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
Feb 16, 2016	2015_377502_0022	032038-15	Resident Quality Inspection

Licensee/Titulaire de permis

MON SHEONG FOUNDATION
36 D'Arcy Street TORONTO ON M5T 1J7

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

MON SHEONG RICHMOND HILL LONG TERM CARE CENTRE
11199 YONGE STREET RICHMOND HILL ON L4S 1L2

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

JULIENNE NGONLOGA (502), JOANNE ZAHUR (589), STELLA NG (507)

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): November 19, 20, 23, 24, 25, 26, 27, 30, December 1 and 2, 2015.

During the Resident Quality Inspection (RQI), the following intakes were inspected concurrently: log #004791-15 and #023380-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Administrative Assistant (AA), Minimum Data Set – Resident Assessment Instrument (MDS- RAI) Coordinator, Director of Care (DORC), Assistant Director of Care (ADORC), Registered Nurses (RNs) Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Manager of Nutrition and Dietary Services (MNDS), Food Service Supervisor (FSS) Registered Dietitian (RD), Dietary Aides, Physiotherapist (PT), Social Worker, Support Service Supervisor, Housekeeping staff, residents, Substitute Decision Makers (SDMs) and family members of residents.

The inspectors also conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staff training records, staffing schedules and relevant policies and procedures.

The following intakes were conducted concurrently with the Resident Quality Inspection: log #004791-15, #023380-15.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

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

Review of resident #009's written plan of care with a specific date, revealed the resident required the incontinent product be checked every two hours and changed as needed for his/her frequent incontinence.

Interview with resident #009's Substitute Decision-Maker (SDM) revealed on occasions when the SDM requested the resident's incontinent product to be changed prior to taking the resident out of the facility; staff responded the incontinent product could hold two urinations, and the incontinent product would be changed after the second urination.

Interview with staff #123 revealed it was their practice not to change the incontinent product if it was less than 50 per cent soaked. The staff further revealed staff do not change incontinent products for residents when the incontinent product was wet because of stress incontinence. Interview with staff #139 revealed sometimes the incontinent product was not changed if there was only a small amount of wetness.

Interview with staff #115 revealed informing the family that the incontinent product could hold two urinations was not the appropriate approach. The staff further revealed staff should change the incontinent product for the resident, and provide the family an extra

incontinent product prior to the resident's leaving the facility. He/she confirmed it was the home's policy and expectation to change the incontinent product for the resident when it was wet, requested by the resident and prior to the resident leaving the facility. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the right of residents, to receive visitors of his or her choice and consult in private with any person without interference, is fully respected and promoted.

Review of the critical incident (CI) report with a specific date, revealed at an identified time, staff #142 observed residents #022 and #023 in the activation room. Five minutes later, the staff heard resident #023 shouting in an angry manner to resident #021. The two residents were separated and there was no injuries identified.

Review of resident's #023 progress notes revealed the following:
- On specific date and time, when resident #023 visited he/she found resident #022 in resident #021's room.

- On a specific date, resident #023 told staff #129 that he/she was very angry about the incident from an identified date and further stated that his/her would kill resident #021 who had inappropriate behaviour with resident #022.

- On specific a date and time, when resident #023 visited, he/she was heard shouting in an angry manner to resident #021. A visitor reported that resident #023 swung his/her fist in an attempt to strike resident #021 and did not make contact as resident #021 moved away from the swing. Later on the same date, resident #023 was escorted off of the unit when he/she came to visit resident #022. The ADORC was informed and advised staff on both units to restrict resident #023 from visiting resident #022 in the evening and on the following day.

- On a specific date and time, resident #023 told staff #129 that he/she could not resist to visit resident #022; he/she needed to check him/her on a regular basis. At an identified time on the same day, resident #023 met with the DORC, the ADORC and the Administrator who asked resident #023 not to visit resident #022 due to an identified condition. Resident #023 insisted he/she needed to check resident #022's security. The resident indicated that he/she would be extremely nervous if he/she was banned from visiting resident #022. The home agreed that resident #023 was allowed to visit resident #022 during meal times on identified date. This was seven days after the resident

expressed his/her need to visit with resident #022.

Interview with staff #142 revealed after the incident on a specific date, resident #023 was very angry. When the resident went to visit resident #022 and staff would not allow him/her to enter to the unit and redirect him/her to the identified unit. That restriction lasted for a week, until the DORC sent an email to the registered staff with specific times where the resident could visit resident #022.

Interview with staff #129 confirmed the above facts and stated resident #023 was going to his/her office daily for a period of one week, talked about the incident, and begging the staff to let him/her visit resident #022.

Interviews with staff #115, staff #129, and staff #136 confirmed that resident #023 was asked during the above mentioned meeting not to visit resident #022, because the resident was exhibiting specified behaviours in the few days following the specified incident.

Interview with staff #115 confirmed the home prevented resident #023 from visiting resident #022 for about a week.

Records review and staff interviews did not identify any alternative arrangement from during the above identified period of time, to allow residents #022 and #023 to spend time together. [s. 3. (1) 14.]

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 resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted, and
- the right of residents, to receive visitors of his or her choice and consult in private with any person without interference, is fully respected and promoted, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (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 has failed to 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 the resident's care needs change or care set out is no longer necessary.

On specific dates, the inspector observed resident #004 with an altered skin integrity.

Review of resident #004's health records revealed a skin assessment was completed on an identified date, and specific altered skin integrity was identified. The skin assessment identified specified medical conditions affecting the resident's skin integrity.

Review of resident #004's written plan of care with an identified completion date, revealed there was not a focus related to the above identified diagnosis and the use of daily identified medication.

Interview with staff #132 revealed since an identified dated in 2011, resident #004 had been on a specific drug regimen for an identified medical condition. Interview with staff #115 confirmed resident #004's had not been reassessed and his/her plan of care revised to indicate the use of the above identified medication. [s. 6. (10) (b)]

2. Review of resident #010's progress notes revealed on an identified date, the resident exhibited an specified altered skin integrity.

On a specific date, the Physician assessed the above mentioned altered skin integrity and prescribed a drug regimen for seven days.

Review of the resident's written plan of care with a specified completion date, revealed the plan of care was not revised to include a focus related to the specified altered skin integrity.

Record review of the minimum data set - resident assessment instrument (MDS-RAI) with a specific date, revealed under skin conditions that resident #010 had an identified altered skin integrity that required the application of ointments or medications.

On a specific date, observations by the inspector revealed resident #010 had an identified altered skin integrity.

Interview with staff #119 revealed the written plan of care was not revised to indicate a focus related to the resident altered skin integrity.

Interview with staff #115 confirmed the written plan of care was not revised to include a focus related to the resident altered skin integrity. [s. 6. (10) (b)]

3. Review of resident #008's RAI-MDS annual assessment with a specific date, revealed the resident was continent of bowel and frequently incontinent of bladder.

Review of resident #008's written plan of care with a specific date, revealed the resident was receiving restorative care and had a specified toileting schedule. For an identified period of time, resident #008 was using disposable specified continence products.

Interviews with staff #145 and staff #147 confirmed resident #008 was frequently incontinent of bladder and used the toilet frequently to stay dry. Interviews with staff #147 and the staff #115 confirmed resident #008's plan of care was not revised to include the resident's need to use the toilet frequently. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is 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 change or care set out is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Skin and Wound Management Program has a policy that is in compliance with and is implemented in accordance with all applicable requirements under the Act. Regulation section 50(2)(b)(iii) states a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian (RD) who is a member of the staff of the home, and any changes made to the residents plan of care relating to nutrition and hydration are implemented.

The home's "Skin and Wound Care Program" policy, reference #RC-4.10, dated July 2015, describes stage I skin impairment as, "skin that is intact with a reddened area that does not resolve in minutes, referred to as non-blanching erythema" and indicates to consult with skin/wound care committee, dietitian and PT/OT as needed. The above mentioned policy reveals stage II pressure ulcers are to be referred to the registered

dietitian (RD) for nutritional assessment. This policy was not in accordance with the above mentioned regulation that states the RD was to make an assessment of any resident with "altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds" and does not refer to any specific staging of skin breakdown.

Interview with staff #148 confirmed the above mentioned policy was not in accordance with all applicable requirements under the Act. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Long Term Care Homes Act section 24(1)2 states a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur must immediately report the suspicion and the information upon which it is based to the Director.

The home's "Mandatory & Critical Incident Report" policy, RC-5.6.2, revised July 2015, indicated the following procedure for reporting to the Ministry of issues that have a major impact on resident safety:
i) For mandatory incident reporting, the RN on-duty is to notify the Administrator or designate immediately.
ii) DORC or designate must file a critical incident report to the Ministry via internet access (www.ltchomes.net) as per Regulation; and/ or report certain matters to the Ministry either via Critical Incident System immediately or calling after hours number at 1-800-268 -6060 when there is reasonable grounds to suspect there has occurred or may occur as listed on the LTCHA section 24(1) and section 23.
iii) DORC or designate must also refer to the decision tree of various resident abuse situations under the LTCHA section 24(1) to determine the necessity of filing a critical incident report to the Ministry.

The above mentioned policy failed to reveal when a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur must immediately report the suspicion and the information upon which it is based to the Ministry.

Interview with staff #136 revealed visitors and volunteers are encouraged to report any abuse or neglect of residents to the Ministry directly. However, staff were asked to follow the home's policy by reporting to their supervisor of any abuse of neglect of residents, and the DORC or designate would report to the Ministry for streamlining purpose. [s. 8. (1) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any abuse of a resident by the licensee or staff that resulted in harm or a

risk of harm to the resident has occurred or may occur must immediately report the suspicion and the information upon which it is based to the Director.

Review of resident #012's progress notes and interview with the resident's SDM revealed the resident and his/her SDM made a complaint to the home on a specific date, that resident #012 was hit by two staff while care was being provided.

Interview with staff #126 revealed on a specific date, resident #012 and his/her SDM complained resident #012 was hit by two night staff and caused altered skin integrity on specified body area while care was being provided. Staff #126 also revealed he/she informed the resident and his/her SDM that according to the shift report and progress notes, resident #012 resisted care and had and altered skin integrity was noted. Staff #126 further revealed he/she observed altered skin integrity when the resident and SDM made the above mentioned complaint. Staff #126 confirmed he/she did not report the alleged abuse to the Ministry as required under the Act.

Interview with staff #129 revealed he/she received a verbal referral from unidentified registered staff on a specific date that resident #012 and his/her SDM complained the resident was hit by staff while care was being provided, and a care conference with the resident, resident's family members and the ADORC was arranged on identified date. Staff #129 confirmed he/she did not report the alleged abuse to the Ministry as required under the Act.

Review of the Critical Incident Report (CIR) revealed the above mentioned incident had been reported to the Director on an identified date. Interview with Administrator #136 revealed he/she became aware of the alleged abuse on an identified date, and confirmed the incident was not reported to the Director until 18 days after the resident and his/her SDM made a complaint to the home. [s. 24. (1)]

2. Review of resident #022's progress notes revealed on a specific date and time, when resident #023 visited he/she found resident #022 in resident #021's room.

Review of the CI report revealed the above mentioned incident was reported to the Director two days after the incident occurred.

Review of resident #023's progress notes revealed on a specific date and time, when resident #023 visited resident #022, he/she was heard shouting in an angry manner to resident #021. A visitor reported that resident #023 swung his/her fist in an attempt to

strike resident #021 and did not make contact as resident #021 moved away from the swing.

Review of the CI report, revealed the above mentioned incident was reported to the Director on identified date.

Interview with staff #136 confirmed the above mentioned incidents were not reported to the Director until two and seven days respectively after the incidents happened. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a person who has reasonable grounds to suspect that any abuse of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur must immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the 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, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Record review of resident #010's progress notes revealed on a specific date, the resident exhibited an identified altered skin integrity. On a specific date, the Physician assessed the above mentioned altered skin integrity and prescribed an identified medication to be applied three times a day for seven days.

Review of the most recent plan of care revealed a skin assessment was not completed using the home's clinically appropriate assessment instrument specifically designed for skin and wound.

Interview with staff #133 revealed a skin assessment was not completed on the altered skin integrity identified on the above identified date.

Interview with staff #115 confirmed a skin assessment was not completed using the home's clinically appropriate assessment instrument specifically designed for skin and wound. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff in the home.

Review of the most recent plan of care revealed on a specific date, an identified altered skin integrity was noted on resident #004.

Record review of resident #004's progress notes revealed a RD referral was not completed for the assessment of altered skin integrity.

Interviews with staff #132 and staff #111 confirmed a referral to the RD was not completed. [s. 50. (2) (b) (iii)]

3. Review of resident #005's progress notes revealed on a specific date, resident #005 sustained an identified alteration on skin integrity in a falls incident.

Record review of progress notes for resident #005 revealed a RD referral was not completed for the assessment of altered skin integrity.

Interviews with staff #119 and staff #111 revealed a referral to the RD was not completed for the assessment of altered skin integrity.

Interview with staff #115 confirmed a RD referral was not completed. [s. 50. (2) (b) (iii)]

4. Review of resident #010's progress notes revealed on an identified date, the resident exhibited altered skin integrity.

On specific date, the physician assessed the above mentioned altered skin integrity and prescribed an identified medication for seven days.

Record review of progress notes for resident #010 revealed a RD referral was not completed for the assessment of altered skin integrity.

Interviews with staff #119, staff #131, and staff #114 confirmed a referral to the RD was not completed.
[s. 50. (2) (b) (iii)]

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 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, using a clinically appropriate assessment instrument that is specifically desgned for skin and wound assessment, and
- the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian, 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. (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 has failed to ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible.

Review of the critical incident report with a specified date, revealed on an identified date and time, when resident #023 visited, he/she found resident #022 in resident #021's room.

Review of resident #022's progress notes for an identified period of time, revealed the following incident occurred:
- On an identified date, resident #022 exhibit an identified inappropriate behaviour toward resident #026. This behaviour lasted for about a month until resident #026 was transferred to another unit.

Review of the home's record summary with an identified date, for resident #022 revealed on multiple occasions for an identified period of time, resident #022 had been assessed for an identified responsive behaviours. There was no assessment identified related to the specified behaviour.

Review of resident #022's written plan of care with a specific date, and MDS-RAI annual assessment with a specific date, revealed resident #022's plan of care did not identify a focus related to the specified behaviour.

Interviews with staff #120,staff #121, staff #142, staff #146, staff #107 and staff #129 confirmed the above incident and revealed resident #022 had a history of a specified inappropriate behaviour.
Interview with staff #121 indicated before the above incident, resident #022 was exhibiting his/her behaviour toward resident #021 frequently. Interview with staff #142 confirmed the plan of care did not address the specified behaviour.

Interview with staff #115 and staff #136 indicated residents #021 and #022 were cognitively impaired and were not able to recall any incident that occurred and confirmed that strategies have not been developed and implemented to address the specified behaviour. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

On a specific date, the inspector observed, in a shared bathroom on identified floor, an unlabeled urinal stored on top of the toilet tank and an unlabeled white specimen collection hat stored on the floor near the toilet.

Interview with staff #107 revealed all personal items, belonging to residents that share a bathroom, were to be labelled. Once used, the white specimen collection hat was to be cleaned and stored in the soiled utility room.

Interview with staff #115 confirmed all resident personal items stored in shared resident bathrooms are to be labeled. [s. 229. (4)]

2. On a specific date, the inspector observed staff #105 providing care to resident, then the staff left the resident's room without performing hand hygiene.

Interview with staff #105 confirmed he/she did not wash his/her hands after assisting the resident and went back to the resident washroom to wash his/her hands.

Interview with staff #115 confirmed staff should carry the portable hand sanitizer when going to provide care and perform hand hygiene after providing care. [s. 229. (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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

On specific dates, the inspector observed identified share rooms called "couple rooms" with one portable privacy curtain in each room occupied by two residents. Further observation revealed the residents residing in the above rooms were not related.

Interviews with staff #143 and staff #144 indicated before providing care to one of the residents, staff are required to move the portable curtain close to the resident's bed, leaving the other resident without a privacy curtain.

Interview with staff #115 confirmed the home provided only one portable privacy curtain per shared room, because these rooms are to be occupied by a couple. [s. 13.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On a specific date, the inspector observed the ceiling of the walk in refrigerator covered with black dust and its walls stained with dried food debris and mold.

Review of the cleaning schedules for an identified month, revealed the walk in refrigerator #2 was signed off as being cleaned on an identified date.

Interview with the FSM, confirmed the walk in refrigerator #2 was cleaned on the above identified date, but staff did not clean the ceiling and the walls. [s. 15. (2) (a)]

2. On November 24, the inspector observed a portable privacy curtain soiled and stained with dried yellow and brown fluid.

Interviews with staff #143 and staff #144 confirmed the portable privacy curtain was not cleaned and indicated the cleaning of the portable privacy curtain was a housekeeping responsibility.

Interview with staff #134 confirmed after observation that the portable privacy curtain was soiled and indicated it was the nursing responsibility.

Interview with staff #115 indicated nursing staff should remove the portable privacy curtain and send it to the laundry for cleaning, and confirmed both department should ensure the portable privacy curtain was kept clean and sanitary. [s. 15. (2) (a)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated.

Review of the progress notes of resident #012 and interview with the resident's SDM revealed the resident and his/her SDM made a complaint to the home on a specific date, that resident #012 was hit by two staff while care was being provided.

Interview with staff #126 revealed on an identified date, resident #012 and his/her SDM complained that the resident was hit by two night staff and caused altered skin integrity while care was being provided. Staff #126 also revealed he/she informed the resident and the SDM that according to the shift report and progress notes, resident #012 resisted care the previous night and an identified an alteration on skin integrity was noted. Staff #126 further revealed he/she observed an alteration on resident's #012's skin integrity when the resident and his/her SDM made the above mentioned complaint. staff #126 confirmed he/she did not conduct immediate investigation as required under the Act.

Interview with staff #129 revealed he/she received a verbal referral from a registered staff on identified date, related to the above mentioned complaint, and a care conference with the resident, resident's family members and the ADORC was arranged on identified date. Staff #129 confirmed an investigation was not conducted when he/she became aware of the above mentioned incident.

Review of the progress note of resident #012 and interview with SW #129 revealed during the above mentioned care conference, the ADORC stated he/she would investigate the incident and a meeting would be arranged with the resident when the investigation was completed.

Interview with staff #136 revealed he/she became aware of the alleged abuse on an identified date, and confirmed that an immediate investigation was not completed when it was brought to the attention of the home as required under the Act. [s. 23. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that were the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of resident #006's written plan of care with a specific date, revealed the resident was at risk for falls. Review of the resident's Fall Risk Assessment with a specific date, revealed the resident was considered moderate risk of fall.

Review of resident #006's progress notes revealed the resident had a fall on an identified date. Review of the post fall assessments and interview with staff #101 revealed a post-fall assessment was not completed after the fall occurred on the above identified date.

Review of the home's "Fall Prevention and Management Program" policy, RC-4.7, revised July 2015, revealed a Fall Risk Assessment at Point Click Care (PCC) Program Assessment and modification of the plan of care in collaboration with the interdisciplinary team are required after each fall.

Interview with staff #115 confirmed it is the home's expectation to complete the Fall Risk Assessment when a resident has fallen, and a Fall Risk Assessment should have been completed after resident #006 experienced a fall on the above identified date. [s. 49. (2)]

WN #12: 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,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are provided with a range of continence care products that promote continued independence wherever possible.

Review of the MDS-RAI annual assessment with a specific date, revealed resident #008 was continent of bowel and frequently incontinent of bladder.

Review of resident #008's plan of care revealed on an identified period of time the resident was using disposable specified continence products. The resident was able to wash his/her hands, adjust clothing, clean him/herself, transfer on and off to toilet.

Observation of the home storage room revealed two boxes of specified continence products with resident #008 and #024's name respectively.

Interviews with staff #116 and staff #147 confirmed the above fact and also confirmed the resident's family bought the specified continence products used by the residents. Staff #116 further stated the home does not provide the specified continence products, because of the higher cost.

Interviews with staff #115 and staff #136 revealed it had not been part of the home's practice to offer residents pull-ups due to the cost. Interview with the Administrator confirmed the home did not provide pull-ups. [s. 51. (2) (h) (iv)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that sufficient time is provided for residents to eat at their own pace.

On specific date and time, on an identified floor the inspector observed staff #106 serving desert to resident #025 while he/she was eating the main course, half of the resident's meal was on the resident's plate. staff #106 attempted to remove the plate but resident #025 held onto his/her plate telling the staff to leave his/her plate.

Review of the diet list with a specific date, did not provide any special request from resident #025 related to meal service.

Interview with staff #106 indicated he/she tried to remove the resident's plate because he/she thought the resident did not want to eat anymore. Interview with staff #145 present in the dining room indicated staff #106 should have asked resident #025 prior to attempting to remove his/her plate and confirmed that resident #025 did not eat at his/her meal.

Interview with staff #145 indicated the home policy directs staff to serve dessert when the residents are almost finished with their main course and staff are not to remove plates until residents leave the table, he/she confirmed staff should not rush residents. [s. 73. (1) 7.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused, or neglected.

Review of the home's "Abuse Policy", RC-2.2, revised July 2015, failed to reveal procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused, or neglected.

Interview with staff #136 confirmed the above mentioned components were not included in the home's "Abuse Policy" that promotes zero tolerance of abuse and neglects of residents. [s. 96. (a)]

2. The licensee has failed to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, identifies measures and strategies to prevent abuse and neglect.

Review of the home's "Abuse Policy" RC-2.2, revised July 2015, and failed to reveal measures and strategies to prevent abuse and neglect.

Interview with staff #136 confirmed the above mentioned components were not included in the home's "Abuse Policy" that promotes zero tolerance of abuse and neglects of residents. [s. 96. (c)]

Issued on this 25th day of February, 2016

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

Original report signed by the inspector.