all medications were to be locked at all times when not attended by a nurse. (561)

C) On a specific date in March 2018, LTCH Inspector #527 observed an unmonitored and unlocked medication cart on two home areas. The Inspector was able to open all the drawers in each cart and observed medical supplies, medication, and personal health information of residents living on these units.

RPN #106 and #129 were interviewed and acknowledged that the medication cart was unlocked, out of their sight and that the medications were not secured.

A review of the licensee's policy titled, "The Medication Cart and Storage Maintenance", number 3-5, and last reviewed February 2017, directed registered staff to keep medication carts locked at all times except: while in sight of a nurse.

The DOC was interviewed and acknowledged that all registered staff who administer medication were responsible for the safety of the medication cart by ensuring it was secured and locked when not in use, not in sight of the nurse and that this was not done.

The licensee failed to ensure that drugs and drug-related supplies were secure and locked.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, (a) drugs were stored in an area or a medication cart, (i) that was used exclusively for drugs and drug-related supplies, and (ii) that was secure and locked, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #011 had a plan of care indicating that they had a specific diagnosis, which required scheduled medication daily.

The Medication Administration Record (MAR) was reviewed, which indicated that there was a specific physician's order in place for the daily scheduled medication based on a test the nurses performed prior to the administration of the medication.

RPN #108 was interviewed and indicated that it was the expectation that when a resident's test result was a certain range, the staff were to call the physician. This should also be documented in the progress notes. If the staff were unable to reach the physician it was expected that the NP was called.

The progress notes were reviewed for the month of July 2017, and on a specific date and time, the resident's test result was outside the range. There was no documentation found indicating that the physician was called. On another date in July 2017, the resident's test result was also outside the range specified by the physician. The nurse paged the physician; however there was no call back. On another date in July 2017, the resident's test result was outside the range specified by the physician. There was no evidence that a physician was called, and the NP was not contacted.

RPN #108 indicated that they were not working on the unit at the time; however indicated that if the physician did not call back the staff should have called the NP.
The DOC stated that the physician should have been notified on the specific dates in July 2017, when the physician did not call back then the NP should have been contacted. (561)

This area of non-compliance was identified during a Complaint Inspection log #021415-17, conducted concurrently during this RQI.

A Complaint was reported to the Director indicating that registered staff failed to apply treatment as per the physician's order for resident #022, when they sustained an injury in September 2017.

The clinical record was reviewed and indicated that this occurred in September 2017. The written plan of care indicated the resident was at risk for altered skin integrity related to bed immobility and incontinence. The staff were to use only products as per the SDM's request and apply dressings, as per the physician's order. The Treatment Administration Record (TAR) was reviewed for the month of September.

The home investigated the issue and found that the registered staff who provided the treatment did not follow the physician's order.

The home's investigation notes indicated that during the interview with the registered staff, they stated that they provided the treatment to the resident's area of altered skin integrity, which was not according to the physician's order.

The DOC was interviewed and acknowledged that the treatment was not provided as per the physician's order.

The licensee failed to ensure that drugs were administered to resident #011 in accordance with the directions for use specified by the prescriber. (561)

This area of non-compliance was identified during the Complaint Inspections, log #022782-17 and #024304-17, conducted concurrently during this RQI.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #18: 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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure the written record of the annual Infection Program and Control program evaluation (d) 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.

The 2017 Annual Program Evaluation for the Infection Prevention and Control program was reviewed by LTCH Inspector #527. The evaluation did not include the date that the changes were implemented based on the annual program evaluation.

The ADOC was interviewed and confirmed that the annual program evaluation for Infection Prevention and Control included the summary of the changes; however there were no dates of when the changes were implemented.

2. The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program (IPAC).

A) On a specific date in March 2018, LTCH Inspector #527 observed RPN #108 perform a test prior to medication administration for resident #011 and #017. The RPN was observed wearing gloves for each of the procedures. The RPN had dropped one of the gloves on the floor, picked it up, placed it back on their hand and then went to resident

#011 and administered their medication. The RPN was observed not removing and disposing of their gloves after performing procedures on both residents until the RPN was outside each of the residents’ rooms and disposed of them in the medication cart garbage receptacle in the hallway. RPN #108 was observed inconsistently performing hand hygiene using the hand sanitizer. In addition, RPN #108 removed the isolation signage off the door of resident #017’s room when the resident was in Contact Isolation.

The licensee's policy titled “Hand Hygiene”, number 3-16, and revised February 2017, directed staff to perform hand hygiene before and after resident contact, before and after an aseptic procedure and before wearing and after removing gloves. The policy also directed staff to not use gloves as a substitute for hand hygiene and gloves should be removed immediately after completion of the procedures, at the point of use and before touching clean environmental surfaces.

RPN #108 was interviewed and indicated that they were trained to wear gloves when performing the test prior to the medication administration. They said that they use clean gloves with each resident. The RPN was unable to provide an answer when asked when they should perform hand hygiene during and after the procedures.

The DOC was interviewed and acknowledged that staff were expected to follow the 4 Moments of Hand Hygiene, as per their policy and procedures. The 4 Moments of Hand Hygiene included before and after resident contact and before and after aseptic procedures.

The licensee failed to ensure that RPN #108 participated in the implementation of the infection prevention and control program, as it related to medication management.

B) On a specific date in March 2018, LTCH Inspector #527 was in resident #016's room. The resident was on isolation precautions.

The resident was observed with their bed in a high position and the resident was exhibiting symptoms of an infection. The LTCH Inspector pulled the call bell and when RPN #106 entered the room, they had no personal protective equipment (PPE) donned. The RPN was observed in the resident's care environment assisting the resident with no PPE.

The licensee's policy titled "Droplet Precautions - Staff / Resident / Visitors", number IX-G-10.70(c), and last revised January 2015, directed staff to follow routine practices at all

times. Gown, gloves and a surgical grade mask with visor will be worn within two metres (six feet) of the resident.

RPN #106 was interviewed and stated that they were expected to wear PPE because the resident was on isolation precautions. The DOC was interviewed and acknowledged that staff were expected to perform hand hygiene and wear PPE when providing care to resident's in isolation.

The licensee failed to ensure that RPN #106 implemented infection prevention and control practices.

3. The licensee failed to ensure that on every shift, (a) 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.

The licensee's policy titled "Line Listing - Resident Surveillance", number IX-E-10.40, and last revised January 2015, was reviewed and the policy directed registered staff to note the signs and symptoms reported on the Infection Control Surveillance Record Form. The staff were expected to review the Infection Control Surveillance Record Form at the beginning of each shift and observe for any potential clusters, which could suggest an outbreak.

The Infection Control Surveillance records (Line Lists) were reviewed on each unit:

- On a specific unit they had no residents identified as exhibiting signs and symptoms of an infection when resident #011 had several infections, and resident #045 also had symptoms of an infection.
- On another unit the Infection Control Surveillance records (Line List) were reviewed and two residents were not listed on the surveillance record. Those residents included: resident #046 and resident #047, who were exhibiting symptoms of an infection.
- On another unit the Infection Control Surveillance record (Line List) was reviewed and two residents were not identified as exhibiting signs and symptoms of an infection. Resident #048 and resident #001 were exhibiting symptoms an infection. Both residents were not documented on the surveillance record.

RPN #100, #106, #108, #109 and #110, as well as RN #132 were interviewed. The registered staff were aware that they were expected to track infections on their units, but were confused as to when they were to document the signs and symptoms of an

infection; they were not aware that they were to review the Infection Control Surveillance Record at the beginning of each shift and observe for potential clusters; four RPNs and the RN did not know they were to report to the Infection Control Practitioner immediately.

The ADOC, who was the Infection Prevention and Control (IPAC) Lead, was interviewed and confirmed that registered staff were expected to review and document on the Infection Control Surveillance Record (Line List) every shift and when residents exhibit any signs or symptoms of an infection.

The licensee failed to ensure that on every shift, registered staff were documenting and monitoring symptoms indicating the presence of infection in residents, in accordance with evidence-based practices.

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, (e) 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, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

LTCH Inspector #527 conducted the critical incident inspection related to resident #017's injury in May 2017.

The home reported to the Director that resident #017, was involved in an incident that caused an injury. As a result the resident was taken to the hospital and resulted in a significant change in the resident's health status.

The CIS was submitted to the Director on a specific date in May 2017; however the home did not report the results of the investigation and the actions taken.

The DOC and ADOC were interviewed and acknowledged that they did not report the results of their investigation of this incident to the Director.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #010866-17, CIS #2911-000013-17, conducted concurrently during the RQI.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, (a) a care conference of the interdisciplinary team providing a resident’s care was held within six weeks following the resident’s admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any.

A) Resident #023 was admitted to the home in February 2017. In March 2017, the home conducted the resident's admission care conference, which included the resident's substitute decision-maker (SDM). The resident's SDM was making decisions related to the resident's care.

The resident's plan of care was reviewed and it was identified that the tool used by the interdisciplinary team members in Point Click Care (PCC) was effective on a specific date in January 2018 and the date of the annual conference was documented as another date in January 2018. The Interdisciplinary Care Conference (IDCC) tool had a section called "Resident/Family Observations". Section 10 of the IDCC identified the Care Conference Attendees. The resident and SDM were not identified on the form as attending.

The SDM was interviewed in March 2018, they indicated that they had not attended an annual care conference to review the plan of care for resident #023 with the interdisciplinary team members.

The DOC and the Social Worker were interviewed and acknowledged that the team completed the IDCC, then they would have the care conference and invite the resident and family. The DOC and Administrator acknowledged that there was no interdisciplinary annual care conference with the resident and/or SDM. (527)

This area of non-compliance was identified during the Complaint Inspection, log #024124 -17 and #025475-17, conducted concurrently during this RQI.

B) During an interview with resident #024's SDM, it was shared that resident #024 nor themselves were given an opportunity to participate in an annual care conference. They shared that they wanted to have an opportunity to discuss resident #024's plan of care and other matters with the interdisciplinary team. They shared they had attended them in the past, but it had been greater than one year since they were invited to participate in a care conference.

The plan of care was reviewed for 2017 and 2018 and no records were found that the care conference took place with the required documentation. An interview was completed with the Resident Relations Coordinator and documentation was provided that showed the last annual care conference was held in April 2016 and they acknowledged that an annual interdisciplinary care conference was not held in 2017 for resident #024. (583)

This area of non-compliance was identified during a Complaint Inspection, log #024592-17 and #025072-17, conducted concurrently during the RQI.

The licensee failed to conduct an annual interdisciplinary care conference for resident #023 and #024 and their SDMs in order to discuss the plan of care and any other matters of importance to the resident and their SDM.

WN #21: 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).

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 the following was 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: 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.

The annual program evaluations were reviewed for 2017, and the written record included the summary of changes made; however the date that those changes were implemented

were not documented in the written record. The annual program evaluations reviewed included:

(i) The falls prevention annual program evaluation for 2017;
(ii) The nursing rehabilitation and restorative care annual program evaluation for 2017;
(iii) The skin and wound care annual program evaluation for 2016 as the 2017 was not completed as yet; and
(iv) The continence care and bowel management annual program evaluation for 2016.

The licensee's policy titled "Falls Prevention", number VII-G-10.00, and revised January 2015, directed the staff to keep a written record of each evaluation, which included the date(s) the changes were implemented.

The DOC was interviewed and acknowledged that the date(s) their changes and accomplishments were implemented for each of the programs noted above, were not documented in the 2016 or 2017 annual program evaluations.

The licensee failed to ensure that the written record of the 2016 and 2017 annual program evaluations for the falls prevention program, the nursing rehabilitation and restorative care program, the skin and wound care program and the continence care and bowel management program included the date that the changes and improvements were implemented.

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including interventions were documented.

Resident #024's plan of care identified their bathing method and it was to be completed two times per week on the resident's scheduled days.

The Point of Care (POC) documentation for bathing was reviewed and it was identified that there was no documentation on specific dates in March 2018, to demonstrate that resident #024 received their scheduled shower.

Both the plan of care and POC documentation was reviewed with RPN #108 and it was identified that there was no documentation that the resident refused or was unavailable for their shower. RPN #108 acknowledged that there was no documentation as to what action was taken with scheduled bathing by staff on resident #024's bath day.

The licensee failed to ensure that any actions taken with respect to resident #024's bath were documented.

This area of non-compliance was identified during a Complaint Inspection, log #024592-17 and #025072-17, conducted concurrently during the RQI.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received individualized care, including hygiene care and grooming, on a daily basis.

An observation was completed of resident #024 on three occasions in March 2018. On a specific date in March 2018, resident #024 was observed to need hygiene care and grooming. RPN #108 observed the resident's hygiene with LTCH Inspector #583.

A review of resident #024's plan of care identified they required staff for personal hygiene and grooming.

Point of Care (POC) documentation and PSW #139 acknowledged that resident #024 received a shower on a specific date in March 2018.

The licensee's policy titled "Hygiene Personal Care and Grooming", number VII-G-10.50, and revised January 2015, identified each resident would receive individualized personal care, including hygiene and grooming, on a daily basis and more often as necessary using an abilities approached focus.

In an interview with RPN #108 it was acknowledged that resident #024 did not receive the individualized care for hygiene care and grooming on a daily basis that was identified in the resident's plan of care and the licensee's policies.

The licensee failed to ensure that resident #024 received individualized care, including hygiene care and grooming, on a daily basis.

This area of non-compliance was identified during a Complaint Inspection, log #024592-17 and #025072-17, conducted concurrently during the RQI.

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was assisted with getting dressed as required, and was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

Resident #001 was observed with soiled clothing on three occasions in February and March 2018. The resident required assistance of one staff for dressing.

PSW #112 was interviewed and indicated that they don't change the resident's clothing when they were soiled because they would have to change the resident after every meal. They wait until after supper then the resident would be changed for bed and clean clothes put on the next morning.

The DOC was interviewed and acknowledged that the PSWs were expected to change residents' clothing when soiled.

The licensee failed to ensure that resident #001 was dressed in clean clothing.

WN #24: 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, (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 was promptly prepared.

The Prevention of Abuse and Neglect 2017 annual program evaluation was reviewed and there was no date(s) identified as it related to when the changes and improvements were implemented.

The licensee's policy titled "Prevention of Abuse & Neglect of a Resident", number VII-G-10.00, and revised January 2015, directed staff to keep a written record of each evaluation, which included the date(s) the changes were implemented.

The Administrator was interviewed and confirmed that they were expected to identify the date(s) on the annual program evaluation, when the prevention of abuse & neglect changes / improvements were implemented and this was not done.

The licensee failed to ensure that the written record of the 2017 annual program evaluation included the date that the changes and improvements were implemented.

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

The SDM for resident #023 contacted the Ministry of Health and Long Term Care (MOHLTC) Action Line in October and November 2017, related to care concerns.

The SDM was interviewed in March 2018, via telephone regarding their concerns and they told the LTCH Inspector #527, that they had spoken to the charge nurses, the ADOC and the DOC and they were not helpful in answering their questions regarding

their concerns. The complainant said they kept notes of all interactions and responses from the home. The SDM told the LTCH Inspector that because they weren't seeing their concerns being addressed, they escalated to the ADOC and the DOC and they had made formal complaints.

The home's complaint records were reviewed for 2017 and 2018; however there were no complaint records regarding the concerns related to resident #023.

RN #107 was interviewed and was aware of concerns the SDM had shared with them and told the inspector that the SDM had subsequently spoken to the ADOC and DOC. The RN said that the SDM was not happy with the response they received from the staff on the unit. The DOC was interviewed and indicated that they had not received any complaints from resident #023's SDM and therefore, no investigation was conducted. The DOC acknowledged that when they receive a written or verbal complaint, they would contact the complainant, investigate and provide feedback on the actions taken to resolve the complaint.

The licensee failed to ensure there was a complaint record, investigation and resolution to the POA regarding the concerns related to resident #023's care.

This area of non-compliance was identified during the Complaint Inspection, log #024124 -17 and #025475-17, conducted concurrently during this RQI.

2. The licensee failed to ensure that a documented record was kept in the home that included the nature of each verbal complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

A complaint was made to the Director from resident #032 related to shortage of staff affecting resident care in October 2017.

Resident #032 was interviewed in March 2018, and informed LTCH Inspector #561 that due to the shortage of staff their shower times were changed. As a result of that the PSWs were not comfortable providing care to the resident as they wished. The resident indicated that this had been an issue until now and there was no resolution and response provided to them yet. The resident indicated that they had reported their concern to a

charge nurse.

RN #128 and RPN #129 were interviewed and confirmed that this was a concern. RN #128 indicated that this was brought to their attention in January 2018. The progress notes indicated that this concern was forwarded to the DOC and ADOC on the same date in January 2018.

The complaints binder for 2017 and 2018 was reviewed and there was no complaint form filled out and no written response provided to the resident in relation to their concern.

The DOC was interviewed and indicated that they were aware of this concern and they had talked to the PSWs about their roles and responsibilities. They had a meeting and informed the PSWs that the resident needed to receive the care as required. If staff were not comfortable with providing the specific care, they needed to notify the registered staff. The DOC indicated that the complaint form was not filled out because this was not considered a complaint; but a concern that staff felt they were not comfortable providing the care.

The licensee's policy titled "Complaints Management Program", number XXIII-A-10.40, and revised October 2017, indicated that for all verbal complaints the Executive Director or designate will:

- Contact or arrange to meet with the complainant to obtain information about the area(s) of concern.
- Conduct and document an internal investigation utilizing the Complaint Record Form or document all information on the Weekly Operational Review (WOR) Complaint Tab.
- Contact complainant and communicate actions taken to resolve the complaint.
- Ensure departmental managers report and follow up on verbal complaints from any source within their department and complete a Complaint Record within one business day of receiving a verbal complaint.
- Update the Complaint Record Form and log verbal complaints within the summary on the WOR Complaint Tab or if not using Complaint Record Form update WOR Complaint Tab.

The licensee failed to ensure that the concern reported by resident #032, related to their care was documented and a response provided to the resident.

This area of non-compliance was identified during a Complaint Inspection, log #024225-

17, conducted concurrently during this RQI.

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee failed to ensure an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The quarterly Professional Advisory Committee (PAC) meeting minutes from April 2017 to January 2018, were reviewed. Although the committee was interdisciplinary and met quarterly to discuss the medication management system, the team did not include the Administrator.

The DOC was interviewed and acknowledged that the Administrator did not attend the quarterly interdisciplinary team meetings from April 2017 to January 2018, to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The licensee failed to ensure the interdisciplinary team included the Administrator, to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and the registered dietitian (RD) who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The 2017 annual program evaluation to evaluate the effectiveness of the medication management system in the home was reviewed. The interdisciplinary team did not include the Administrator, the RD and the Medical Director.

The DOC was interviewed and acknowledged that the Medical Director, the RD and the Administrator were not included in the 2017 annual program evaluation to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The licensee failed to ensure the interdisciplinary team included the Medical Director, the Administrator and the registered dietitian (RD) to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

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

Issued on this 13th day of July, 2018

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) :	KATHLEEN MILLAR (527), DARIA TRZOS (561), JESSICA PALADINO (586), KELLY HAYES (583)
Inspection No. / No de l'inspection :	2018_544527_0005
Log No. / No de registre :	004036-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 13, 2018
Licensee / Titulaire de permis :	2063415 Ontario Limited as General Partner of 2063415 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Maple Grove Care Community 215 Sunny Meadow Boulevard, BRAMPTON, ON, L6R-3B5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michele Mackenzie

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

To 2063415 Ontario Limited as General Partner of 2063415 Investment LP, 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 :

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

Order / Ordre :

The licensee must be compliant with s. 6 (4) of the LTCHA, 2007 and Regulations 79/10.

The licensee will do the following:

1. Ensure that staff are knowledgeable regarding the plan of care for resident #017 and any other resident and that the different aspects of the plan of care is integrated, consistent and complement each other, especially related to chewing and swallowing difficulties.

2. Ensure that staff notify the physician or nurse practitioner (NP) when a resident has a change in pain and skin changes and that requires an assessment and further treatment.

3. Ensure that registered staff take action when a PSW reports a change in pain and skin changes for a resident and that requires an assessment and intervention(s).

Grounds / Motifs :

1. The licensee failed to 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 were integrated and were

with and complement each other.

Resident #017 was diagnosed with an injury in May 2017. The resident's clinical record, the home's investigative notes and communication books were reviewed and identified the resident had a change in status prior to the diagnosis. Based on the investigative notes the PSWs were reporting changes in the resident's status to the registered staff; however the registered staff did not notify the physician and/or the nurse practitioner (NP) to assess the resident until later. When the NP assessed the resident, they ordered a diagnostic test. The order was faxed to the service provider, which was three days after the resident's status changed, and the diagnostic test was not performed until four days after it was ordered by the NP. Once the home was notified of the abnormal results, the resident was transferred to the hospital for treatment.

Interview with the Physiotherapist (PT) confirmed that it was after the NP's assessments that they received a referral to assess the resident and changed their transfer status. The PT stated that they did not receive a referral when the resident's transfer and mobility status had changed and they should have been re-assessed.
The DOC was interviewed and stated that when the staff identified the change in status the registered staff were expected to contact the physician or NP, and to make a referral to the PT to re-assess the resident's transfer and mobility needs.

The licensee failed to collaborate with other staff in the different aspects of care related to the resident #017's injury, therefore the care was not integrated and consistent and complemented each other.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection #2911-000013-17, log #010866-17, conducted concurrently during the RQI.

2.The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s.299(1) of the Regulation, in respect of the actual harm that resident #017 experienced, the scope of one isolated incident, and the Licensee's history of noncompliance (WN) on April 28, 2017 Resident Quality Inspection, Inspection #2017_561583_0009) and a Complaint Inspection, Inspection #2016_337581_0015 on October 5, 2016 (VPC) with the s. 6 (4)(a) related to the plan of care to ensure 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 were integrated and were consistent with and complement each other. (527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 16, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA, 2007 and Regulations 79/10, and will do the following:

1. Ensure that resident #022 is not excluded from recreational activities and that the resident is invited to attend and encouraged to attend activities and programs provided by the home.

2. Ensure that staff follow the physician's order in the Treatment Administration Record (TAR) for resident #022 and ensure that resident receives the appropriate treatment.

3. Ensure that staff comply with resident #022's plan of care related to a specific mobility device and foot pedals are removed when the resident is in the TV room.

4. Ensure that PSW staff and registered staff monitor output for resident #011 and other residents in the home. Ensure PSWs and registered staff document the amount of output in resident #011's clinical record.

5. Ensure that registered staff comply with the physician's orders for resident #011 and registered staff ensure that actions taken are documented in resident's clinical record.

6. Ensure that staff comply with the approaches set out in resident #038's plan of care when providing care to the resident to avoid triggering responsive behaviours.

7. Ensure that staff launder resident #013's specific medical clothing as directed in the plan of care.

Grounds / Motifs :

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

A) Resident #010 had a fall in January 2018, was injured and then transferred to the hospital. The resident was assessed prior to the fall as a moderate risk for falls.

The clinical record was reviewed and indicated on the written plan of care that

the resident was to have specific interventions to reduce the risk for falls.

The resident was observed on three specific dates in March 2018, and the fall prevention interventions were not implemented, as required.

RPN #110 and PSW #112 indicated what the specific falls prevention interventions were for the resident; however they were not implemented.

The licensee failed to ensure the falls prevention interventions were implemented for resident #010, as specified in the plan of care.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection #2911-000005-18, log #006935-18, conducted concurrently during the RQI.

B) In March 2018, Long Term Care Home (LTCH) Inspector #583 heard a staff member providing direction to resident #038, behind a closed door in a loud tone. LTCH Inspector #583 approached the resident's room and resident #038 was brought out by PSW #148 and #149. The LTCH Inspector interviewed the resident asking how they were feeling and how the care was that they received. The resident was non-responsive and was not distressed.

A review of resident #038's plan of care directed staff to approach the resident in a certain way to avoid triggering responsive behaviours.

In an investigation completed by the home, which included interviews with PSW's #148 and #149, it was confirmed that the resident was experiencing responsive behaviours during care.

In an interview with the ED in March 2018, they acknowledged that resident #038's plan of care directed staff to use a specific approach with the resident. The care set out in the plan of care was not provided to the resident as specified in the plan. (583)

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #005020-18, conducted concurrently during the RQI.

C) Resident #016 had a fall in December 2017, was transferred to the hospital and diagnosed with an injury. The resident was assessed prior to the fall as a

moderate risk for falls.

The clinical record was reviewed and indicated on the written plan of care that the resident was to have specific falls prevention interventions implemented.

The resident was observed in March 2018, and the falls prevention interventions were not implemented.

RPN #106 was interviewed and indicated what the falls prevention interventions were for the resident; however they were not implemented. The RPN acknowledged that the staff did not follow the falls preventions interventions outlined in the written plan of care for resident #010.

The licensee failed to ensure that the specific falls interventions were implemented for resident #010, as specified in the plan. (527)

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection #2911-000035-17, log #028853-17, conducted concurrently during the RQI.

D) Resident #023 was assessed as exhibiting a specific behaviours. The clinical record was reviewed and the plan of care identified the interventions to manage these behaviours.

The resident was observed on three dates in March 2018, and the interventions were not implemented.

PSW #156 was interviewed and acknowledged what the interventions were to manage the resident's behaviours; however they were not implemented.

The licensee failed to ensure that the care for managing resident #023's behaviour was provided as specified in the plan. (527)

This area of non-compliance was identified during the Complaint Inspections, log #024124-17 and #025475-17, conducted concurrently during this RQI.

E) The plan of care for resident #013 identified that their specific medical clothing was not to go down to the laundry department as they needed to be hand washed.

In an interview with Housekeeping and Laundry Services Manager in March 2018, it was shared that two items of resident #013's medical clothing was sent down to the laundry department and washed. One piece of clothing was located and the other was missing. A missing item and clothing form was posted in the laundry department, but the medical clothing had not been located.

In an interview with PSW #163, they said that resident #013's medical clothing was put in the laundry basket by staff by mistake and sent to laundry. Resident #013's room was observed and one piece of the medical clothing was found, the resident was wearing one and one of the three remained missing. It was acknowledged by staff that resident #013's care of their medical clothing was not followed as specified in the resident's plan of care. (583)

This area of non-compliance was identified during a Complaint Inspection, log #005224-18, conducted concurrently during the RQI.

F) Resident #011 had a written plan of care indicating that resident had a persistent condition. The plan of care indicated that they had a specific device that was to be monitored and the output documented.

The clinical record was reviewed and there was no evidence that the output was recorded by staff on any shifts. The POC was reviewed for the months of January and February 2018, and the staff did not document the resident's output on any of the days during those months. The progress notes were reviewed and only on one shift in February 2018, the registered staff documented the output.

PSW #102 indicated that they monitor residents' who have specific devices for output on every shift and document in POC the amount. RPN #126 was interviewed and acknowledged that the output needed to be monitored and documented in the progress notes on every shift.

The licensee's policy, number VII-D-10.30, and revised September 2016, indicated that the PSW will empty the specific device each shift and record the output on the PSW flow sheet / electronic documentation.

The DOC was interviewed and stated that the output was expected to be monitored by PSWs and documented in POC.

This area of non-compliance was identified during a Complaint Inspection log #021415-17, conducted concurrently during this RQI.

G) Resident #022 had a plan of care indicating that staff were to remove a piece of the resident's mobility device, so that they could self-propel. In addition, program staff were to invite and porter the resident to and from group activities.

(i) The resident's SDM was interviewed and stated that the resident was not able to fully self-propel; however many times the staff did not follow the directions related to the resident's mobility device, which prevented the resident from being able to propel.

The resident was observed several times in March 2018. The housekeeping staff pushed the resident from the dining room back to the activity room and left the mobility device in a locked position. They did not follow the directions on the plan of care, which prevented the resident from being able to self-propel.

PSW #158 was interviewed and they stated that the housekeeping staff might not have been aware of the directions on the written plan of care related to the resident's mobility device.The DOC was interviewed and stated that staff should have followed the written plan of care for resident #022.

(ii) The plan of care for resident #022, also indicated the resident attended mostly group activities and program staff were to invite and porter the resident to and from group activities.

Resident #022's family members were interviewed and stated that many times the resident was not included in activities because of their cognitive impairment.

In March 2018, the resident was observed and was excluded from a group activity provided by the Physiotherapy Assistant (PTA) in the activity room.

The PTA was interviewed and they stated that this group activity was on a referral basis and only residents who were candidates for this activity were included.
The DOC was interviewed and they acknowledged that this group activity was provided for any resident in the home and anyone could attend. The resident should not have been excluded from participating in the group activity. (561)

The licensee failed to ensure that the care for resident #022, was provided as specified in the plan.

This area of non-compliance was identified during the Complaint Inspections, log #022782-17 and #024304-17, conducted concurrently during this RQI.

H) Resident #001's physician ordered a specific test to be collected in February, July, October and November 2017, as well as in February 2018. The specific sample for the test was not collected and the resident had no procedures performed to ensure the sample was obtained.

The clinical record was reviewed, which confirmed the physician's orders for the specific test and the procedure to be performed, if staff were unable to collect the sample; however there was no documentation in the progress notes that the physician was notified within 24 to 48 hours that the test and/or the procedure was performed.

RPN #109 was interviewed and indicated that they obtain an order from the physician for a specific test, they will try to collect the sample and if they were unable to collect the sample within 24 hours, they would call the physician for an order for a specific procedure to obtain the sample. If this was not effective, they would notify the physician. RPN #161 was interviewed and also acknowledged this process for the specific test.

The DOC and ADOC were interviewed and they both indicated that registered staff were expected to contact the physician if they had concerns that the resident may be experiencing new behaviours or an increase in behaviours for an order to collect a sample for a specific test. If the registered staff were unable to collect the sample within 24 hours and they didn't have a physician's order for another procedure to obtain the sample, they were expected to contact the physician again. If this procedure also failed to obtain the sample, registered staff were expected to notify the physician. (527)

The licensee failed to ensure that resident #001 received the care as specified in the plan of care.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection #2911-000017-17, log #015954-17, conducted concurrently during the RQI.

I) Resident #019's physician had ordered a specific test and a sample was to be collected in March, April, and November 2017. The physician also ordered another sample to be collected in August 2017; however the sample was not collected until six days later. The samples for the specific test were not collected as ordered by the physician and the resident did not have any additional procedures to obtain the sample.

The clinical record was reviewed, which confirmed the physician's order for the specific test and the procedure to collect the sample; however there was no documentation in the progress notes that the physician was notified within 24 to 48 hours that the test and/or the procedure was performed.

RPN #109 was interviewed and indicated that they would obtain an order from the physician for specific test, they will try to collect the sample and if they were unable to collect the sample within 24 hours, they would call the physician for an order for a procedure to collect the sample. If this was not effective, they would notify the physician. RPN #161 was interviewed and also acknowledged this process for obtaining a sample for the specific test.

The ADOC was interviewed and confirmed that staff were expected to collect the sample as ordered by the physician and if they were not able to within 24 hours, the registered staff were expected to obtain an order from the physician for a procedure to obtain the sample. The ADOC indicated that if the registered staff continued to have difficulty obtaining the sample, they were expected to contact the physician.

The licensee failed to provide resident #019 with the care that was specified in the plan.

This area of non-compliance was identified during the Critical Incident System (CIS) Inspections #2911-000017-17, log #015954-17, and CIS #2911-000014-17, log #011464-17, conducted concurrently during the RQI.

J) Resident #033's physician had ordered a specific test and the sample was to be collected in October 2017 and January 2018. The samples were not collected as ordered and the resident had no other procedures to obtain the sample.

The clinical record was reviewed, which confirmed the physician's orders for the

specific test and the procedure to obtain the sample; however there was no documentation in the progress notes that the physician was notified within 24 to 48 hours that the test and/or the procedure was performed.

RPN #109 was interviewed and indicated that they would obtain an order from the physician for a specific test, they would try to collect the sample and if they were unable to collect the sample within 24 hours, they would call the physician for an order for a procedure to obtain the sample. If this was not effective, they would notify the physician. RPN #161 was interviewed and also acknowledged this process for the specific test.

The ADOC was interviewed related to the sample collection for resident #033. The ADOC acknowledged that when the resident was admitted, the physician ordered the specific test in October 2017, and then again in January 2018. The physician also ordered a specific procedure to be performed, if needed; however the samples were not collected by staff. The ADOC acknowledged that staff were expected to collect the samples as ordered by the physician and if they were not able to, then perform a procedure to obtain the sample. If this was not feasible for the resident, then staff were expected to contact the physician within 24 hours to notify them of the difficulties obtaining the samples and this did not occur.

The licensee failed to ensure that the care set out in the plan of care for resident #033, was provided to the resident as specified in the plan.

K) A Complaint was reported to the Director indicating that registered staff failed to apply treatment as per the physician's order for resident #022, when they sustained altered skin integrity in September 2017.

The clinical record was reviewed and the written plan of care indicated the resident was at risk for altered skin integrity. The staff were to use a specific treatment as per the SDM's request and apply, as per the physician's order. The Treatment Administration Record (TAR) was reviewed, which confirmed the SDM's request and the physician's order.

The home investigated the complaint and found that the registered staff who provided treatment did not follow the physician's order. The home's investigation notes indicated that during the interview with the registered staff, they stated that they applied the treatment, which was not according to the physician's order.

The DOC was interviewed and acknowledged that the treatment was not provided as per the physician's order.

This area of non-compliance was identified during the Complaint Inspections, log #022782-17 and #024304-17, conducted concurrently during this RQI.

The licensee failed to ensure that the care set out in the plan of care for resident #001, #010, #011, #013, #016, #019, #022, #023, #033 and #038 was provided to the resident as specified in the plan.

2. The severity of this issue was determined to be a level 2 as there was potential for harm to the residents. The scope was a level as it related to a number of residents related to a number of care concerns. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:
Voluntary Plan of Correction (VPC) was issued October 27, 2016 (2016_267528_0023);
Voluntary Plan of Correction (VPC) was issued October 5, 2016 (2016_337581_0015); and
Voluntary Plan of Correction (VPC) was issued September 13, 2016 (2016_240506_0018).

(561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 16, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee must comply with s. 55 (a) of the LTCHA, 2007 and Regulations 79/10.

The licensee will do the following:

1. Review and revise, as needed, the interventions to ensure they are effective and address the responsive behaviours for resident #001, #019, and #035 to minimize the risk of altercation and/or potentially harmful interactions between/among residents.

2. Re-educate registered staff and PSWs on the triggers and interventions to manage the responsive behaviours for resident #001, #019, and #035, and know how to identify escalation of behaviours and when to intervene with residents in order to mitigate the potential for altercations and resident to resident abuse situations.

3. Ensure residents #001, #019 and #035 are monitored by registered staff and PSWs as documented on their written plan of care / kardex.

Grounds / Motifs :

1. The licensee failed to ensure that, (a) procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A) The responsive behaviour procedures and interventions developed and implemented to assist resident #019, and to minimize the risk of altercations and potentially harmful interactions between and among residents was not effective. Although, the altercations between resident #019 and co-residents in two consecutive months in 2017, were witnessed by staff, the responsive behaviour interventions were not implemented and the staff did not intervene immediately to prevent altercations.

As a result of the two altercations with resident #001 and #018, resident #019 sustained an injury, which required the resident to be transferred to the hospital for treatment.

The clinical record was reviewed and the interactions among residents were observed on several occasions in March 2018.

RPN # 110 and PSW #112 were interviewed and acknowledged the resident had aggressive behaviours and interventions were not always effective when the resident's behaviours were escalating. RPN #110 confirmed that both incidents in 2017, were witnessed by staff and the staff member was unable to answer why the staff did not intervene sooner when both residents in each incident had increased responsive behaviours, which resulted in the altercations.

This area of non-compliance was identified during the Critical Incident System (CIS) Inspections #2911-000017-17, log #015954-17, and CIS #2911-000014-17, log #011464-17, conducted concurrently during the RQI.

B) The responsive behaviour interventions that were developed and implemented to assist resident #018, and to minimize the risk of altercations and potentially harmful interactions among residents were not effective. Although, the incidents in two different months in 2017, were witnessed by staff, the responsive behaviour interventions were not implemented and the staff did not intervene immediately to prevent the altercations with resident #019 and #035. As a result of the altercation with resident #019, they sustained an injury and

required transfer to the hospital for treatment.

The interactions among residents were observed on three occasions in March 2018. The resident's interventions were effective when the Behavioural Support Officer (BSO) redirected the resident.

RPN #110 and PSW #112 were interviewed and acknowledged the resident had responsive behaviours. The staff indicated that the interventions were not always effective when the resident's behaviours were escalating. RPN #110 confirmed that both incidents in 2017, were witnessed by staff and they were unable to answer why the staff did not intervene sooner when both residents in each incident had increased responsive behaviours, which resulted in altercations.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection #2911-000017-17, log #015954-17, conducted concurrently during the RQI.

The licensee failed to implement responsive behaviour interventions to assist the resident who was at risk of harm as a result of the resident's behaviours and to minimize the risk of altercations and harmful interactions between resident #001, #018, #019 and #035.

2. The severity of this issue was determined to be a level 3 as there was actual harm to residents. The scope of the issue was a level 2 as it related to over 33% of residents inspected as a result of responsive behaviours. The home had a level 3 history as they had one or more related non-compliance in the last three (3) years with this section of the LTCHA. (527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 29, 2018

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with O.Reg 79/10 s. 23.

The licensee shall ensure that:

1) Ensure that all Alenti Arjohuntleigh tub lifts are equipped with safety belts.

2) Ensure that the manufacturer's instructions for the Alenti Arjohuntleigh tub lifts are followed by staff and that the safety belts are used at all times on the tub lift chairs when bathing residents.

3) Ensure that when all Alenti Arjohuntleigh tub lifts are equipped with safety belts, that all staff that use the tub lifts and safety belts are trained regarding their use. Maintain attendance records of the training on the use of the tub lift safety belts.

Grounds / Motifs :

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.

The manufacturer's instructions for the Alenti ArjoHuntleigh, June 2012, indicated that the safety belt must be used at all times on the tub lift chairs. Furthermore, it indicated that the safety belt when not in use was to be attached to the belt clip on the hand rest-handle arm.

During the initial tour of the home in February 2018, LTCH Inspector #561 observed that the Alenti tub lifts in all five home areas had no safety belts

attached to the lifts in the tub rooms. In two of the home areas, the safety belt could not be found in the tub rooms.

Interview with PSW #101 and PSW #105, revealed that they used the tub lifts while bathing residents without using the safety belts. Both of the PSWs indicated that the arm rests on the lift were enough to ensure that residents were safe. PSW #101 indicated that they had never seen a safety belt with the tub lift. The DOC was interviewed and acknowledged that the safety belts were required to be used while residents were bathed using the Alenti tub lift.

The licensee failed to ensure that staff used the Alenti tub lifts according to the manufacturer's instructions.

B) Resident #011 had a plan of care indicating that they had altered skin integrity. The resident had a specific intervention, which allowed the staff to select the function to assist with the resident's positioning. The written plan of care indicated the resident was to be repositioned every two hours.

Interview with PSW #127 and RPN #108 indicated the resident was expected to be repositioned every two hours; however the resident was not always compliant.

Observations were made over several days and the resident was observed in bed most of the time. The resident had a specific intervention for positioning and when LTCH Inspector #561 asked the resident if the function was ever set at rotating, they said no.

The wound care nurse was interviewed and stated that the resident had a specific intervention implemented and they were also being turned and repositioned while in bed every two hours.

The manufacturer's instructions for the specific intervention indicated that there were two settings on the device that could be implemented.

The DOC was interviewed regarding the functionality of this intervention and they stated that they were not aware that it had these settings. The DOC indicated that they never tried this option and for this resident it might be beneficial.

The licensee failed to ensure that the specific device was being used in accordance with the manufacturer's instructions to assist with management of resident #011's altered skin integrity.

This area of non-compliance was identified during a Complaint Inspection, log #021415-17, conducted concurrently during the RQI.

2. The severity of this issue was determined to be a level 2 as there was a potential risk for actual harm to residents living in the home. The scope was a level 3 as the risk of harm was related to all residents living in the home and all tub lifts in the home were observed without safety belts. The home had a level 4 compliance history as they had a previous non-compliance with this section of the LTCHA that included: Voluntary Plan of Correction (VPC) issued on January 3, 2017 (#2016_267528_0023) (527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 26, 2018

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 13th day of June, 2018

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

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

Name of Inspector /
Nom de l'inspecteur : Kathleen Millar

Service Area Office /
Bureau régional de services : Central West Service Area Office