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

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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
Jan 27, 2016	2015_323130_0028	H-003438-15	Resident Quality Inspection

Licensee/Titulaire de permis

1365853 ONTARIO LIMITED
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

MAPLE PARK LODGE
6 Hagey Avenue Fort Erie ON L2A 5M5

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

GILLIAN TRACEY (130), BERNADETTE SUSNIK (120), CATHY FEDIASH (214), PHYLLIS HILTZ-BONTJE (129), ROSEANNE WESTERN (508)

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): October 22, 23, 26, 27, 28, 29, November 3, 4, 5, 6, 9, 10, 12, 16, 17, 18, 19 and 20, 2015.

During this inspection all areas of the home were toured, illumination levels were measured, housekeeping\maintenance and infection control and nursing staff schedules, relevant policies and procedures were reviewed, lunch time meal services and snack passes were observed, resident bed rail use assessments and clinical records were reviewed. The home's complaint process, logs and investigation notes were reviewed.

The following critical incident and complaint inspections were conducted simultaneously with this RQI:
Complaints:
000014-14 related to housekeeping, menu planning, duty to protect and plan of care, 002411-14 related to activities, 002050-15 related to duty to protect, 022070-15 related to nutritional care and activities, 023274-15 related to Bill of Rights, 023322-15 related to reporting and complaints and skin and wound care, 024259-15 related to sufficient staffing and the following Critical incidents: 001711-15 related to alleged staff to resident abuse, 005800-15 related to alleged staff to resident abuse, 029341-15 related to medication administration, 011275-15 related to responsive behaviours and 013635-15 related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Resident Assessment Instrument (RAI) Coordinator, Special Projects Nurse, Physician, registered staff, personal support workers (PSW), Food Services and Nutrition Manager (FSNM), dietary staff, Director of Therapeutic recreation, maintenance staff, Housekeeping/Laundry Manager, Infection Control Designate, Presidents of Family and Residents' Councils, resident and families.

The following Inspection Protocols were used during this inspection:

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

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

- **19 WN(s)**
- **7 VPC(s)**
- **5 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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) Resident #002's written plan of care for bed mobility indicated the resident had a self care deficit related to the inability to follow instructions for turning and positioning when in bed; however, the interventions identified under bed mobility indicated the resident required extensive assistance of two staff; encourage resident to grab onto the bed rail as staff assist. The written plan of care also identified that the resident required the use of restraints and personal assistance services devices (PASD) to provide safety.

Staff #003 confirmed the resident did not require the use of restraints and that the plan of care did not provide clear directions related to bed mobility.

The plan of care for resident #002 did not provide clear direction to staff providing care. (Inspector #130)

B) The plan of care for resident #010 indicated the resident had an allergy to a specific

drug. This allergy was identified on the written care plan, the medical directives, progress notes, physician's orders and Medication Administration Record (MAR). According to the clinical record, the resident had received an oral dose of this drug routinely over a number of months in 2015 and on an identified date they had also received the drug subcutaneously. RPN #011 confirmed the plan of care did not provide clear directions to staff regarding the drug allergy. This non compliance was issued as a result of a CIS. (Inspector #130)

C) Resident #010 had a physician's orders for a specific treatment. The signed medical directive also included this identified treatment, but under specific parameters. Interviews held with RPNs #004 and #011 confirmed that staff were interpreting the physician's orders for the specific treatment to include the parameters as indicated in the medical directive. The DOC confirmed the orders for the administration of the treatment did not provide clear direction to registered staff. (Inspector #130)

D) The written plan of care for resident #009 indicated the resident had behaviours related to their diagnosis. The plan of care identified specific interventions. Registered staff #005 confirmed that the resident no longer demonstrated the identified responsive behaviour. The written plan indicated the resident required extensive assistance with toileting to restore function to maximum self sufficiency; however, the planned intervention stated the resident did not have the cognitive ability to follow through with tasks. The plan indicated the resident required extensive assistance of one staff to have maximum self-sufficiency for dressing. The planned intervention indicated staff were to break dressing into sub-tasks and give one instruction at a time; resident could perform tasks if broken down; assist resident with dressing only after they have attempted each step; however, the plan had indicated the resident did not have the cognitive ability to follow through with tasks.

Registered staff #005 confirmed the resident could not follow through with tasks and that the plan of care did not provide clear directions to staff providing care. (Inspector #130)

E) The plan of care for resident #400 was reviewed as well as a Critical Incident Submission (CIS) that was completed by the home in 2015. The plan of care that was in place at the time of this CIS indicated under bathing that the resident required the assistance of one person total dependence and also indicated that the resident required the assistance of two person's total dependence to complete this task. An interview with staff #002 confirmed that the resident required the assistance of two person's total dependence and that the plan of care had not set out clear directions to staff and others

who provided direct care to the resident. (Inspector #214) [s. 6. (1) (c)]

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

A) The plan of care for resident #005 identified specific food preferences and intolerances.

On an identified date in 2015, the resident was served a meal tray at lunch containing a food item that according to the plan of care, was not tolerated by the resident. The family members present returned the food item to the kitchen and requested an alternate item. Care was not provided in accordance with the plan of care. (Inspector #130).

B) A review of a Critical Incident Submission (CIS) that was completed by the home in 2015, indicated that an identified resident called out for help and when staff approached, they observed the resident to be in the doorway of a co-resident's room. A review of the resident's written plan of care in place at the time of this CIS indicated that the resident required interventions related to a diagnosis to provide a safe quality of life. The plan identified specific interventions to manage this behaviour.

An observation of the resident's room on a date in 2015, indicated that the identified intervention was not in place. An interview with staff #006, confirmed that the resident was to have the intervention in place. Staff #006 confirmed that the care set out in the resident's plan of care was not provided as specified in the plan. (Inspector #214) [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A) The MDS assessments completed on two identified dates in 2015 for resident #010, identified the resident demonstrated an increase in a specific responsive behaviour during the observation periods. Registered staff #005 confirmed that the written plan of care had not been revised when the responsive behaviour was first identified during the first review period in 2015. (Inspector #130).

B) Resident #012's plan of care was not reviewed or revised when the resident's care needs in relation to continence care level (CCL) changes. Registered staff #003 and

clinical documentation on the MDS review completed on an identified date in 2015, indicated the resident was incontinent of urine; the following MDS review completed later in 2015, indicated the resident was continent of urine and the MDS review completed after that in 2015, indicated the resident was both continent and incontinent of urine. Throughout the three month period of time on each of the MDS reviews completed, staff concluded there had been no change in the resident's urinary continence compared to the previous three month period of time. Registered staff #016 and clinical documentation confirmed that care directions for the urinary care of the resident were last reviewed/revised on a date in 2015. When the care needs of the resident changed later in 2015 and then again on another date in 2015 there had been no changes made to the plan of care for this resident related to urinary continence. (Inspector #129)

C) A review of a CIS that was completed by the home on an identified date in 2015, indicated that resident #403 was demonstrating responsive behaviours towards co-residents. A review of resident #403's written plan of care over a seven month period in 2015, indicated that no plan was in place to manage the resident's behaviours. An interview with staff #002 confirmed that there was no plan in place and that the plan of care was not reviewed and revised when the resident's care needs changed. (Inspector #214)

D) Resident #012 was not reassessed and their plan of care was not reviewed or revised when the resident's care needs in relation to pain changed. Registered staff #005 and clinical documentation confirmed that MDS data collected on a specific date in 2015, indicated the resident had no pain. The MDS data collected on another date in 2015, indicated the resident's pain level had changed and that the resident experienced mild pain on a daily basis. Data collected again on a later date in 2015, indicated the resident's pain score was identified at a level of six out of ten and indicated a sad look, frowning, uncooperative/resistant to care, verbal aggression, not wanting to be touched and not allowing people near, were identified as contributing factors to this pain score. Administrative staff #002, registered staff #003 and #005 confirmed there was no documentation in the resident's clinical record to indicate the staff who collected the above data regarding the resident's pain took any action to analyze the data collected for the impact this data had on the management of pain, nor did staff review or revise the resident's plan of care based on the data that indicated the resident pain care needs had changed. Further data collected in 2015, indicated the resident's pain level had increased and was identified at a level of seven out of ten. Data collected at this time indicated a sad look, frowning, grim face, uncooperative/resistance to care, verbally aggressive, not wanting to be touched and not allowing people near, were identified as contributing

factors to this pain score. Administrative staff #002, registered staff #003 and #005 confirmed there was no documentation in the resident's clinical record to indicated the staff who collected the above data regarding the change in the resident's pain level took any action to analyze the data collected for the impact this data had on the management of pain for resident #012 or reviewed or revised the resident's plan of care based on the data that indicated the resident's pain care needs had changed. A review of clinical documentation over a four month period in 2015, confirmed there were no new interventions identified in the care plan for the management of pain, there were no new physician's orders that related to the management of pain. The MAR indicated there were no changes in medication to manage pain during this period of time. (Inspector #129). [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

A) The "Resident Weight; Blood Pressure and Pulse Record, CN-W-04-1" indicated: "All residents are to have their weight recorded on the first bath day of every month by HCA/PSW assigned to them. If there is a significant weight gain or loss of 5% from the

previous month(s), the resident is to be re-weighed. The registered staff transcribes the weights from Form A and compares results to previous month(s) and initiate weight change policy as applicable. Any resident with a significant weight change of 5% in one month, 7.5% over 3 months, 10% over 6 months will be reweighed by nursing staff as soon as possible after the noted weight change is recorded. If there is a significant weight change or if there is any other weight change that compromises the resident's health status the FSNM and Registered Dietitian will be notified to intervene. The Registered Dietitian will chart what actions will be taken, update the care plan and evaluate the outcomes. Physician to be notified of Registered Dietitian recommendations".

i) The weight summary report and the FSNM confirmed that there was no weight recorded and entered in Point Click Care (PCC) for resident #010 for an identified month in 2015. According to the recorded weights, there was a 7.2% change in weight over a one month period in 2015 and greater than 5% change in weight over another one month period in 2015. The FSNM confirmed the resident was not re-weighed when the weight loss was noted. The DOC confirmed it was the expectation that night staff record the weights in PCC.

ii) The weight summary record for resident #009 indicated the resident had a 5% weight loss over a two month period in 2015; however, there were no reweighs recorded. The resident's weight record indicating a 9.8% weight loss. The FSNM confirmed there was no weight recorded in PCC for one of the identified months and no reweighs recorded for the other two months in 2015 as per the home's policy. (Inspector #130)

iii) The document titled: "Resident Weight; Blood Pressure and Pulse Record" indicated resident #002's weight was recorded on four occasions in 2014. The FSNM confirmed the weights recorded on three of the identified months in 2014 were likely not accurate, but confirmed that staff did not re-weigh the resident to verify the weight variances. The FSNM also confirmed that the weight for an identified month in 2014 was not recorded in PCC, which resulted in untriggered weight variance not being identified. The FSNM confirmed the resident’s weight on the identified month identified a weight loss of 8%. The FSNM verified the resident was not re-weighed as per the policy.

Staff interviewed and documentation confirmed, registered staff did not make referrals to the RD when there were weight variances for four identified months in 2014. The FSNM confirmed the RD assessed the resident on an identified date in 2014, but did not update the care plan despite an 8% weight loss in one month.

The home's policy titled: "Weight Change Policy, CN-W-04-1, dated August 2010" was not complied with. (Inspector #130).

B) The home's policy titled "Student Placements", CA-05-55-01, dated March 2015, indicated: "Students are to be supervised during medication passes and treatments".

i) On an identified date in 2015, student nurse #010, reported to RPN #011, that resident #010 required medication for complaints of pain. RPN #011 gave student nurse #010 the keys to the medication room. Student #010 administered the resident a subcutaneous medication which exceeded the prescribed amount. RPN #011 confirmed the student nurse was not supervised when they were given the medication room keys, granting access to medications, nor when the medication was administered.

The home's policy titled "Student Placements", CA-05-55-01, dated March 2015, was not complied with. This non compliance was issued as a result of an identified CIS. (Inspector #130)

C) Policy CN-R-05-7 under “Requirements Related to the Use of a PASD (Personal Assistive Services Device)”, the policy directed that “a PASD in use is well maintained and is applied by staff in accordance with any manufactures directions”. Manufacturer's directions provided by the home and confirmed by registered staff #004 indicated that the seat belt should be applied with just enough space for two fingers to fit between the belt and the pelvic crest.

i) Staff did not comply with this direction when on an identified date in 2015 resident #003 was noted to have a device applied incorrectly. Registered staff #004 confirmed that the device was applied incorrectly.

D) Policy CN-R-05-8 under “Requirements That Must Be In Plan Of Care Prior To PASD Use” the policy directed that “the following is to be included in the resident’s plan of care: alternatives to the use of a PASD have been considered and tried where appropriate, but would not or have not been effective to assist the resident”.

i) Staff did not comply with this direction when clinical documentation, administrative staff #002 and registered staff #003 confirmed that an assessment including what alternatives, if any, to the use of a device for resident #003 was not included in the resident’s plan of

care.

E) Staff did not comply with directions contained in the home's policy titled "Skin and Wound Care Program" dated June 2010.

Policy CN-S-13-7 directed that "residents who are assessed with altered skin integrity will have a wound assessment protocol completed by registered nursing staff upon discovery of the wound".

i) Registered staff #003 and #004 confirmed that this direction was not complied with when resident #011 fell on an identified date in 2015, sustained an injury to an identified area and a wound assessment protocol was not completed.

F) Staff did not comply with the directions contained in the home's policy titled "Pain Management Policy" dated January 2013.

i) Policy CN-P-09-5 directed that "the interdisciplinary team will assess the residents for pain when there is a change in condition that impacts or causes pain, using the Resident Assessment Protocol (RAP), Minimum Data Set (MDS) tool.

ii) Administrative staff #002, registered staff #003 and #005 confirmed this direction was not complied with when on an identified date in 2015, data collected on a MDS tool indicated the resident #012's pain level had changed and the resident was experiencing pain daily at a mild level. The above noted staff confirmed that a RAP was not completed when data indicated the resident's pain level had changed. The above noted staff also confirmed that a RAP was not completed when clinical documentation collected on a specific date in 2015 indicated resident #012's pain level score had increased from six out of ten to seven out of ten.

E) Staff did not comply with the directions contained in the home's program titled "Continence Care and Bowel Management Program" dated January 2010.

Policy CN-C-32-1 directs that "factors contributing to incontinence care will be reviewed and considered in the program of continence care and an individualized program of continence care will be documented on the resident's plan of care based on assessments and reassessments".

i) Staff did not comply with this direction when staff #015 confirmed that resident #012's

individual program of urinary continence was not based on behavioural factors that were contributing to the resident's urinary incontinence. This staff person confirmed that the care intervention "to toilet the resident before and after meals and prior be the hour of sleep" was not being implemented because the resident demonstrated resistive behaviours when staff suggested that they should go to the toilet. This staff person indicated that the resident ambulated independently with a walking aid and felt that they knew when there was a need to go to the bathroom.

F) Staff did not comply with the directions contained in the home's program titled "Responsive Behaviour Management" and dated June 2010.

Policy CN-B-04-3 directs that "where possible the triggers to behavior are identified on the care plan along with any strategies or interventions to respond to the behaviours and the care plan will document the responsive behaviours, the possible triggers and strategies to prevent minimize and respond to responsive behaviours".

i) Staff did not comply with these directions when it was identified that resident #012 began demonstrating responsive behaviours. Registered staff #005 confirmed that there was not an assessment for responsive behaviors in the computerized record, the home did not have a process for assessing behaviours, there was no attempt made to identify possible triggers for the identified behaviours and there were no strategies to prevent, minimize and respond to the responsive behaviours being demonstrated by resident #012. (Inspector #129)

G) A review of a CIS that was completed by the home, as well as documented progress notes at the time of this incident, indicated that on an identified date in 2015, following their shower, resident #400 was dressed in the same clothing that they had on prior to their shower which was documented as having stains on two areas. The CIS also indicated that the resident's hair had not been dried and was dripping water down their back, soaking their top. A review of a progress note on an identified date in 2015, indicated that registered staff #017 who responded to this incident observed the resident to be visibly upset.

A review of the CIS under actions taken, indicated that it was not the home's practice not to provide clean clothing and drying of hair following resident bathing and an interview with staff #002 confirmed that it was the home's protocol that residents' hair be dried and clean clothes were to be applied following all bathing care and that the home's protocol had not been complied with. (Inspector #214) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, in relation to the following: [50(2)(b)(i)]

A) Resident #011 did not receive a skin assessment when it was identified that the resident had fallen and had a visible injury. Staff #003 and staff #004 confirmed that a

document identified as "#536 Fall" was completed for resident #011 on an identified date in 2015 in response to a fall the resident sustained on the same date. This document confirmed that the resident had an injury. Registered staff #003 and the clinical record confirmed that a skin and wound assessment was not completed following documentation that indicated the resident's skin integrity had been altered when the resident sustained a fall. (Inspector #129) [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

A) On an identified date in 2015, Inspector #130 interviewed staff #006, #007 and #008 regarding the care of resident #002, specifically around the use of a safety device. Staff confirmed the resident was not repositioned from 0930 hours to 1330 hours and that repositioning activities were not documented for this resident because the safety device in place was considered a PASD and not a restraint. Staff verified the resident could not remove the device and that the resident was dependent on staff for repositioning. (Inspector #130)

B) Resident #003 was unable to reposition themselves and was not repositioned at least every two hours. The resident was observed on an identified date in 2015 at 1015 hours, sitting in their wheelchair. The resident was noted to be sleeping in the wheelchair and when approached it was observed that a safety device was applied. Staff #006 confirmed during an interview that this resident was not able to position themselves. Registered staff #004 and staff #009 confirmed that resident #003 would not be able to reposition themselves while sitting in the wheelchair or while in bed. Resident #003's clinical record also confirmed that the resident required two persons for constant supervision and mechanical lift for transfers and required two staff for positioning in bed. Staff #009 assigned to provide care to resident #003 on an identified date in 2015 confirmed that the resident was not repositioned every two hours during the day shift on the identified date and that there was no documentation in the plan of care to indicate that the resident was being repositioned. (Inspector #129) [s. 50. (2) (d)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

A) On an identified date in 2015, lunch was observed in the Cardinal Court dining room and the following was observed:

Resident #300 was served soup at 1205 hours, but not offered assistance until 1237 hours.

Resident #301 was served there soup at 1210 hours but not offered assistance until their entree was served at 1230 hours.

Resident #302 was served soup at 1205 hours but not offered assistance until 1215 hours.

Resident #303 was served soup at 1210 hours but not offered encouragement or assistance. They were served their entree at 1230 hours but not offered assistance with the meal until 1255 hours.

Resident #304 was served their soup at 1205 hours and staff immediately assisted with set up, by adding crushed crackers to the soup. Staff confirmed the resident required total feeding by one staff. The resident was assisted with feeding for five minutes then staff left the table to assist someone else. Staff returned to feed resident at 1215 hours then left again at 1225 hours. The resident had consumed approximately 50% of their meal when the plate was cleared and dessert was served at 1250 hours.

Resident #305 was served their dessert at 1245 hours, but did not receive assistance until 1255 hours.

Resident #306 was served their entree at 1220 hours and received assistance with the meal; however, staff left the table to assist someone else at 1225 hours, before the resident had finished. Staff returned to help the resident at 1230 hours.

Staff interviewed confirmed the identified residents required moderate to total assistance with eating. (Inspector #130)

B) On an identified date in 2015, lunch service was observed in the Cardinal Court secured area dining room. It was observed that beverages had been placed on the tables prior to the start of meal service and before all residents had been seated. Front line staff confirmed that beverages were placed on tables before someone was available to immediately assist residents. This non compliance was issued as a result of complaint inspection. (Inspector #130) [s. 73. (2) (b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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 did not ensure that the home was maintained in a state of good repair.

A) The balcony on the second floor used by residents on Robin and Blue Jay home areas was noted to have several areas that shifted (depressions) when the concrete tiles were stepped on. The licensee was not aware of the issue and did not have a schedule of repair in place.

B) The second floor corridor was observed to have areas where the sub floor was disintegrating, causing the floor tiles on top to cave in, crack and break (depression in floor in corridor between room #225 and room #227, just outside room #227 and between room #207 and room #201). Other tiles were lifting (corridor outside room #206) and some were cracked or missing corners in resident rooms (253, 233, 249, 250 by toilet). The licensee was aware of the construction flaw and reported that the subfloor needed to be replaced. No schedules were developed to replace the floor tiles where necessary to ensure the floor remained even and tight-fitting. (Inspector #120) [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is maintained in a state of good repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the 2014 evaluation related to the management of responsive behaviours contained an evaluation of the matters referred to in O. Reg. 79/10, s. 53(1).

A) The 2014 program evaluation for the management of responsive behaviours provided by the home identified that there were monthly meetings held to review complex cases as well as all current active residents in the Behavioural Support Ontario (BSO) program and specific changes in the care for three identified residents, but did not contain an evaluation of the effectiveness of the overall written approaches to care, overall written strategies for managing responsive behaviours, overall resident monitoring and internal reporting protocols or the effectiveness of the protocols established for the referral of residents to specialized resources where required. (Inspector #129) [s. 53. (3) (b)]

2. The licensee failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

A) The MDS assessments completed on two identified dates in 2015, for resident #010 indicated the resident exhibited increased resistiveness on one to three days during the observed time period. However, there was no written plan of care, or strategies developed to address the responsive behaviour. This information was confirmed by registered staff #005. (Inspector #130).

B) Registered staff #005 and clinical documentation confirmed that behavioural triggers were not identified and strategies were not developed and implemented to respond to the responsive behaviors being demonstrated by resident #012. MDS data collected on an identified date in 2015 identified that resident #012 demonstrated verbally abusive behaviour daily that was easily altered and resistance to care behaviours on a daily basis that were not easily altered. Clinical documentation recorded by staff indicated resident #012 demonstrated persistent anger with self or others four times in one month in 2015, ten times in another month in 2015 and four times 2015. Registered staff #005 confirmed that there was not an assessment for responsive behaviors in the computerized record and the home did not have a process for assessing behaviours. The clinical record confirmed that an attempt to identify behavioural triggers for resident #012 was not undertaken and there were no strategies developed or implemented to respond to the responsive behaviours being demonstrated by resident #012. (Inspector #129) [s. 53. (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 the 2014 evaluation related to the management of responsive behaviours contains an evaluation of the matters referred to in O. Reg. 79/10, s. 53(1), to be implemented voluntarily.

WN #7: 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 ensure that a written response was provided to Residents' Council within 10 days of receiving concerns or recommendations the Residents' Council had raised about the operation of the home.

A) A review of Residents' Council minutes from January 2015 to current date was completed. Council minutes and staff #012 confirmed that response sheets included in Residents' Council minutes did not contain information to verify that the responses to concerns and suggestions raised were provided to the Council within 10 days of the concern or suggestion being brought to the attention of the home.

B) Minutes of the January 2015 meeting confirmed that residents raised concerns about a suggestion made that they purchase their own wash clothes and towels. “Staff #012 confirmed that response sheets included in the Residents' Council meeting minutes did not contain information to verify that responses to concerns and suggestions raised by Residents' Council were responded to within 10 days of those concerns and responses being raised.”

C) Minutes of the March 2015 meeting confirmed that residents raised concerns about clothing coming back from laundry with holes in them, concerns that white socks were coming back a gray colour and concerns that recycling bins were not being emptied. Record keeping did not indicate a response was provided within 10 days of this concern being raised.

D) Minutes of the May 2015 meeting confirmed residents raised a concern that the track at the front entrance was too high for them to get their wheelchairs and walkers over. Record keeping did not indicate a response was provided within 10 days of this concern being raised.

E) Minutes of the June 2015 meeting confirmed residents raised concerns that staff were throwing out items in their rooms without asking the resident first, staff were sending residents clothing to the laundry before asking permission to do so. A resident raised concerns that there were loose tiles in the bathroom and around the toilet; concerns that their room had not been painted since they moved in and needed to be done. Concerns were also raised about damaged clothing. Record keeping did not indicate a response was provided within 10 days of these concern being raised. (Inspector #129) [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written response is provided to Residents' Council within 10 days of receiving concerns or recommendations the Residents' Council has raised about the operation of the home, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) The planned menu for lunch on October 22, 2015, indicated that whole wheat bread would be offered to residents who chose the alternate entree choice. It was observed that no residents who received the alternate entree choice at lunch on October 22, 2015, were offered or provided with whole wheat bread. This information was confirmed by the dietary staff. (Inspector #130) [s. 71. (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 planned menu items were offered and available at each meal and snack, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The manufacturer's instructions for seatbelts titled: Belt Application for Proper Positioning indicated that "Positioning belts are designed as part of seating system, to improve pelvic stability and to reduce risk of pressure ulcers. To be effective, any belt must be: Not too loose to allow client to slide under belt, nor too tight to irritate bony prominences or soft tissue. (Just enough space for two fingers to fit between the belt and pelvic crest).

A) On an identified date in 2015, an identified resident was observed seated in their wheelchair in the common lounge with a safety device applied. The resident was fidgeting in their chair and it was observed that the device was incorrectly applied. The Administrator confirmed the device was a restraint and that the resident was at risk for falls. The Administrator observed the device and confirmed it was incorrectly applied. (Inspector #130) [s. 110. (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 the physical device was applied in accordance with the manufacturer's instructions (if any), to be implemented voluntarily.

WN #10: 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.

A) Resident #010 had a physician's order for a specific medication. On an identified date in 2015, resident #010 received a dose which exceeded the prescribed amount. The resident was transferred to hospital for treatment of the medication overdose. This information was confirmed by the DOC and clinical record. This non compliance was issued as a result of a CIS. (Inspector #130). [s. 131. (2)]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

1. The licensee did not ensure that the infection prevention and control program, specifically the component related to cleaning and disinfection was evaluated and updated at least annually in accordance with prevailing practices.

The licensee's infection prevention and control program with respect to cleaning and disinfection practices of resident personal care devices such as wash basins, bed pans and urinals was reviewed. The home's procedure titled "Cleaning Nursing Equipment - CIC 02-26-1" May 2011 instructed staff to clean and disinfect wash basins and bed pans after every use. Bed pans not used were to be stored in the soiled utility room and wash basins were to be stored in the resident's bathroom (no specific location mentioned). No specific cleaning instructions were provided regarding the use of any equipment or fixture (sink, disinfection machine). Separately, in a binder titled "PSW night shift routines" for personal care workers, the cleaning and disinfecting instructions were to collect the devices once per week and place the items in a "cart washer" located in a designated soiled utility room. No specific instructions were available on the use of the machine. Verification was made with day time and night time staff regarding their usual practices. Night shift staff reported that they did not disinfect the devices once they were removed from the cart washers, but sprayed the devices with a disinfectant before they were washed. Once the devices were washed, the devices were returned to the resident's room or washroom and the staff member was to sign off that they had completed this

task.

A) Staff reported that during the day, the devices were washed with disposable paper towel, hand soap and water over the resident's sink (sink not large enough to accommodate the basin) and left to dry by either hanging them on the wall below the vanity, or turning them upside down on the faucet of the sink. No disinfection action was carried out. The staff reported that the additional action of spraying the articles with a liquid disinfectant was not feasible in time nor was it practical (how the spray would be transported from room to room, where it would be stored to keep inaccessible to residents and amount that would be inhaled by the worker, the fact that it needed 10 minutes of contact time and the residual left on the surface if not wiped off before the article used again).

During the tour of the home, three soiled utility rooms were observed to be equipped with a white large deep sink, two out of the three were equipped with a wheelchair washer and one out of the three was equipped with a specific personal care devices washer. None of the rooms had any cleaning and disinfection instructions posted. Many resident rooms were observed to have wash basins on the floor under the vanities and some were tipped upside down on the sink faucet. Two rooms in particular had bed pans on grab bars next to the toilet, one was very dusty and one had visible soiling on it on November 4, 2015. Both articles were still dusty or soiled on November 9, 2015. The PSW night shift cleaning routine sign off sheet for the two rooms was blank from Nov 1st to Nov. 9th, 2015.

According to current prevailing practices titled "Best Practices for Cleaning, Disinfecting and " Sterilization in all Health Care Settings, May 2013" personal care devices that are re-used more than once on the same resident are considered non-critical devices (as they are used on intact skin only) do not need to be disinfected between use as long as they are adequately cleaned between use and stored in a manner to keep them from being re-contaminated. According to the best practices, the reprocessing method, level and products required for the devices shall reflect the intended use of the device and the potential risk of the infection involved in the use of the device. The infection control designate did not establish in the procedures at what point the devices would require disinfection, how specifically the products would be used and applied (sprayed, immersed, wiped on), when the products would be applied (during outbreak, when resident is on special precautions) and where they would be cleaned (sink, appropriate washer, resident washroom etc). As the wheelchair washer units in the home are not designed to be used to clean bed pans, basins or urinals, an alternative option would be

required, which was not identified in any of the existing procedures. The home's current cleaning and disinfection procedures and practices were not developed in accordance with current prevailing practices. (Inspector #120)

B) During an interview with the infection control designate for the home on November 9, 2015, confirmation was made that the individual did not receive any training or education with respect to (b) and (c) noted above and received some assistance with (e) and was learning while on the job. The individual was not aware of and did not read the Provincial Infectious Diseases Advisory Committee Best Practices Documents regarding the 3 areas of practice noted above or had taken courses offered by their local Regional Infection Control Network for the three areas of practice noted above. (Inspector #120) [s. 229. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the infection prevention and control program, specifically the component related to cleaning and disinfection is evaluated and updated at least annually in accordance with prevailing practices and to ensure that the infection prevention and control program, specifically the component related to cleaning and disinfection is evaluated and updated at least annually in accordance with prevailing practices, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee did not ensure that the lighting requirements set out in the lighting table were maintained.

The long term care home was built prior to 2009 and therefore the section of the lighting table that was applied was titled "In all other areas of the home". A hand held analogue light meter was used (Sekonic Handi Lumi) to measure the lux levels in various locations in the home. The meter was held a standard 30 inches above and parallel to the floor. Lighting conditions were bright outdoors at the time of the inspection and in order to prevent natural light from affecting indoor measurements all efforts were made to control the natural light by closing blinds. Lights were turned on five minutes prior to measuring

to allow them to warm up to maximum output. Resident rooms were not measured. Tub, shower rooms, resident ensuite and common washrooms and corridors were spot checked and those measured met the minimum required levels.

A) The three dining rooms in the home were all equipped with the same number and style of ceiling light fixtures, a dome shaped flush mounted fixture with an opaque lens. The lux levels in the Robin and Blue Jay dining rooms were measured. Directly below the ceiling lights in both of the dining rooms, the lux was approximately 190 and when the meter was held over some tables or between tables (in between lights), the lux dropped to 100-150. Some of the lights were brighter, depending on the age of the bulb. Illumination levels vary depending on the type of fixture, type of bulb, the lens cover and the height of the ceiling. The minimum required amount is 215.28 lux.

B) The lounge spaces on each home area and the main lobby were all equipped with the same light fixtures as the dining rooms. Many were measured to be approximately 150-200 lux, depending on the age of the bulb. The 2nd floor Robin living room was equipped with 2 dome lights and directly under both lights, the lux was 50. On the 2nd floor, in the corridor opposite the elevators, the dome lights were 190-200 lux. The dome lights just outside of the elevators on 1st floor and towards the Cardinal home area were 100-125 lux. The minimum required amount is 215.28 lux.

The maintenance manager reported on November 20, 2015 that he verified with his light meter that the illumination levels in resident rooms did not meet the minimum required amount of 215.28 lux. As a result, beginning in 2015, he has been slowly replacing light fixtures and will continue to replace them in 2016. The maintenance manager reported that the light fixtures in the lounge spaces, main lobby and areas identified above had new light bulbs installed, however the light bulbs did not increase the level of illumination to or above 215.28 lux. (Inspector #120) [s. 18.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of the home's policy, titled, Abuse-Prevention, Reporting and Elimination of Abuse and Neglect (CA-05-37-1 and dated June 2010), indicated the following:

i) "Any person who suspects that abuse or neglect has occurred must report it to the Registered staff who follows the same steps as if the abuse/neglect was witnessed".

ii) "Registered staff must contact the Administrator or his/her designate immediately for direction on sanctions to be imposed immediately and for direction on how to proceed with the investigation of any alleged, suspected or witnessed abuse or neglect".

A) A review of a CIS that was completed by the home as abuse/neglect as well as documented progress notes for this incident, indicated that on an identified date 2015, following their shower, resident #400 was dressed in the same clothing that they had on prior to their shower which was documented as having two identified stains. The CIS also indicated that the resident's hair had not been dried and was dripping water down their back, soaking their top. The CIS indicated that registered staff #017 responded to this unusual occurrence. An interview with staff #002 confirmed that they had not been made aware of this incident until the following day when they received a voice message from a family member. Staff #002 confirmed that the home had not complied with their written policy to promote zero tolerance of abuse and neglect of residents. (Inspector #214) [s. 20. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of special treatments and interventions, in relation to the following: [26(3) 18]

A) Administrative staff #002 and registered staff #003 confirmed that an interdisciplinary assessment was not completed when a restraint being used to restrain resident #003 was converted to a PASD. Documentation in the clinical record on a specific date in 2015 indicated that the restraint had been changed from a restraining device to a PASD. This notation in the progress notes indicated "the resident required the use of FFSB as a PASD to promote proper posture and prevent the resident from leaning out of wheelchair". Resident #003's plan of care was not based on an interdisciplinary assessment of the changing needs of the resident related to the use of a PASD. (Inspector #129) [s. 26. (3) 18.]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (2) The policy must comply with such requirements as may be provided for in the regulations. 2007, c. 8, s. 29 (2).

Findings/Faits saillants :

1. The home failed to ensure that the policy titled Restraint Policy complied with requirements as provided for in the regulations. 2007, c. 8, s. 29 (2).

A) The home's Restraint Policy dated July 2010, page CN-R-05-02, indicated: "PASD that limits or inhibits movement means the use of a PASD where the PASD has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release himself or herself from the PASD". The home's policy does not provide directions regarding the care of a resident who has a PASD that limits movement as specified in the regulations. (Inspector #130) [s. 29. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written record of the 2014 evaluation of the organized program of Pain Management as well as Continence and Bowel Management contained an evaluation of the program, the changes made and the dates those changes were implemented, in relation to the following:[30(1)4]

A) The 2014 program evaluation for the Continence and Bowel Management Program provided by the home identified a second quarter rate of worsening continence at 10% and a third quarter rate of worsening continence at a 50%. The potential causes for this increasing rate of worsening continence were identified as; inaccurate coding, inconsistency of team leader and managing products/toileting program as well as deterioration in resident condition. The written program evaluation does not contain changes made to address the potential causes of the increased rate of worsening continence identified in the third quarter of 2014.

The 2014 program evaluation for the Pain Management Program provided by the home did not contain a written evaluation of the program. The narrative section of the evaluation documents the pain management strategies identified in the home's policies and procedures but did not contain a written evaluation of the effectiveness of those strategies in the overall management of resident pain. (Inspector #129) [s. 30. (1) 4.]

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

A) A review of a CIS that was completed by the home on an identified date in 2015, indicated that resident #403 was demonstrating responsive behaviours toward resident #405. A review of resident #405's clinical record indicated that no documentation regarding this incident had been completed. A review of the Risk Management section in PCC which the home used to document incidents indicated that this incident had been documented in this section; however; the Risk Management section had a statement that stated that the incident report was "Privileged and Confidential – Not part of the Medical Record – Do not Copy". An interview with staff #002 confirmed that actions taken with respect to this incident had not been documented. (Inspector #214) [s. 30. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition of the resident required.

A) Resident #701 was frequently incontinent of both bowel and bladder during an identified month in 2014. Over the next two quarters the resident's level of incontinence declined and in an identified month the resident was totally incontinent of bladder and later totally incontinent of both bowel and bladder.

A review of the resident's clinical record indicated that the resident's continence had declined during a seven month period in 2014; however, the resident had not been reassessed. A bowel and bladder assessment was completed on an identified date in 2014, as a scheduled quarterly and not due to the resident's decline in continence.

It was confirmed through documentation that the resident's level of incontinence had declined and that the resident had not been reassessed using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident was required. (Inspector #508) [s. 51. (2) (a)]

WN #18: 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

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. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee did not ensure that procedures were developed and implemented for cleaning of the home, specifically resident bedroom floors, servery floors, light covers, exhaust vents and dining room chairs.

A) A tour of the home was completed on November 4 and 5, 2015 and the flooring was observed to be stained black either around the perimeter of the room or in heavy traffic areas in but not limited to #103, 112, 119, 129, 204, 210, 234, 254, all 3 dining rooms and in each corridor on every home area. Discussion was held with the Housekeeping Supervisor who could not confirm when the above identified areas were last stripped, re-waxed or buffed (other than room #103). According to the supervisor, the designated floor person did not document where and when the floors were buffed. She did however provide a calendar that listed 17 resident rooms that received stripping or re-waxing when they were vacated between March and November 6, 2015, but did not include the rooms observed above. The calendar also identified that rooms were buffed, but did not identify which rooms. If a room was not vacated in 2015, it did not receive any stripping or re-waxing. The dining rooms did not receive any floor care in 2015 (other than use of floor machine).

The floor care procedures provided included how to strip and re-wax the floors, but none

were provided regarding how to buff the floors and how often. The supervisor reported that the floor care expectations were to buff dining rooms every 2 weeks, buff resident rooms monthly and corridors as needed. A bedroom cleaning procedure and routine was provided which included the need to strip and re-wax all resident rooms on an annual basis. Documentation provided could not establish whether this was implemented. A routine was provided that identified specific tasks for a designated floor person to buff or wax resident rooms on Tuesdays, Thursdays and Fridays and other areas (corridors, dining rooms) on Thursdays based on a rotating schedule. However, the schedule or calendar that was provided did not include what areas or room numbers were buffed or whether all resident room floors were stripped and re-waxed in 2015. Adequate documentation could not be provided to establish whether the floor care program was being implemented.

B) Exhaust vents located in the Robin home area tub room and resident washrooms in but not limited to #102, 104, 106, 108, 109, 129, 207, 242, 243, 247, 250, 251 and 253 were observed to have a heavy coating of dust on both the exterior vent cover and the internal baffles, restricting the opening space by almost half. The licensee's policies and procedures did not include any references as to who would clean the interior baffles, how or how often. The housekeeping procedures for washroom cleaning directed housekeeping staff to dust (exterior) vents on a daily basis. No tub room cleaning procedures were developed other than the expectation that the floors and vents be cleaned daily. The procedures were not implemented as evidenced by the above noted dust accumulations and procedures were not developed to address the cleaning requirements of the rest of the exhaust system (interior baffles and duct system).

C) Light covers located in resident washrooms (118, 120, 126, 204, 205, 207, 215, 218, 221, 231), various resident bedrooms, corridors and lounges were observed to have an accumulation of dead insects inside them. The licensee's bedroom and washroom cleaning routine and procedure identified that housekeeping staff are to "dust" light fixtures daily, monthly and annually. No instruction was included identifying the need to dismantle the light fixture to remove accumulated matter inside light fixture covers or whether this task was to be deferred to maintenance staff. The maintenance procedures did not include light fixture cleaning tasks.

D) On November 4 & 5, 2015, over 50% of all of the dining room chairs were observed to be soiled (frames and seats) in all three dining rooms. The Food Services Supervisor confirmed that her procedures for dietary staff included the cleaning of tables and not the chairs. The Housekeeping Supervisor reported that the chairs were cleaned monthly.

No procedure was developed to ensure that the chairs were cleaned on an as needed basis. According to the Housekeeping Supervisor, chair cleaning is considered "project work" and would be assigned when needed. However, no formal auditing was completed of the chairs to determine extent of soiling and no procedures were written identifying how to clean them, when and by whom.

E) On Wednesday, November 4 & Thursday, November 5, 2015, all three serveries were observed to have debris accumulations under the steam tables and around the stove on Cardinal Court. The routine provided by the Housekeeping Supervisor for floor care identified that the servery floors were to be cleaned on Tuesdays. However, the routine did not include removal of debris under equipment but the use of a floor machine that could be worked "side to side". The dietary aide routines provided by the Food Services Supervisor identified that staff were to sweep and mop the servery floors daily, but no task to clean under equipment was mentioned. The Housekeeping Supervisor was not able to provide any written procedures that identified what specifically needed to be cleaned, how, and by whom in the serveries. (Inspector #120) [s. 87. (2) (a)]

2. The licensee did not ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

A) On the morning and afternoon of November 4 and 9, 2015, lingering offensive odours related to urine were noted in the corridor and confirmed to be emanating from an identified washroom. When the washroom was entered on November 9, 2015, no visual evidence of urine was noted in the room and the room appeared clean and garbage fairly empty. Housekeeping staff were provided with odour counteractant cleaners and were aware of when to use them. According to the licensee's "Odour Control Policy", the options listed included regular cleaning, garbage removal and the use of odour eliminators or odour counteractants, which were employed without much success. No other options were included in the policy to continue to explore the source of odours such as assessing fixtures, flooring, drywall and baseboards for urine penetration. The policy was limited and did not include a referral to maintenance staff (other than if sewer odours were identified). (Inspector #120) [s. 87. (2) (d)]

WN #19: 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:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, has responded to the person who made the complaint indicating what the licensee has done to resolve the complaint.

A) On an identified date in 2014, resident #700's family member called in a complaint to the home and reported to a registered staff member that they were upset about an incident that occurred earlier that evening. The family member indicated that they were visiting with resident #700 in the resident's room and staff had missed resident #700 when distributing snacks and fluids.

A review of the resident's clinical record indicated that the registered staff member who received the complaint documented these concerns into the resident's clinical record. The documentation indicated that the registered staff member notified management of the complaint.

A review of the home's complaint log for 2014, indicated that these concerns had not been documented in the complaint log, only in the resident's clinical record by registered staff. The resident's family member indicated that after they had complained to the home, they did not receive any follow up to this complaint.

On an identified date in 2015, the DOC had indicated during an interview that she could recall this complaint and indicated that follow up had been done;however, it had been the Administrator that had followed up on this concern, not the DOC. The Administrator indicated that she could not recall this complaint and could not provide any information on the follow up or actions taken. (Inspector #508)

It was confirmed through documentation that a response had not been made to the person who made the complaint indicating what the licensee had done to resolve the complaint. (Inspector #508) [s. 101. (1) 3.]

Issued on this 8th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN TRACEY (130), BERNADETTE SUSNIK (120), CATHY FEDIASH (214), PHYLLIS HILTZ-BONTJE (129), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2015_323130_0028
Log No. / Registre no:	H-003438-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 27, 2016
Licensee / Titulaire de permis :	1365853 ONTARIO LIMITED 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	MAPLE PARK LODGE 6 Hagey Avenue, Fort Erie, ON, L2A-5M5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karen Nix

To 1365853 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
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Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident, including resident, #002 related to their mobility needs, specifically the level of assistance required for bed mobility, resident #010 related to allergies and oxygen requirements, specifically identifying what allergies the resident has and clear direction on when the resident should have oxygen in use and when not, resident #009 related to responsive behaviours; identifying what behaviours if any the resident has and what interventions are in place to manage the behaviouirs and resident #400 related to hygiene and grooming requirements; specifically identifying how many staff are required to assist the resident with hygiene and grooming tasks.

Grounds / Motifs :

1. Previously issued as WN on January 27, 2014.

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) Resident #002's written plan of care for bed mobility indicated the resident had a self care deficit related to the inability to follow instructions for turning and positioning when in bed; however, the interventions identified under bed mobility indicated the resident required extensive assistance of two staff; encourage resident to grab onto the bed rail as staff assist. The written plan of care also identified that the resident required the use of restraints and personal assistance

services devices (PASD) to provide safety.

Staff #003 confirmed the resident did not require the use of restraints and that the plan of care did not provide clear directions related to bed mobility.

The plan of care for resident #002 did not provide clear direction to staff providing care. (Inspector #130)

B) The plan of care for resident #010 indicated the resident had an allergy to a specific drug. This allergy was identified on the written care plan, the medical directives, progress notes, physician's orders and Medication Administration Record (MAR). According to the clinical record, the resident had received an oral dose of this drug routinely over a number of months in 2015 and on an identified date they had also received the drug subcutaneously. RPN #011 confirmed the plan of care did not provide clear directions to staff regarding the drug allergy. This non compliance was issued as a result of a CIS. (Inspector #130)

C) Resident #010 had a physician's orders for a specific treatment. The signed medical directive also included this identified treatment, but under specific parameters. Interviews held with RPNs #004 and #011 confirmed that staff were interpreting the physician's orders for the specific treatment to include the parameters as indicated in the medical directive. The DOC confirmed the orders for the administration of the treatment did not provide clear direction to registered staff. (Inspector #130)

D) The written plan of care for resident #009 indicated the resident had behaviours related to their diagnosis. The plan of care identified specific interventions. Registered staff #005 confirmed that the resident no longer demonstrated the identified responsive behaviour. The written plan indicated the resident required extensive assistance with toileting to restore function to maximum self sufficiency; however, the planned intervention stated the resident did not have the cognitive ability to follow through with tasks. The plan indicated the resident required extensive assistance of one staff to have maximum self-sufficiency for dressing. The planned intervention indicated staff were to break dressing into sub-tasks and give one instruction at a time; resident could perform tasks if broken down; assist resident with dressing only after they have attempted each step; however, the plan had indicated the resident did not have the cognitive ability to follow through with tasks.

Registered staff #005 confirmed the resident could not follow through with tasks and that the plan of care did not provide clear directions to staff providing care. (Inspector #130)

E) The plan of care for resident #400 was reviewed as well as a Critical Incident Submission (CIS) that was completed by the home in 2015. The plan of care that was in place at the time of this CIS indicated under bathing that the resident required the assistance of one person total dependence and also indicated that the resident required the assistance of two person's total dependence to complete this task. An interview with staff #002 confirmed that the resident required the assistance of two person's total dependence and that the plan of care had not set out clear directions to staff and others who provided direct care to the resident. (Inspector #214) [s. 6. (1) (c)]
(130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that residents are reassessed and the plan of care reviewed and revised, at least every six months and at any other time when, a goal in the plan is met; the resident's care needs change or care set out in the plan is no longer necessary; or care set out in the plan has not been effective. Including resident # 010, specifically related to the identification of responsive behaviours , resident #012, specifically related to their continence status and required interventions and pain management requirments, and resident #403, specifically related to the identification of responsive behaviours and interventions required to manage the behaviours.

Grounds / Motifs :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A) The MDS assessments completed on two identified dates in 2015 for resident #010, identified the resident demonstrated an increase in a specific responsive behaviour during the observation periods. Registered staff #005 confirmed that the written plan of care had not been revised when the responsive behaviour was first identified during the first review period in 2015. (Inspector #130).

B) Resident #012's plan of care was not reviewed or revised when the resident's

care needs in relation to continence care level (CCL) changes. Registered staff #003 and clinical documentation on the MDS review completed on an identified date in 2015, indicated the resident was incontinent of urine; the following MDS review completed later in 2015, indicated the resident was continent of urine and the MDS review completed after that in 2015, indicated the resident was both continent and incontinent of urine. Throughout the three month period of time on each of the MDS reviews completed, staff concluded there had been no change in the resident's urinary continence compared to the previous three month period of time. Registered staff #016 and clinical documentation confirmed that care directions for the urinary care of the resident were last reviewed/revised on a date in 2015. When the care needs of the resident changed later in 2015 and then again on another date in 2015 there had been no changes made to the plan of care for this resident related to urinary continence. (Inspector #129)

C) A review of a CIS that was completed by the home on an identified date in 2015, indicated that resident #403 was demonstrating responsive behaviours towards co-residents. A review of resident #403's written plan of care over a seven month period in 2015, indicated that no plan was in place to manage the resident's behaviours. An interview with staff #002 confirmed that there was no plan in place and that the plan of care was not reviewed and revised when the resident's care needs changed. (Inspector #214)

D) Resident #012 was not reassessed and their plan of care was not reviewed or revised when the resident's care needs in relation to pain changed. Registered staff #005 and clinical documentation confirmed that MDS data collected on a specific date in 2015, indicated the resident had no pain. The MDS data collected on another date in 2015, indicated the resident's pain level had changed and that the resident experienced mild pain on a daily basis. Data collected again on a later date in 2015, indicated the resident's pain score was identified at a level of six out of ten and indicated a sad look, frowning, uncooperative/resistant to care, verbal aggression, not wanting to be touched and not allowing people near, were identified as contributing factors to this pain score. Administrative staff #002, registered staff #003 and #005 confirmed there was no documentation in the resident's clinical record to indicate the staff who collected the above data regarding the resident's pain took any action to analyze the data collected for the impact this data had on the management of pain, nor did staff review or revise the resident's plan of care based on the data that indicated the resident pain care needs had changed. Further data collected in 2015, indicated the resident's pain level had increased and was identified at a

level of seven out of ten. Data collected at this time indicated a sad look, frowning, grim face, uncooperative/resistance to care, verbally aggressive, not wanting to be touched and not allowing people near, were identified as contributing factors to this pain score. Administrative staff #002, registered staff #003 and #005 confirmed there was no documentation in the resident's clinical record to indicated the staff who collected the above data regarding the change in the resident's pain level took any action to analyze the data collected for the impact this data had on the management of pain for resident #012 or reviewed or revised the resident's plan of care based on the data that indicated the resident's pain care needs had changed. A review of clinical documentation over a four month period in 2015, confirmed there were no new interventions identified in the care plan for the management of pain, there were no new physician's orders that related to the management of pain. The MAR indicated there were no changes in medication to manage pain during this period of time. (Inspector #129). [s. 6. (10) (b)] (130)

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures any plan, policy, protocol, procedure, strategy or system is complied with, specifically: Resident Weight; Blood Pressure and Pulse Record, Policy CN-W-04-1, Student Placements, Policy CA-05-55-01, Requirements Related to the Use of a PASD, Policy CN-R-05-7, Requirements That Must Be In Plan Of Care Prior To PASD Use, Policy CN-R-05-8, Skin and Wound Care Program, Policy CN-S-13-7, Pain Management, Policy CN-P-09-5, Continence Care and Bowel Management Program, Policy CN-C-32-1 and Responsive Behaviour Management, Policy CN-B-04-3.

The plan shall include education for relevant staff and identify quality monitoring activities to ensure ongoing compliance.

The plan shall be submitted to Gillian.Tracey@ontario.ca on or before January 31, 2016.

Grounds / Motifs :

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

A) The "Resident Weight; Blood Pressure and Pulse Record, CN-W-04-1" indicated: "All residents are to have their weight recorded on the first bath day of every month by HCA/PSW assigned to them. If there is a significant weight gain

or loss of 5% from the previous month(s), the resident is to be re-weighed. The registered staff transcribes the weights from Form A and compares results to previous month(s) and initiate weight change policy as applicable. Any resident with a significant weight change of 5% in one month, 7.5% over 3 months, 10% over 6 months will be reweighed by nursing staff as soon as possible after the noted weight change is recorded. If there is a significant weight change or if there is any other weight change that compromises the resident's health status the FSNM and Registered Dietitian will be notified to intervene. The Registered Dietitian will chart what actions will be taken, update the care plan and evaluate the outcomes. Physician to be notified of Registered Dietitian recommendations".

i) The weight summary report and the FSNM confirmed that there was no weight recorded and entered in Point Click Care (PCC) for resident #010 for an identified month in 2015. According to the recorded weights, there was a 7.2% change in weight over a one month period in 2015 and greater than 5% change in weight over another one month period in 2015. The FSNM confirmed the resident was not re-weighed when the weight loss was noted. The DOC confirmed it was the expectation that night staff record the weights in PCC.

ii) The weight summary record for resident #009 indicated the resident had a 5% weight loss over a two month period in 2015; however, there were no reweighs recorded. The resident's weight record indicating a 9.8% weight loss. The FSNM confirmed there was no weight recorded in PCC for one of the identified months and no reweighs recorded for the other two months in 2015 as per the home's policy. (Inspector #130)

iii) The document titled: "Resident Weight; Blood Pressure and Pulse Record" indicated resident #002's weight was recorded on four occasions in 2014. The FSNM confirmed the weights recorded on three of the identified months in 2014 were likely not accurate, but confirmed that staff did not re-weigh the resident to verify the weight variances. The FSNM also confirmed that the weight for an identified month in 2014 was not recorded in PCC, which resulted in untriggered weight variance not being identified. The FSNM confirmed the resident's weight on the identified month identified a weight loss of 8%. The FSNM verified the resident was not re-weighed as per the policy.

Staff interviewed and documentation confirmed, registered staff did not make referrals to the RD when there were weight variances for four identified months

in 2014. The FSNM confirmed the RD assessed the resident on an identified date in 2014, but did not update the care plan despite an 8% weight loss in one month.

The home's policy titled: "Weight Change Policy, CN-W-04-1, dated August 2010" was not complied with. (Inspector #130).

B) The home's policy titled "Student Placements", CA-05-55-01, dated March 2015, indicated: "Students are to be supervised during medication passes and treatments".

i) On an identified date in 2015, student nurse #010, reported to RPN #011, that resident #010 required medication for complaints of pain. RPN #011 gave student nurse #010 the keys to the medication room. Student #010 administered the resident a subcutaneous medication which exceeded the prescribed amount. RPN #011 confirmed the student nurse was not supervised when they were given the medication room keys, granting access to medications, nor when the medication was administered.

The home's policy titled "Student Placements", CA-05-55-01, dated March 2015, was not complied with. This non compliance was issued as a result of an identified CIS. (Inspector #130)

C) Policy CN-R-05-7 under “Requirements Related to the Use of a PASD (Personal Assistive Services Device)”, the policy directed that “a PASD in use is well maintained and is applied by staff in accordance with any manufactures directions”. Manufacturer's directions provided by the home and confirmed by registered staff #004 indicated that the seat belt should be applied with just enough space for two fingers to fit between the belt and the pelvic crest.

i) Staff did not comply with this direction when on an identified date in 2015 resident #003 was noted to have a device applied incorrectly. Registered staff #004 confirmed that the device was applied incorrectly.

D) Policy CN-R-05-8 under “Requirements That Must Be In Plan Of Care Prior To PASD Use” the policy directed that “the following is to be included in the resident’s plan of care: alternatives to the use of a PASD have been considered and tried where appropriate, but would not or have not been effective to assist

the resident".

i) Staff did not comply with this direction when clinical documentation, administrative staff #002 and registered staff #003 confirmed that an assessment including what alternatives, if any, to the use of a device for resident #003 was not included in the resident's plan of care.

E) Staff did not comply with directions contained in the home's policy titled "Skin and Wound Care Program" dated June 2010.

Policy CN-S-13-7 directed that "residents who are assessed with altered skin integrity will have a wound assessment protocol completed by registered nursing staff upon discovery of the wound".

i) Registered staff #003 and #004 confirmed that this direction was not complied with when resident #011 fell on an identified date in 2015, sustained an injury to an identified area and a wound assessment protocol was not completed.

F) Staff did not comply with the directions contained in the home's policy titled "Pain Management Policy" dated January 2013.

i) Policy CN-P-09-5 directed that "the interdisciplinary team will assess the residents for pain when there is a change in condition that impacts or causes pain, using the Resident Assessment Protocol (RAP), Minimum Data Set (MDS) tool.

ii) Administrative staff #002, registered staff #003 and #005 confirmed this direction was not complied with when on an identified date in 2015, data collected on a MDS tool indicated the resident #012's pain level had changed and the resident was experiencing pain daily at a mild level. The above noted staff confirmed that a RAP was not completed when data indicated the resident's pain level had changed. The above noted staff also confirmed that a RAP was not completed when clinical documentation collected on a specific date in 2015 indicated resident #012's pain level score had increased from six out of ten to seven out of ten.

E) Staff did not comply with the directions contained in the home's program titled "Continence Care and Bowel Management Program" dated January 2010.

Policy CN-C-32-1 directs that "factors contributing to incontinence care will be reviewed and considered in the program of continence care and an individualized program of continence care will be documented on the resident's plan of care based on assessments and reassessments".

i) Staff did not comply with this direction when staff #015 confirmed that resident #012's individual program of urinary continence was not based on behavioural factors that were contributing to the resident's urinary incontinence. This staff person confirmed that the care intervention "to toilet the resident before and after meals and prior be the hour of sleep" was not being implemented because the resident demonstrated resistive behaviours when staff suggested that they should go to the toilet. This staff person indicated that the resident ambulated independently with a walking aid and felt that they knew when there was a need to go to the bathroom.

F) Staff did not comply with the directions contained in the home's program titled "Responsive Behaviour Management" and dated June 2010.

Policy CN-B-04-3 directs that "where possible the triggers to behavior are identified on the care plan along with any strategies or interventions to respond to the behaviours and the care plan will document the responsive behaviours, the possible triggers and strategies to prevent minimize and respond to responsive behaviours".

i) Staff did not comply with these directions when it was identified that resident #012 began demonstrating responsive behaviours. Registered staff #005 confirmed that there was not an assessment for responsive behaviors in the computerized record, the home did not have a process for assessing behaviours, there was no attempt made to identify possible triggers for the identified behaviours and there were no strategies to prevent, minimize and respond to the responsive behaviours being demonstrated by resident #012. (Inspector #129)

G) A review of a CIS that was completed by the home, as well as documented progress notes at the time of this incident, indicated that on an identified date in 2015, following their shower, resident #400 was dressed in the same clothing that they had on prior to their shower which was documented as having stains on two areas. The CIS also indicated that the resident's hair had not been dried and was dripping water down their back, soaking their top. A review of a

progress note on an identified date in 2015, indicated that registered staff #017 who responded to this incident observed the resident to be visibly upset.

A review of the CIS under actions taken, indicated that it was not the home's practice not to provide clean clothing and drying of hair following resident bathing and an interview with staff #002 confirmed that it was the home's protocol that residents' hair be dried and clean clothes were to be applied following all bathing care and that the home's protocol had not been complied with. (Inspector #214) [s. 8. (1) (a),s. 8. (1) (b)] (130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(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).

Order / Ordre :

The licensee shall ensure that any resident who is dependent on staff for repositioning, including residents #002, #003 and any other resident restrained by a physical restraint or PASD, is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

Grounds / Motifs :

1. The licensee failed to ensure that any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

A) On an identified date in 2015, Inspector #130 interviewed staff #006, #007 and #008 regarding the care of resident #002, specifically around the use of a safety device. Staff confirmed the resident was not repositioned from 0930 hours to 1330 hours and that repositioning activities were not documented for this resident because the safety device in place was considered a PASD and not a restraint. Staff verified the resident could not remove the device and that the resident was dependent on staff for repositioning. (Inspector #130)

B) Resident #003 was unable to reposition themselves and was not repositioned at least every two hours. The resident was observed on an identified date in 2015 at 1015 hours, sitting in their wheelchair. The resident was noted to be sleeping in the wheelchair and when approached it was observed that a safety device was applied. Staff #006 confirmed during an interview that this resident was not able to position themselves. Registered staff #004 and staff #009 confirmed that resident #003 would not be able to reposition themselves while sitting in the wheelchair or while in bed. Resident #003's clinical record also confirmed that the resident required two persons for constant supervision and mechanical lift for transfers and required two staff for positioning in bed. Staff #009 assigned to provide care to resident #003 on an identified date in 2015 confirmed that the resident was not repositioned every two hours during the day shift on the identified date and that there was no documentation in the plan of care to indicate that the resident was being repositioned. (Inspector #129) [s. 50. (2) (d)]
(130)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 26, 2016

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Order / Ordre :

The licensee shall ensure that residents who require assistance with eating or drinking, including residents #300, #301, #302, #303, #304, #305 and #306, are only served a meal when someone is available to provide the assistance immediately.

Grounds / Motifs :

1. 1. The licensee failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

A) On an identified date in 2015, lunch was observed in the Cardinal Court dining room and the following was observed:

Resident #300 was served soup at 1205 hours, but not offered assistance until 1237 hours.

Resident #301 was served there soup at 1210 hours but not offered assistance until their entree was served at 1230 hours.

Resident #302 was served soup at 1205 hours but not offered assistance until 1215 hours.

Resident #303 was served soup at 1210 hours but not offered encouragement or assistance. They were served their entree at 1230 hours but not offered

assistance with the meal until 1255 hours.

Resident #304 was served their soup at 1205 hours and staff immediately assisted with set up, by adding crushed crackers to the soup. Staff confirmed the resident required total feeding by one staff. The resident was assisted with feeding for five minutes then staff left the table to assist someone else. Staff returned to feed resident at 1215 hours then left again at 1225 hours. The resident had consumed approximately 50% of their meal when the plate was cleared and dessert was served at 1250 hours.

Resident #305 was served their dessert at 1245 hours, but did not receive assistance until 1255 hours.

Resident #306 was served their entree at 1220 hours and received assistance with the meal; however, staff left the table to assist someone else at 1225 hours, before the resident had finished. Staff returned to help the resident at 1230 hours.

Staff interviewed confirmed the identified residents required moderate to total assistance with eating. (Inspector #130)

B) On an identified date in 2015, lunch service was observed in the Cardinal Court secured area dining room. It was observed that beverages had been placed on the tables prior to the start of meal service and before all residents had been seated. Front line staff confirmed that beverages were placed on tables before someone was available to immediately assist residents. This non compliance was issued as a result of complaint inspection. (Inspector #130) [s. 73. (2) (b)] (130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 19, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : GILLIAN TRACEY

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