Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 11, 2018	2017_525596_0019	026651-17	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd. Suite 300 TORONTO ON L3R 0E8

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

Weston Terrace Care Community
2005 LAWRENCE AVENUE WEST TORONTO ON M9N 3V4

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

THERESA BERDOE-YOUNG (596), JOY IERACI (665), JULIENNE NGONLOGA (502)

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): November 27, 28, 29, 30 and December 1, 4, 5, 6, 7 and 8, 2017.

The following critical incident (CI) reports were inspected concurrently with the Resident Quality Inspection (RQI):
log #023541-16 for CI 2874-000025-16, log #021376-17 for CI 2874-000023-17 related to staff to resident abuse.
The following complaint logs were inspected concurrently with the RQI:
log #022683-17 related to restraints, log #000984-17, 005994-17, 006641-17, 007658-17, 012245-17, 024118-17, 025617-17 and 025833-17 related to resident care concerns.

During the course of the inspection, the inspector(s) spoke with the Director of Administration (DOA), interim Director of Care, Environmental Services Manager (ESM), Associate Directors of Care (ADOC), Programs Manager (PM), Resident Relations Coordinator (RRC), Resident Assessment Instrument (RAI) Coordinator, Housekeeping Supervisor, registered nurse (RN), registered practical nurse (RPN), housekeeper, personal support worker (PSW), Family Council member, Residents' Council president, residents and family members.

During the course of this inspection, the inspectors toured the home, observed resident care and staff to resident interaction, observed medication administration, provision of care, reviewed resident health records, meeting minutes, training records, schedules, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
12 WN(s)
4 VPC(s)
0 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity was fully respected and promoted.

Record review of a critical incident (CI) report related to physical abuse, submitted to the Ministry of Health and Long Term Care (MOHLTC) in August 2016, indicated that on a specified date in July 2016, a personal support worker (PSW) found resident #010 restrained in bed with a prohibited device, and the resident was unable to move.

Review of the resident's minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment, required extensive assistance by two staff for transfer, and one bed rail halfway raised for safety and positioning.

Review of the written plan of care for a specified date in June 2016, revealed the resident was at high risk for falls and included specified interventions. The resident also exhibited responsive behaviours toward staff and they were directed to transfer the resident to the wheelchair, and place him/her close to the nursing station when he/she starts exhibiting responsive behaviours.

During interview the resident was not able to remember the incident that occurred 17 months ago.

In an interview PSW #142 stated that resident #010 attempted to hit him/her during care, and was trying to climb out of bed. PSW #142 confirmed that he/she restrained resident #010 in bed using a prohibited device, to prevent him/her from falling out of bed, as he/she needed to assist another resident.

During interviews, PSW #139 and registered practical nurse (RPN) #136 stated that the resident was covered with a blanket when they completed their initial round at the beginning of the day shift on a specified date in July 2016. After shift report PSW #139 stated that resident #010 was heard calling for help, and when he/she went to assist and provide morning care, he/she noted that resident #010 was restrained in bed using a prohibited device PSW #139 called for assistance from PSWs #140, #141, and RPN #136. All staff confirmed the above observation and stated that resident #010 was unable to move.

Associate Director of Care (ADOC) #110 conducted an investigation and its outcome revealed that restraining resident #010 resulted in discomfort, as movement was

restricted when he/she was calling for assistance. ADOC #110 also stated that PSW #142 was disciplined as he/she had no reason to restrain the resident #010. [s. 3. (1) 1.]

2. A CI report was submitted to the MOHLTC by the home, as well as a complaint called into the MOHLTC infoline by resident #007's substitute decision maker (SDM), related to staff to resident physical abuse. The complainant informed the infoline that the home reported to the family that resident #007 was found by staff restrained in bed using a prohibited device on a specified date in September 2017.

At the time of the inspection, resident #007 was no longer a resident of the home and was deceased.

Review of the CI report indicated that during PSW #130's morning rounds, he/she found resident #007 restrained in bed using a prohibited device.

The home conducted an investigation and terminated PSW #144 as a result of the incident.

Interview with PSW #130 indicated he/she found resident #007 laying in bed with a prohibited device applied and the resident could not move or turn. The PSW indicated the resident was restrained and the incident did not respect the resident’s bill of rights.

Review of resident #007's plan of care indicated the resident required two person assistance with bed mobility, and had responsive behaviours during the night.

Interview with PSW #123 who worked the night shift on a specified date in September 2017, indicated resident #007 had responsive behaviours during the night. PSW #123 indicated he/she heard the resident making noises as if he/she was crying.

Interview with PSW #144 who was assigned to the resident on the night shift of a specified date in September 2017, indicated upon his/her rounds at a specified time, one side of the resident's incontinent product was open and he/she provided care to the resident. The PSW stated that he/she provided care to the resident on his/her own during the night, knowing the resident required two person assistance. The PSW denied applying the prohibited device to the resident and was unaware who would have left the resident in that condition. The PSW stated that the incident was an inappropriate way of restraining a resident.

Interviews with RPN #145 and RN #146 stated on the morning of a specified date in September 2017, they were called to the resident's room by PSW #130 and found the resident restrained in bed using a prohibited device. The RPN and PSW indicated the device was tight enough that the resident was not able to move.
Interview with PSW #143 indicated resident #007 was restrained inappropriately and the incident did not protect the resident's right to be treated with respect.

Interview with ADOC #112 indicated the resident was not able to move and the bed sheet was tied to the bed frame. The ADOC indicated it is the home's expectation for staff to follow the residents' bill of rights and restraining resident #007 did not treat the resident with respect and dignity. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, is fully respected and promoted, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Record review of a complaint received by MOHLTC infoline in March 2017, indicated that an injury was discovered on identified areas of resident #016's body.

Interview with PSW #117 revealed he/she informed ADOC #112 that the bilateral velcro tabs located at the back of the resident's incontinent product could be the possible cause of the injury; when staff remove the soiled product they may pull it from under the resident causing shearing force and irritation to the skin by the rough velcro tabs. PSW #117 stated that he/she tears the velcro tabs off before removing the resident's incontinent product, in order to prevent irritation of the resident's skin.

During interview with ADOC #112 he/she confirmed information mentioned above by PSW #117 was shared with him/her in the past, and it was passed onto the previous Director of Care (DOC). The ADOC stated he/she agreed that the velcro tabs on the resident's incontinent product could possibly be the cause of the recurrent skin irritation and injury to the resident's body, however it was shared with the previous DOC and nothing further was done.

Record review of resident #016's plan of care did not include special instructions regarding the velcro tabs on the incontinent product and removal of the resident's incontinent product.

Interview with the Director of Administration (DOA) acknowledged that the previous DOC was aware of PSW #117's concern regarding the removal of resident #016's incontinent product and the velcro tabs as mentioned above, but staff did not collaborate in the development and implementation of the resident's plan of care. [s. 6. (4) (b)]

2. The skin and wound inspection protocol (IP) triggered from stage one of the resident quality inspection (RQI) for resident #005.

Review of the resident's clinical records revealed resident has altered skin integrity to an identified body part and suspected injury to another identified body part. The written plan

of care indicated that resident is to use a particular preventative skin product at all times for support and offloading pressure 24/7.

Observations conducted on two specified dates in November and one in December 2017, found resident sitting in a wheelchair not using the preventative skin product.

Interview with resident #005 indicated he/she uses the preventative skin product only when in bed and not during the day when out of bed. The resident indicated the staff were aware of his/her preference.

Review of resident #005's weekly skin assessments for four specified dates in November 2017, and progress notes, did not include documentation of the resident's preference regarding using the preventative skin product.

Interview with PSW #107 indicated resident #005 only uses the preventative skin product when in bed and not when up in the wheelchair. The PSW stated the resident had been doing this for some time.

Interview with registered nurse (RN) #105 revealed resident #005 had not been using the preventative skin product at all times for the past two to three weeks, and only uses it in bed as per the resident's preference. The RN reviewed the written plan of care and acknowledged it did not indicate the resident's preference regarding use of the preventative skin product.

Interview with the skin and wound champion/RPN #147 revealed he/she was not aware resident #005 was not using the preventative skin product at all times. RPN #147 acknowledged the written plan of care and care being provided were not consistent.

Interview with ADOC #128 indicated it was the home's expectation for the plan of care to reflect the care provided to the resident. The ADOC reviewed resident #005's written plan of care and confirmed the plan of care for the resident was not integrated and consistent with each other. [s. 6. (4) (b)]

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

A complaint was received at the MOHLTC infoline on a specified date in November 2017, regarding a staff member who used the incorrect mechanical lift to lift resident

order to adjust the resident's clothing.

Interview with the complainant confirmed the same as mentioned above, and that he/she witnessed the resident in his/her room being lifted using an incorrect lift on a specified date in November 2017; the unfamiliar and incorrect lift caused the resident discomfort.

Record review of resident #016's written care plan and kardex indicated use of a specified type of lift for transfers with two staff assistance, and the lift logo above the resident's bed indicated the same.

Interview with PSW #114 revealed he/she provided care to resident #016 during the day shift on the above mentioned specified date in November 2017, when the resident's family member noticed the resident's clothing needed to be adjusted and requested that staff adjust it. PSW #114 stated that he/she used an incorrect lift to lift the resident with assistance from another PSW staff, then they adjusted the clothing. The PSW reported he/she was aware that the plan of care indicated use of a specified type of lift for resident #016, but used a different lift anyway as they were just adjusting the resident's clothing. PSW #114 stated that he/she should have used the correct lift to lift the resident as indicated in the resident's plan of care.

Interview with PSW #116 reported that on the above mentioned specified date in November 2017, he/she assisted PSW #114 to lift resident #016 using a specified lift, which was the incorrect lift for the resident; the resident's plan of care indicated use a specified type of lift for all transfers.The PSW stated that they did not provide care as specified in the resident's plan of care, and should have used the correct lift. [s. 6. (7)]

4. The skin and wound IP triggered from stage one of the RQI for resident #006.

Review of resident #006's clinical record revealed he/she had altered skin integrity to an identified area of the body.
Review of the resident's plan of care revealed the resident was using a therapeutic surface to relieve pressure, and an identified product was to be used when in bed.

Observation conducted on a specified date in November 2017, revealed resident #006 was laying in bed with a different identified product instead of the one mentioned above.

RPN #106 confirmed resident #006 was laying on a slider transfer sheet instead of a dri flo pad and that staff did not follow the resident's plan of care.

Interview with PSW #107 indicated only dri flo pads are to be used when resident is in bed as per the plan of care.
Interviews with RPN #106, RN #105 and the skin and wound champion/RPN #147, indicated it is the home's expectation that staff follow residents’ plan of care. The registered staff indicated dri flo pads are only to be used on the therapeutic surface to ensure the resident received the pressure relieving benefits for his/her altered skin integrity.

Interview with ADOC #128 indicated it is the home’s expectation for the resident's plan of care to be followed by all staff. The ADOC stated the slider transfer sheet should only be used for repositioning then removed. The ADOC acknowledged staff did not provide care as specified in the plan of care for resident #006. [s. 6. (7)]

5. The skin and wound IP triggered from stage one of the RQI for resident #006.

Review of resident #006's clinical record revealed he/she had altered skin integrity on a particular area of the body.

Review of the resident’s current written plan of care included an intervention that the resident can be up in wheelchair at meals for a specified period of time then back in bed. Staff to turn and reposition when in bed at least every two hours, and as needed or requested.

Observations conducted on specified dates in November and December 2017, revealed resident was in the wheelchair for one meal and returned to bed after a subsequent meal which exceeded the specified period of time that the resident can be up in the wheelchair.

Interviews with RN #105 and PSW #107 revealed resident #006 had been getting out of bed for one meal and then back to bed after a subsequent meal for the past two months.

Interview with the skin and wound champion/RPN #147 revealed the staff should have been following the resident’s written plan of care. RPN #147 reviewed the resident’s current plan of care and stated the resident’s wound care was scheduled for a specified time daily. After wound care has been completed the resident can be out of bed. He/she indicated resident should be in the wheelchair for a specified period of time to offload pressure to the area of impaired skin integrity; he/she was not aware the resident was in

the wheelchair for one meal then back to bed after the subsequent meal.

Interview with ADOC #128 revealed it was the home's expectation for staff to be aware of and follow the resident's plan of care. The ADOC acknowledged that staff did not follow the plan of care for resident #006. [s. 6. (7)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other 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, and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of section 35 of the Act, sheets,

wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose were not used in the home.

In August 2016, a CI report was submitted to the MOHLTC related to physical abuse. The CI indicated that on a specified date in July 2016, during morning rounds a PSW found resident #010 restrained in bed by a prohibited device and the resident was unable to move.

In interviews, PSW #139 and RPN #136 stated that the resident was covered with a blanket when they completed their rounds at the beginning of the day shift on a specified date in July 2016. After the shift report PSW #139 stated resident #010 was calling for help and when he/she went to assist and provide morning care, he/she noted that resident #010 was restrained in bed using a prohibited device. PSW #139 called for assistance from PSWs #140, #141, and RPN #136. All staff confirmed the above observation.

In an interview, PSW #142 stated that he/she had restrained resident #010 using a prohibited device to prevent the resident from falling out of bed, as he/she needed to answer a call bell.

In an interview, ADOC #110 confirmed that resident #010 was restrained with the hospital gown by PSW #142 which was not part of resident #010's plan of care, and it did not have any therapeutic purpose. [s. 112.]

2. The MOHLTC infoline received a complaint from resident #007's SDM related to staff to resident physical abuse. The complainant indicated the family was informed of an incident that occurred on a specified date in September 2017, where resident #007 was found by staff to have been restrained by a prohibited device. A CI report about the same was also submitted by the home.

Review of the CI report the home submitted indicated on the above mentioned specified date in September 2017, resident #007 was found by a PSW in bed restrained by a prohibited device.

Interview with PSW #130 indicated he/she found the resident laying in bed and when he/she pulled a blanket off the resident, a prohibited device was pressing against the resident's identified body part. The PSW indicated the resident could not move other than his/her head and informed the charge nurse right away.

Interview with RPN #145 reported PSW #130 called him/her to resident #007's room where he/she found a prohibited device over resident #007's body parts. RPN #145 indicated the resident could only move his/her head and legs, but not the rest of the body.

PSW #130 and RPN #145 indicated the resident was restrained with the prohibited device which is against the home's policy.

Interview with ADOC #112 indicated the home has a policy not to use prohibited devices as a form of restraint. He/she stated the home completed an investigation and acknowledged a prohibited device was used to restrain resident #007. [s. 112.]

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 for the purposes of section 35 of the Act, sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose are not used in the home, to be implemented voluntarily.

WN #4: 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 home failed to ensure that drugs were stored in a medication cart that was secure and locked.

During the initial tour of the home on a specified date in November 2017, on an identified resident home area (RHA), the inspector observed a medication cart unlocked and parked beside room 108 in the hallway; a nurse was not seen in the hallway. A PSW and a visitor wheeling a resident's wheelchair walked past the medication cart. At 1036 hours RPN #108, walked out of room 108 and returned to the medication cart.

Another observation was made at 1118 hours, when the inspector observed the medication cart in the same identified RHA parked in front of the nursing station, unlocked and unattended by a registered staff. RPN #108 was observed coming out of the unit lounge and returned to the medication cart.

RPN #108 indicated it was the home's policy to ensure medications are secured and locked when not attended. The RPN stated that the medication cart contained medications of residents and should be locked when unattended to ensure resident safety. The RPN acknowledged the medication cart was unlocked on the two above mentioned occasions and he/she did not follow the home's policy.

Interview with ADOC #128 revealed that it is the home's expectation for medication carts to be locked when unattended to ensure safety of residents and the security of the drugs stored in the cart. The ADOC acknowledged RPN did not follow the home's expectation ensuring drugs were stored in a medication cart that was secure and locked. [s. 129. (1) (a)]

Additional Required Actions:

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

WN #5: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

According to O.Reg. 79/10, s. 20 (1), the licensee is required to have a written hot weather related illness prevention and management plan for the home that meets the needs of the residents, developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat.

Record review of a complaint called into the MOHLTC infoline, indicated that staff did not follow the plan of care for resident #016 related to heat risk.

Interview with complainant #148 revealed that on a specified date in June 2017, he/she was told by day staff that the resident was received on the day shift drenched in sweat from being too hot and covered up with a comforter overnight. The complainant reported that the resident was high risk for heat stroke according to the home's assessment in May 2017 and should not have been covered up with a comforter overnight in June when temperatures were very hot.

Record review of the home's policy titled heat contingency protocols, #VII-G-10.10(a), dated July 2015, indicated it is the responsibility of nursing to ensure that only a light cover sheet is used on the bed.

Record review of resident #016's heat risk assessment for a specified date in May 2017, indicated a high score.

Interview with PSW #131 revealed he/she worked the night shift and provided care for resident #016 on a specified date in June 2017. The PSW stated that staff were informed about residents' heat risk status by the registered staff, but he/she was not aware of where to find the heat risk status of residents himself/herself. The PSW reported that he/she covered the resident with both sheet and comforter on the above mentioned specified date, but didn't cover the resident's whole body with the comforter. He/she usually uses her judgement to put on or remove sheets or comforters from residents, and open or close the windows as necessary.

Interview with PSW #117 reported he/she worked the day shift the following day and received resident #016 very hot and drenched with sweat. The resident was covered with both a sheet and comforter; the comforter was up to the resident's waist. PSW #117 stated that he/she immediately called the charge nurse to come and see the state of the resident, removed all clothing and washed the resident down from head to toe.

Interview with ADOC #128 revealed that he/she remembered the incident in June 2017 when resident #016 was received by day staff at the beginning of the shift, very hot and covered with a comforter. The resident was high risk for heat stroke and the home has a protocol in place to prevent heat exhaustion, which was not followed by staff for resident #016 on the above mentioned date. He/she stated that staff are expected to follow the home's heat contingency protocols from May to September each year. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that every licensee of a long-term care home who received a written complaint concerning the care of a resident or the operation of the long-term care home immediately forwarded it to the Director.

1. Record review of a complaint called into the MOHLTC infoline in October 2017, indicated that an injury was discovered on resident #016.

Record review of a letter of complaint subsequently emailed to the home by the complainant on a specified date in October 2017, revealed a concern about an injury that staff discovered on a specified body part of resident #016.

Interviews with ADOCs #128 and #112 revealed they were not aware that they were supposed to forward email complaints received by residents and family to the Director.

The DOA reported that the above mentioned email complaint from resident #016's family member was not forwarded to the Director as he/she was not aware that complaints/concerns from resident or family members sent to the home via email were considered written complaints. He/she stated that going forward the home will submit all email complaints to the Director as required.

2. Record review of the home's concern form of a specified date in September 2017, revealed an email concern from a family member of resident #017 regarding cleanliness of the resident's room and unsatisfactory personal hygiene.

Interview with the DOA revealed that the home did not forward the above mentioned email complaint to the Director as required. [s. 22. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

In August 2016, a CI report was submitted to the MOHLTC related to physical abuse. The CI report indicated that on a specified date in July 2016, during morning rounds, a PSW found resident #010 restrained with a prohibited device, and the resident was unable to move.

During interview ADOC #110 confirmed he/she became aware of the alleged incident of abuse on the same day it occurred, but it was reported to the Director on August 2, 2016, which was four days later. [s. 24. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to respond in writing to the Residents' Council within 10 days of receiving Residents' Council advice related to concerns or recommendations.

During the RQI the minutes of Residents' Council meetings for September, October, and November 2017 were reviewed.

Review of the minutes for the September 19, 2017, meeting and the Resident's Council Concern and Recommendation Form revealed the following concerns were raised:
- request of a new shower chair as resident #011's chair was broken and concern for his/her safety. Written response was provided on October 10, 2017, which was 21 days after the concern was raised.

Review of the minutes for the October 17, 2017, meeting revealed the following concerns were raised:
- residents feel as though their new clothing was going missing and clothes were being put away in the wrong rooms
- coffee machine clogging grounds several times a day.
A written response was provided on October 31, 2017, which was 14 days after the concern was raised.

Interview with Programs Manager (PM) #113 reported that when a concern is raised during the Residents' Council meetings, he/she had five days to complete the Resident's Council Care and Recommendation form, then he/she would give the form to the respective department, who then has 10 days to respond. He/she confirmed that the concerns identified above were not responded to in writing within 10 days.

In an interview the DOA confirmed that the written response to the concerns raised during the Residents' Council meeting on September 19 and October 17, 2017, were not provided within 10 days. [s. 57. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Room odour triggered from stage one of the RQI during resident observation. The inspector noted on a specified date in November 2017 a lingering odour in two identified resident washrooms.
Further observations were made the following day, three days later with housekeeping supervisor #109, and seven days later with ESM #125. In both resident washrooms lingering odours were noted.

Review of the home's task information sheet revealed that in August 2017, an email was sent to the housekeeping department requesting for the floor to be mopped and cleaned in one of the above mentioned identified room’s, as the room had an unpleasant smell.

Review of the home’s policy titled Odour Neutralizers - Housekeeping # XII-G-10.30 revised on January 2015, revealed that housekeeping staff are provided with odour neutralizer chemicals to eliminate offensive odours when cleaning and are to seek help from their supervisor and manager if unsatisfied with results.

In an interview resident #012 who shared the room with resident #002 stated that the lingering odour is ongoing and it stopped bothering him/her.

In an interview, PSW #104 stated that he/she had noted lingering odours in the above mentioned identified washroom, which had been persistent since he/she assumed the duties on the identified unit a year prior to this inspection. PSW #104 further stated that

the only thing to remove the odours was to remove the tiles on the floor.

In an interview, RPN #136 stated that the above mentioned identified washrooms have had ongoing lingering odours for the past four to six months, and he/she had informed the supervisor of housekeeping services.

In interview, housekeeping staff #101 stated he/she pours the odour neutralizer "Virudex-7" on the floor and mopped the washroom two to three times a day.

In an interview, housekeeping supervisor #109 and environmental services manager (ESM) #125 stated that they had been aware of the lingering odours in the above mentioned identified washroom for at least a month, but were not aware of the lingering odour in the other resident's washroom .

The housekeeping supervisor stated he/she had provided a bucket and mop for nursing staff to clean the floor after housekeeping staff leaves for the day, to remove the lingering odour.

According to ESM #125, the odours were caused by the residents continuously urinating on the washroom floors. He/she confirmed that the housekeeping staff had reported the issue of lingering odours to him, but he/she had not followed through to ensure that the home's procedure for addressing lingering offensive odours was implemented. [s. 87. (2) (d)]

WN #10: 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).

Findings/Faits saillants :

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident was dealt with as follows: 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 resident, the investigation shall be commenced immediately.

The MOHLTC received a complaint from resident #007's SDM. The complainant reported the resident was found by a family member to have altered skin integrity on a specified body part and was warm to touch. The complainant stated it looked as though the resident had been slapped.
During interview the SDM informed the inspector that the RPN working that day and the previous DOC were verbally informed.

Review of the resident's progress notes of a specified date in September 2017, revealed an identified RPN spoke to resident #007's SDM and requested information as to what happened to the resident's above mentioned body part; it was warm and there was an injury in the same area.

Interview with PSW #130 indicated on the same identified date mentioned above, he/she noticed the area of altered skin integrity to the resident's specified body part after speaking to the resident's SDM. The PSW indicated the next day the area of altered skin integrity was gone.

Review of the home's investigation notes revealed staff were interviewed 17 days later.

Interview with ADOC #112 indicated he/she was aware of the verbal concern the family had raised regarding redness to the resident's body part one day after PSW #130 noticed it. The ADOC stated that he/she had informed the previous DOC about the concern three days later, and was directed to conduct an investigation. The ADOC indicated it is the home’s process when a concern is received, to conduct an investigation and to resolve the concern within 10 days. The ADOC confirmed the home's investigation was initiated when staff were interviewed seventeen days after the above mentioned RPN discussed the concern with the resident's SDM. The ADOC did not provide the inspector the reason for the delay in investigating the verbal concern. [s. 101. (1) 1.]

WN #11: 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.

The skin and wound IP triggered from stage one of the RQI for resident #006.

Review of the resident's physician orders revealed he/she was ordered analgesic medication half tablet by mouth one hour before dressing. Also the analgesic was ordered to be administered once daily. Review of the November and December 2017, electronic medication administration record (EMAR) and ETAR revealed the analgesic medication was scheduled to be administered one hour before wound care.

During interviews with RPN #111 on December 1, 2017, and RPN #122 on December 3, 2017, the RPNs indicated they did not administer resident #006's analgesic medication prior to completing wound care to the resident.

Interviews with ADOCs #128 and #112 indicated it is the home's expectation for medications to be administered according to the physician's order. Both ADOCs acknowledged RPNs #111 and #122 failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident’s health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident’s health and reported to the resident, the resident’s SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Resident #006 was being treated for altered skin integrity to a specified area of the body. Review of the physician orders revealed he/she was to receive half tablet of an analgesic medication one hour before dressing for pain. Also the analgesic was ordered to be administered once daily.

During interviews with RPN #111 on December 1, 2017, and RPN #122 on December 3, 2017, the RPNs indicated they did not administer resident #006’s analgesic medication

prior to completing wound care to the resident; both RPNs acknowledged a medication incident had occurred. RPN #122 stated when a medication incident occurs, a medication incident form should be completed, the nurse manager is informed and the resident's SDM and MD are notified.

Interviews with ADOCs #128 and #112 indicated it is the home's expectation when a medication incident occurs, for the registered staff to complete a medication incident form and notify the physician, SDM/resident if capable, the ADOC and pharmacy. The medication incident form is then forwarded to the ADOC where it would be entered into Medical Pharmacies' online portal. The ADOCs indicated they were not aware of the medication incidents that occurred with resident #006 on two specified dates in December as they did not receive a medication incident form from the registered staff. Both ADOCs reviewed the resident's progress notes and did not locate documentation of the medication incidents. Both ADOCs acknowledged the two medication incidents for resident #006 were not documented and notification to the SDM and MD were not completed as per home's expectation. [s. 135. (1)]

2. The licensee has failed to ensure a quarterly review was undertaken of all medication incidents that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents.

Interviews with ADOCs #128 and #112 indicated the last review of all medication incidents was for the period of August to October 2017. Review of the medication incidents for the quarter revealed there were three medication incidents. ADOC #112 stated the medication incidents were only reported in the home's Professional Advisory Committee (PAC) and Resident Safety Committee meetings. The ADOCs acknowledged the home does not do a quarterly review of all medication incidents that have occurred. [s. 135. (3)]

Issued on this 31st day of January, 2018

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

Original report signed by the inspector.