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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 12, 2015	2015_391603_0013	S-000795-15	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - NORTH BAY
401 WILLIAM STREET NORTH BAY ON P1A 1X5

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

SYLVIE LAVICTOIRE (603), MARINA MOFFATT (595), MONIKA GRAY (594), SARAH CHARETTE (612)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 20-24 and April 27-30, 2015

During the course of the inspection, the inspector(s) reviewed residents' health care records, reviewed various policies, procedures, and programs, conducted a daily walk-through of the home, observed the delivery of resident care, staff to resident interactions, and medication administration. The following Ministry logs were also inspected: S-000544-14, S-000623-14, S-000632-14, S-000668-14, S-000767-15, S-000761-15, S-000784-15.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Resident Relations Coordinator, Environmental Services Manager, Registered Nursing Staff (RN, RPN), Dietitian, Dietary Aides, Housekeeping Staff, Recreational Staff, Personal Support Workers, Residents, and Family Members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
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
Pain
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

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

- **11 WN(s)**
- **7 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. 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. (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 plan of care for resident #008 set out clear directions to staff and others who provide direct care to the resident.

On April 21, 2015, Inspector #603 interviewed S#103 who stated that resident #008 did not receive any Boost as a nutritional intervention. Inspector #603 reviewed the care plan and medication administration records and there were no entries regarding Boost to be provided or that it had been provided. Inspector #603 reviewed the physician's orders which indicated that Boost 1.0 - 125mL PO was to be given twice daily, on evenings and at bedtime snack passes. This was to have started on November 8, 2014 and was put on hold on February 19, 2015. Inspector #603 interviewed S#105 who explained that even though the care plan did not identify direction for Boost, the resident did receive Boost 1.0 - 125ml PO twice daily, in the evening and at bedtime snack passes. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care for resident #002 set out clear directions to staff and others who provide direct care to the resident.

Inspector #594 reviewed the resident's plan of care which stated a focus of high nutritional risk related to chewing problems from poorly fitting dentures. A focus of potential for oral health problem indicated an intervention that the resident had their own teeth (upper/lower). Review of the most recent Material Data Sheet (MDS) dated March 16, 2015, indicated that the resident has some or all of their natural teeth lost and does not have or does not use dentures (or partial plates). Inspector #594 observed the resident with their own teeth (upper/lower), and in an interview with S#119, it was stated

the resident had their own teeth. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care for resident #017 set out clear directions to staff and others who provide direct care to resident.

Inspector #595 reviewed resident #017's health care record. The health care record did not identify wake patterns or preferences, although it identified the resident's sleep time preferences and patterns. Inspector spoke with S#107, S#101, and S#149 who said that the resident is vocal and can voice when they want to get up in the mornings. The staff also mentioned that there are days when the resident wants to sleep longer or might want to get up earlier, however the care plan did not identify this. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the plan of care for resident #014 set out clear directions to staff and others who provide direct care to resident.

Inspector #595 reviewed resident #014's health care record. Upon review of the care plan, the sole sleep pattern intervention identified that the resident liked to be in bed when not in the dining room or at activities. There was no identification of the resident's wake pattern or preferences. Inspector spoke with S#148, S#124, and S#103 who stated that the resident likes to be in bed and sleep, however the resident needs to get up for breakfast. [s. 6. (1) (c)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #009 as specified in the plan.

On April 29, 2015, at 0915, Inspector #603 observed resident sitting in wheelchair. The resident remained in this chair until 1300. At that time, the staff positioned the resident in bed. Inspector #603 interviewed #S-126 who stated that the resident did stay in the wheelchair all morning until they went to bed at 1300. At no time, was the resident moved or repositioned by staff. Staff #126 stated that the resident is not able to get out of wheelchair on their own. Inspector #603 reviewed the care plan which indicated that the resident is to be turned or repositioned every 2 hours by staff to off-load from a wound and more often as needed or requested.

On April 29, 2015, at 1300, Inspector #603 reviewed the physician's orders written on April 10, 2015. The physician's order indicated that the resident had a wound which required a dressing change every second day. [s. 6. (7)]

6. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #007 as specified in the plan.

Inspector #612 reviewed a Critical Incident Report which indicated that S#128 witnessed S#129 using excessive force while providing care to resident #007. Resident #007 was cognitively impaired and had a history of resisting care. Staff #129 held the resident's legs and wrists while providing care. Inspector #612 reviewed the home's investigation reports dated February 9, 2015. Staff #129 admitted that they had held resident #007's hands by interlacing their hands in the resident's and as the resident continued to kick their legs and resisted care, S#129 rolled the resident on their side and S#129 placed their knee over the resident's knees to restrain resident while in bed. Inspector #612 reviewed resident #007's care plan. Under the behavior focus, the interventions listed for when resident was resisting care were for the staff to re-approach the resident; talk to resident #007 during care to decrease resistance; maintain eye contact and approach resident in a calm manner; if the resident exhibits more behavior, leave and obtain 2-3 staff to assist to prevent injury to resident or staff. Inspector #612 interviewed S#130 and S#131 who confirmed that the interventions from the care plan are used and are effective to manage resident #007's responsive behaviors and resistance to care. Consequently the care provided was not as set out in the plan. [s. 6. (7)]

7. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

Inspector #594 reviewed resident #003's care plan, which indicated a focus of resident #003 being a high risk for falls related to unsteady gait and history of falls. A corresponding intervention indicated that staff is to ensure that resident #003 is transferred to a normal dining room chair. The wheelchair is then taken out of dining room. On April 24, 20,5 Inspector #594 observed resident #003 sitting in a regular wheelchair in the dining room for lunch. In an interview with the inspector, S#159 explained that the staff do not transfer the resident in a regular chair, they leave the resident in the wheelchair while in the dining room. [s. 6. (7)]

8. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003.

On April 21, 2015 Inspector #594 observed resident #003 sitting in a wheelchair which was tilted back from the upright position. The resident's plan of care failed to identify the use of a tilted wheelchair but identified use of a wheelchair. In an interview with

Inspector #594, S#126 stated that the resident should not have been tilted. The resident had recently received a new wheelchair but the previous wheelchair was able to be tilted and staff would tilt resident while in the tilted wheelchair. The wheel chair had foot pedals which helped the resident but the wheelchair was too big. The resident was in the wheelchair for about three weeks. Staff #143 and S#144 stated the resident may have used a tilted wheelchair because it was the only chair available and it may have been tilted for comfort or positioning because the resident sustained a fracture. During an interview with Inspector #594, S#101 stated the resident had never used a tilted wheelchair. The inspector reviewed the resident's health care record, including physician's orders, which failed to identify use of a tilted wheelchair. In an interview with the Inspector #594, S#142 stated that the care plan did not identify use of a tilted wheelchair. [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 plan of care sets out clear direction to staff and others who provide direct care to the resident, 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 #2: 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 the pain management policy was complied with.

Inspector #612 reviewed the home's pain management policy. The policy indicated that the resident's self reporting of pain is the most reliable indicator of how much pain the resident is experiencing. The policy also indicated that the pain assessment will be completed upon admission and weekly until effective pain management is achieved and quarterly thereafter. If the initial pain assessment or subsequent quarterly review reassessment demonstrates that the resident's pain is not being managed effectively; the registered nursing staff will initiate follow up with other members of the inter-professional team, in collaboration with the resident, to determine alternative treatment protocols. In this event, the registered nursing staff will continue to complete weekly pain assessments (at minimum) until such time that the resident's pain is being managed effectively and will then resume quarterly reviews.
on April 29, 2015, Inspector #612 interviewed resident #006 in regards to their pain control and they reported that the pain is not well managed and that they continued to be in pain. Inspector #612 reviewed resident #006's pain assessment history. Resident #006 had a quarterly pain assessment completed March 30, 2015 and previous to that December 29, 2014.
Inspector #612 interviewed S#146, S#147, S#142 and S#106 who all confirmed that resident #006 has a history of uncontrolled chronic pain. Staff #142 confirmed that the policy indicated that when pain is not controlled, weekly pain assessments are to be completed until pain is managed. Staff #146 and S#147 confirmed that resident #006 was not receiving pain assessments weekly as identified in the policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the Medication Incident-Incident Reporting policy #V3-960 was complied with.

Inspector #603 reviewed a Critical Incident Report which indicated that a Fentanyl patch was noted to be missing on December 27, 2014. The CI report was filed 3 days later, on December 30, 2014. Inspector #603 reviewed another Critical Incident Report, which also indicated that a Fentanyl patch was noted to be missing on December 25, 2014. This report was filed 5 days later, on December 30, 2014. Inspector #603 reviewed the home's policy on Medication Incident - Incident Reporting #V3-960, which indicated that: The MOH is to be informed no later than one business day and the report to be completed within 10 days for a missing or unaccounted controlled substance or narcotic. On April 28, 2015, at 0930, Inspector #603 met with S#106 who confirmed that the staff have not been following policy where they are to report no later than one business day,

any missing or unaccounted controlled substance or narcotic. [s. 8. (1) (b)]

3. The licensee has failed to ensure that the home's Restraint Physical and PASD policy #V11-053 was complied with.

Inspector #594 reviewed the home's Restraint Physical and PASD policy #V11-053 which indicated that implementation of a PASD is not based solely on the wishes of the Resident, Substituted Decision-Maker or Power of Attorney. Written consent for a PASD is obtained from the resident and/or Substitute Decision-Maker before implementation of the PASD. Inspector #594 observed resident #001 with one half and one quarter bed rail in use during the course of the inspection. Inspector #595 interviewed S#146 and S#147 who stated for resident #001 the bed rails are PASDs to help with bed mobility. Staff #146 stated to Inspector #595 that consents for bed rails are located in the resident's chart. Inspector #595 reviewed resident #001's chart which failed to contain a consent form. [s. 8. (1) (b)]

4. The licensee has failed to ensure that the home's Restraint Physical and PASD policy #V11-053 was complied with.

Inspector #594 reviewed the home's Restraint Physical and PASD policy #V11-053 which indicated that implementation of a PASD is not based solely on the wishes of the Resident, Substituted Decision-Maker or Power of Attorney. Written consent for a PASD is obtained from the resident and/or Substitute Decision-Maker before implementation of the PASD and the care plan outlines the type of device, the purpose of the device, and when the device is to be used. On April 21, 2015 Inspector #594 observed resident #003 in bed with one half, and one quarter bed rail in use. On April 29, 2015, the inspector observed one quarter rail in use. Inspector #595 interviewed S#146 and S#147 who stated for resident #003 the bed rails are PASDs to help with bed mobility. Staff #146 stated to Inspector #595 that consents for bed rails are located in the resident's chart. Inspector #595 reviewed resident #003's health care record, which failed to contain a consent form. In an interview with the inspector, S#126 stated that in each resident's closet, there is a logo identifying the number of bed rails to be used. The inspector and S #126 reviewed resident #003's closet logo for the number of bedrails in use which stated no bedrails in use. In an interview with inspector #594, S#142 stated bed rails are to be identified in the care plan. Inspector #594 reviewed the resident's care plan which failed to identify use of bed rails. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any policy put in place, more specifically, the Pain Management, Medication Incident-Incident Reporting, Restraint Physical and PASD policies that they are complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy that promotes zero tolerance of abuse and neglect of residents was complied with.

On April 30, 2015, Inspector #603 reviewed a Critical Incident Report which indicated that resident #004 requested to go to the bathroom and S#138 requested resident #004 to stand at the bedside and then transfer to the commode. The resident indicated that they were not comfortable standing at the bedside, and then transfer to the commode. Since S#138 insisted, resident #004 asked to speak to whomever was in charge and was told by S#138 that they could not speak to person in charge, that they would not be toileted, and would be the last one to go to bed. On review of the home's investigation, the actions of S#138 were found to be inappropriate, negligent, and failed to advocate for resident's rights. For this reason, the home issued a disciplinary action to S#138. Inspector #603 reviewed the home's policy Abuse and Neglect Resident # V3-010 which indicated: All residents have the right to dignity, respect and freedom from abuse and neglect. The home has a zero tolerance policy for resident abuse and neglect. [s. 20. (1)]

2. The licensee has failed to ensure that the policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Inspector #612 reviewed a Critical Incident Report which indicated that Staff #128 witnessed S#129 using excessive force while providing care to resident #007. Resident #007 was cognitively impaired and had a history of resisting care. Staff #129 held resident's legs and wrists while providing care. Inspector #612 reviewed the home's investigation reports from February 9, 2015. Staff #129 admitted that they had held resident #007's hands by interlacing their hands in resident's hands and as the resident continued to kick their legs and resisting care, S#129 rolled resident #007 on their side and S#129 placed their knee over the resident's knees to restrain resident in bed. Inspector #612 reviewed the home's policy for Abuse and Neglect #V3-010. The policy states there is zero tolerance for abuse. The definition of abuse in the policy includes: improper or incompetent treatment or care of a resident that resulted in risk of harm to the resident and abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in a risk of harm to the resident. Inspector #612 reviewed the staff education history which confirmed that S#129 attended the home's mandatory training on the Abuse and Neglect policy. [s. 20. (1)]

3. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Inspector #612 reviewed a Critical Incident Report which indicated that Staff #139 witnessed S#140 roughly grabbing resident #005's shoulders and pant leg to transfer resident from a partially standing position into their bed. Inspector #612 reviewed the investigation report which confirmed S#139's witnessed account of the incident. Inspector #612 reviewed the home's policy for Abuse and Neglect #V3-010. The policy indicated that there is zero tolerance for abuse. The definition of abuse in the policy includes: improper or incompetent treatment or care of a resident that resulted in risk of harm to the resident and abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in a risk of harm to the resident. [s. 20. (1)]

Additional Required Actions:

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

WN #4: 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 abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in a risk of harm to the resident was reported immediately to the Director.

Inspector #612 reviewed a Critical Incident Report which indicated that Staff #128 witnessed S#129 using excessive force while providing care to resident #007. Resident #007 was cognitively impaired and had a history of resisting care. Staff #129 held resident's legs and wrists while providing care. Staff #128 reported the incident in writing to administration, 2 days later and the Critical Incident was reported to the Director, the same day by the home. Inspector #612 reviewed the home's investigation reports and S#129 admitted that they had held resident #007's hands by interlacing their hands in the resident's hands, and as he continued to kick his legs and resisted care, S#129 rolled resident #007 on their side and S#129 placed their knee over the resident's knees to restrain the resident in bed. Consequently the licensee failed to ensure the abuse of a resident was immediately reported to the Director. [s. 24. (1)]

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

On April 29, 2015, Inspector #603 discovered a Notice of Discipline letter for S#138, dated September 2014, which indicated that resident #021 sustained a large skin tear during a transfer. According to the investigation, S#138 and another staff member rolled resident #021 from side to side to apply a sling for the mechanical lift transfer. The resident's arm was pinned while applying the sling and again when the resident was up. An attempt was made to get the arm out but was unable as it was wedged too tightly. Once in the chair, the sling was loosened and the arm was lifted out. The resident sustained a large skin tear. Staff #138 had received training in the application of slings, the use of mechanical lifts, and the review of the Lift and Transfer policy #V3-850 with their annual mandatory education in 2013. The home's investigation resulted in a written warning for S#138 and the requirements of policy reviews and retraining of mandatory inservicing and application of slings were conducted. On review of the file, Inspector #603 noted that there was no Critical Incident reported to the Director. On April 30, 2015 at 0920, Inspector #603 interviewed S#141 who explained that there was no Critical Incident Report reported to the Director because the incident was not abuse by a staff member. [s. 24. (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 a person who has reasonable grounds to suspect improper or incompetent treatment or care of a resident, 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, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a PASD was used to assist a resident with a routine activity of daily living only if the use of the PASD was included in resident #003's plan of care.

On April 21, 2015 Inspector #594 observed resident #003 in bed with one half and one quarter bed rail in use. Review of the most recent Resident Assessment Instrument –

Minimum Data Set dated April 06, 2015 identified that resident #003 used bed rails for bed mobility or transferring. Inspector #595 interviewed S#146 and S#147 who stated that for resident #003 the bed rails are PASDs to help with bed mobility. In an interview with the inspector, S#126 stated in each resident's closet there is a logo identifying the number of bed rails to be used. The inspector and S#126 reviewed resident #003's closet logo for the number of bedrails in use, which stated no bedrails in use. In an interview with inspector #594, S#142 stated bed rails are to be identified in the care plan, however this information was not included in the care plan. Inspector #594 reviewed the home's Restraint Physical and PASD policy #V11-053 which indicated a PASD is a physical device used for the purpose to promote and support the resident's activities of daily living and to enhance or increase the resident's comfort, physical actions, and mobility. According to the same policy an example of a PASD are bed rails so a resident can turn in bed or get up to a seating position, and acceptable PASDs include (but are not limited to) bed rails. Any size of a bed rail is a PASD if the purpose of the bed rails is to assist the resident in moving or turning in bed, improves access to bed controls, and/or promotes movement of the resident from a sitting to a standing position. The policy further indicated that implementation of a PASD is not based solely on the wishes of the Resident, Substituted Decision-Maker or Power of Attorney. Written consent for a PASD is obtained from the Resident and/or Substitute Decision-Maker before implementation of the PASD. [s. 33. (3)]

2. The licensee has failed to ensure that the use of a PASD has been consented to by resident #001 or a substitute decision-maker with authority to give that consent.

Inspector #594 observed resident #001 with one half and one quarter bed rail in use during the course of the inspection. Review of the most recent Resident Assessment Instrument – Minimum Data Set dated March 09, 2015, indicated resident #001 used bed rails on a daily basis for bed mobility or transferring. In an interview with Inspector #594, resident #001 stated bed rails are in place for comfort and to assist when getting out of bed. Inspector #595 interviewed S#146 and S#147 who stated for resident #001 the bed rails are PASDs to help with bed mobility. Staff #146 stated to Inspector #595 that consents for bed rails are located in the resident's chart. Inspector #595 reviewed residents #001 chart which failed to contain a signed consent form.
Inspector #594 reviewed the home's Restraint Physical and PASD policy #V11-053 which stated a PASD is a physical device used for the purpose to promote and support the resident's activities of daily living and to enhance or increase the resident's comfort, physical actions, and mobility. According to the same policy an example of a PASD are bed rails so a resident can turn in bed or get up to a seating position, and acceptable

PASDs include (but are not limited to) bed rails. Any size of a bed rail is a PASD if the purpose of the bed rails is to assist the resident in moving or turning in bed, improves access to bed controls, and/or promotes movement of the resident from a sitting to a standing position. The policy further stated implementation of a PASD is not based solely on the wishes of the resident, Substituted Decision-Maker or Power of Attorney. Written consent for a PASD is obtained from the resident and/or Substitute Decision-Maker before implementation of the PASD. [s. 33. (4) 4.]

3. The licensee has failed to ensure the use of PASD has been consented to by resident #003 or a substitute decision-maker with authority to give that consent.

On April 21, 2015 Inspector #594 observed resident #003 in bed with one half, and one quarter bed rail in use. On April 29, 2015 the inspector observed one quarter rail in use. Review of the most recent Resident Assessment Instrument – Minimum Data Set dated April 06, 2015, indicated resident #003 used bed rails for bed mobility or transferring. Inspector #595 interviewed S#146 and S#147 who stated for resident #003 the bed rails are PASDs to help with bed mobility. Staff #146 stated to Inspector #595 that consents for bed rails are located in the resident's chart. Inspector #595 reviewed residents #003 chart which failed to contain a signed consent form. [s. 33. (4) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that PASDs are used to assist a resident with a routine activity of daily living only if the use of the PASDs are included in the resident's plan of care and that the resident or a substitute decision-maker with authority give consent for PASDs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

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

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, 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. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

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

Inspector #603 reviewed the protocol for disposal of Fentanyl Patches. On January 15, 2015, the home sent out a memo to staff explaining that effective January 15, 2015, registered staff are to remove and affix the used Fentanyl patches to the Fentanyl Patch Tracking Sheet, before being disposed of in the narcotic bin. Inspector reviewed the home's policy on Safe Handling of Fentanyl Patches #04-07-20, which indicated: a) Immediately upon removal, used patches are folded so that the adhesive side sticks to itself. Patch is then placed in a pharmaceutical waste container. b) Immediately upon removal, the entire used patch is affixed to a "used fentanyl patch" sheet or a "patch calendar". Store this sheet in a double locked container in the medication room or in the narcotic box of the medication cart and dispose of as per facility policy for all narcotics and controlled substances. Staff #106 stated that the home had not yet updated the policy to reflect the mandated changes. The last time the policy had been reviewed was December 13, 2013. [s. 114. (2)]

2. The licensee has failed to ensure that the written Medication Management policies and protocols are reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider.

On April 28, 2015, Inspector #603 interviewed S#106, who explained that the home does not review medication management policies and procedures unless asked by the Corporate Office. The Corporate Office is responsible for the home's medication management policies. Staff #106 also explained that it is not the expectation of the home to have the Director of Nursing and Personal Care and the pharmacy provider to develop policies, nor is there dedicated time to review existing ones. [s. 114. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that written policies are developed for the medication management system to ensure the accurate destruction and disposal of all drugs used in the home and that the Director of Nursing and Personal Care and the pharmacy service provider review and approve medication management policies, to be implemented voluntarily.

WN #7: 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. (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 has failed to ensure that staff participate in the infection prevention and control program specific to hand hygiene.

On April 20, 2015 during the lunch service in the Pier 1 dining room, S#145 was observed clearing dirty dishes from resident tables and then serving the next course of meal for residents without performing hand hygiene in between clearing and serving meals.
Inspector #594 reviewed of the home's Hand Hygiene policy #V6-090 which indicated that hand hygiene will be performed before preparing, handling, serving, or eating food (resident and care givers). [s. 229. (4)]

2. The licensee has failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Inspector #595 reviewed the health care record for resident #013. It was identified in the most recent Material Data Sheet assessment dated February 16, 2015, that the resident had a respiratory infection. Inspector #595 interviewed S#122, S#136, and S#137 who all confirmed that they would monitor and document a resident's symptoms at a minimum of every shift. It was also clarified by S#136 that even if a resident wasn't part of an outbreak, they are still to be monitored at least once a shift. Staff #103, S#122, S#136, and S#137 stated that symptoms would be documented in the progress notes or under the Vitals Assessment tab in Point Click Care. Inspector #595 reviewed the progress notes for resident #013. Notes were documented on February 6, 11, and 12, 2015. In the note dated February 12, 2015 it was documented that the resident had nasal congestion with a slight occasional cough. No further notes documented the resident's symptoms past this date. Inspector #595 reviewed the Vital Signs tab in Point Click Care and noted that there were no documentation of monitoring symptoms around the time of this respiratory infection. [s. 229. (5) (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 staff participate in the infection prevention and control program specific to hand hygiene and monitoring symptoms of infection in residents on every shift, to be implemented voluntarily.

WN #8: 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 has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

Throughout the Resident Quality Inspection, Inspectors #594 and #603 observed residents' rooms that were dusty and inspectors were also advised by various residents that there was not much dusting completed in the home. Inspector #595 spoke with S#116 who said that housekeeping staff dust resident rooms when they can. They further explained that the home was trying to get back to regular dusting but there is no set routine in place. Staff #116 commented that any complaints about housekeeping are usually about the dusting. Inspector #595 spoke with S#113, who stated that during the daily cleaning of resident rooms, the dusting likely does not get done, it is at "the bottom of the list". Staff #113 also explained that the priorities were washrooms, floors, and railings. The dusting is an ongoing issue that the home has been working on and that they are trying to develop a routine, but has not been implemented.

Inspector #595 reviewed the home's policy 'Furnishings - Resident Rooms' which indicated that the furnishings will be kept clean and sanitary, and a cleaning schedule would be in place to maintain a safe environment. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On April 20, 2015, Inspector #603 observed a window in the Pier 3 lounge to be leaking water on the window sill. A staff member had to put towels down to stop the rain from coming in. On April 29, 2015, Inspector #595 interviewed S#135 to inquire whether or not they were aware of the leaking window in the lounge. The staff member stated that the leaking window has been an ongoing issue for about a year, and that a request for repair should have been submitted.

Inspector #595 spoke with S#-122, S#-132, S#-134, S#-135, and s#-136 who stated that any maintenance issues would be documented on the Point-of-Care (POC) computers, and would be sent to the Environmental Services Manager (ESM) or Maintenance staff. Inspector reviewed the home's policy 'Preventative Maintenance Program' reviewed April 2012 which identified that a 'work order/requisition' system would be in place for all staff to be used when reporting required repairs and malfunctioning of any equipment or building systems to the ESM or designate.

Inspector asked the ESM if any orders/requisitions came through the POC system for the window in the Pier 3 lounge area. The ESM indicated that nothing had been submitted. [s. 15. (2) (c)]

WN #9: 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,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Inspector #595 reviewed resident #012's health care record. It was identified in the most recent RAI-MDS assessment dated February 9, 2015, that the resident had a stage II pressure ulcer. A note linked to the assessment identified that the resident had a blister, and that ulcer care would be implemented. It was also identified on the MDS assessment and in the home's policy 'Skin Care Program' revised 2012 that a stage II pressure ulcer is a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. This was also confirmed by S#122. Inspector reviewed the care plan dated February 9, 2015, on Point Click Care (PCC). An intervention identified that staff were to report any signs or symptoms of skin breakdown (e.g. discoloration to buttocks or

heels, open areas, blisters, redness, etc.) to registered staff for assessment. Inspector #595 reviewed the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the month of February 2015. No treatment order for the blister were identified in either MAR or TAR, and this was confirmed by S#107 and S#122. Inspector reviewed completed assessments in PCC and was unable to find a skin assessment other than the RAI-MDS assessment of February 9, 2015, which first identified the blister. Additionally, there was no documentation in the progress notes about the blister. [s. 50. (2) (b) (ii)]

2. The licensee has failed to ensure that the resident, who is dependent on staff for repositioning, was repositioned every two hours or more frequently.

On April 29, 2015, at 0915, Inspector #603 observed resident #009 sitting in wheelchair. The resident remained in this wheelchair until 1300. At that time, the staff positioned the resident in bed. Inspector #603 interviewed S#126 who stated that the resident did stay in the wheelchair all morning until after lunch, approximately 1300. At no time, was the resident moved or repositioned by staff. Staff #126 stated that the resident is not able to get out of wheelchair on their own and is dependent on staff for repositioning. Inspector #603 reviewed the care plan which indicated that the resident is to be turned, repositioned by staff every 2 hours from side to side for pressure off-loading a wound, more often as needed or requested.
Inspector #603 also reviewed the Skin Care Program Policy # V3-1400 which indicated that intervention-prevention for skin breakdown includes: turning and repositioning for dependent residents will occur every two hours. [s. 50. (2) (d)]

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

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food is served using methods to preserve appearance.

On April 20, 2015 Inspector #594 observed the lunch service in the Pier 1 dining room. At 12:45pm staff was observed to be serving ice cream desserts which were supplied in small bowls on a push cart. Between the time the ice cream was brought to the dining room and when the final resident received their dessert, the bowls of ice cream remained on the cart in the open dining room with no method of keeping the desserts cold. The final resident received their ice cream dessert at 1:10pm, at which point the inspector observed that the ice cream had melted. The inspector reviewed the home's Meal Service Objectives Policy #V9-310 which indicated that the dining room experience guidelines to enhance the mealtime service include, but are not limited to, plate presentation that will be designed to ensure food is presented in an appetizing manner. During an interview with the inspector, S#110 stated that the home's expectations are for staff to leave ice cream in the freezer if not ready to serve all the desserts, given that Pier 1 dining room is right across from the kitchen, and that if this occurred on other floors, staff would be expected to make two trips. [s. 72. (3) (a)]

WN #11: 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 has failed to 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.

On April 28, 2015, Inspector #603 interviewed S#106 who explained that the home's policy is for the Pharmacy and Therapeutics Committee to meet quarterly, however, the committee has not met this year. Inspector #603 reviewed the Pharmacy and Therapeutics Committee minutes and the Committee had not met since September 24, 2014. Inspector #603 also reviewed the Pharmacy and Therapeutics Committee minutes for year 2014 and the Committee met three times on March 20, 2014, April 30, 2014, and September 24, 2014. [s. 115. (1)]

Issued on this 14th day of August, 2015

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

Original report signed by the inspector.