Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 20, 2015	2015_247508_0010	H-002398-15	Resident Quality Inspection

Licensee/Titulaire de permis

NIAGARA HEALTH SYSTEM
63 THIRD STREET WELLAND HOSPITAL SITE WELLAND ON L3B 4W6

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

NIAGARA HEALTH SYSTEM, WELLAND HOSPITAL SITE, EXTENDED CARE UNIT
155 Ontario Street St. Catharines ON L2R 5K3

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

ROSEANNE WESTERN (508), BERNADETTE SUSNIK (120), CATHY FEDIASH (214), KELLY HAYES (583)

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): May 25, 26, 27, 28, 29, June 2, 3, 4, 5, 8, 9, 10, 11.

This inspection was conducted simultaneously with Critical Incident #H-001510-14, H-001824-14, H-002303-15, Complaint #H-001400-14, H-001698-14 and follow up #H-000766-14, H-000765-14, H-00764-14, H-000760-14, H-000767-14, H-000762-14, H-000761-14, H-002122-15, H-002123-15, H-002187-15 and H-002188-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Programs Manager, Food Services Supervisor (FSS), Registered Dietitian (RD), Housekeeping Supervisor, Physiotherapist (PT), registered staff, Personal Support Workers (PSW), family members and residents. The inspectors toured the home, observed provision of care, observed residents and resident's bed systems, observed meal service in dining rooms, reviewed clinical records, staffing schedules, maintenance logs and bed safety records, complaint log, Resident Council minutes, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
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
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.
- **20 WN(s)**
- **10 VPC(s)**
- **6 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 68. (2)	CO #006	2014_191107_0009	583
O.Reg 79/10 s. 73. (1)	CO #007	2014_191107_0009	583
O.Reg 79/10 s. 8. (1)	CO #002	2014_191107_0009	508
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #004	2014_191107_0009	508

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A) Resident #110 was a high risk for falls and had multiple falls in the first quarter of 2015. The resident's plan of care had indicated that the resident was to have one full bed rail up while the resident was in bed. In May, 2015, two full bed rails were implemented to minimize the resident's risk of falls.

A review of the resident's current plan of care that staff refer to for direction in providing care to residents had two different directions. Under the restraint focus the care plan indicated that two full bed rails were to be up while the resident was in bed. Under the falls focus, the resident's plan of care still directed staff to use only one full bed rail up while the resident was in bed.

It was confirmed by the DOC on June 9, 2015, that the plan of care did not set out clear directions to staff and others who provided direct care to the resident.

B) A review of resident #112's current plan of care, indicated that they required one person constant supervision and extensive physical assistance for safety to transfer on and off the toilet and complete all parts of the task. In the same plan of care under the focus for urinary incontinence, it indicated that the resident is not a candidate for routine toileting/toileting program. They do not want to be toileted for urine and do not know when they need to void and are unaware when voiding. An interview with front line nursing staff indicated that the resident is transferred on and off the toilet for voiding with the assistance of two staff.

An interview with the DOC confirmed that the written plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A) A review of resident #101's written plan of care, indicated under the falls focus to ensure front fastening seat belt is in place when in wheelchair and that the resident is able to undo the seat belt and needs reminder not to try and stand. A review of the "Welland Restraint Initial/Reassessment Tool completed at the end of 2014, confirmed by the DOC to be the most current restraint assessment indicated that the resident's front

closing seat belt was a restraint. On June 3, 2015, the resident was asked if they could undo their seat belt and over the course of approximately 5 minutes, they were unable to undo their seat belt.

The DOC confirmed that the care set out in the plan of care was not based on an assessment of the resident's needs.

B) A review of resident #112's Minimum Data Set (MDS) coding for March, 2015, indicated under section G. Physical Functioning and Structural Problems that the resident required extensive assistance of two or more staff for the purpose of toilet use. A review of the resident's written plan of care, indicated under the focus for toileting that one person constant supervision and extensive physical assistance was required for safety to transfer the resident on and off the toilet and complete all parts of the task.

An interview with the DOC confirmed that the plan of care was not based on an assessment of the resident's needs. [s. 6. (2)]

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

A review of resident #113's Resident Assessment Protocol (RAP) for urinary incontinence for April 2015, indicated that the resident's appliance was removed in early 2015 and that the resident was incontinent of bladder. A review of the home's bladder assessment, titled, "Welland Bladder/Bowel Continence Assessment/Reassessment" that was completed later that year, indicated that the resident was currently using an appliance. A review of the physician's order's indicated that this appliance was discontinued in early 2015. An interview with the DOC confirmed that the resident no longer used this appliance and that staff had not collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other. (214) [s. 6. (4) (a)]

4. The licensee has failed to ensure that the Substitute Decision Maker (SDM) of the resident had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A) Resident #110 had been identified as a high risk for falls and a restraint for two full

bed rails was ordered by the Physician and implemented in May, 2015. A review of the resident's clinical record indicated that this intervention had not been discussed with the resident's SDM and consent for the use of this restraint had not been obtained.

It was confirmed during an interview with the DOC that the SDM of the resident had not been provided the opportunity to participate in the development and the implementation of the plan of care.

B) Resident #110 was cognitively impaired and had appointed a family member as their SDM to make decisions regarding their care. During stage one interviews of this Resident Quality Inspection (RQI), the family member had indicated that in 2013, she came into the home to visit resident #110 and discovered that the resident had been moved to another room.

A review of the resident's clinical record indicated that the resident was upset and had increased confusion after being relocated to a different room. The family member had inquired why the resident was moved without their knowledge and was informed by staff that a male resident was admitted next to resident #110 and these rooms shared a bathroom therefore, resident #110 was moved to a different room.

It was confirmed by the Administrator that resident #110 was moved to a different room without giving the SDM the opportunity to participate in the development and the implementation of the resident's plan of care. [s. 6. (5)]

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

A) A review of resident #109's clinical record indicated that they were currently using a tabletop that was affixed to their wheelchair and was being used as a personal assistance services device (PASD) that also limited or inhibited their movement. According to the current written plan of care under mobility, staff were to check the PASD with restraining properties every hour and to remove the PASD with restraining properties every two hours.

An interview with the DOC confirmed that these actions had not been done and that the care set out in the plan of care was not provided to this resident as specified in their plan.

B) A review of the plan of care for resident #105 identified they were a falls risk, had a

history of falls and had known behaviors of doing activities of daily living without required staff assistance. Resident #105's continence care plan identified staff were to offer assistance with toileting before and after meals. Resident #105 was on a restorative walking program and the resident would be offered to be walked with a walker to and from the dining room three times per day with staff assistance. During an observation of resident #105 in June, 2015, a PSW walked by the resident's room and asked the resident if they were going to get them self down to the dining at which time the resident responded yes. After additional observations in the hall, Inspector #583 entered resident #105's room and found the resident sitting on the toilet unattended.

Staff were immediately notified and it was confirmed with the resident and registered nursing staff that resident #105 was not offered assistance with toileting prior to lunch service and was not offered to be walked to dining room as specified in the plan of care.

C) Resident #110's plan of care directed staff to apply a restraint which consisted of two full bed rails when the resident was in bed as ordered, check hourly and ensure the restraint was secured.

It was observed by the inspector on June 4 and June 8, 2015, that the resident was in bed after lunch with only one full bed rail up. During an interview with PSW staff on June 8, 2015, staff indicated that the resident should have two full bed rails up while in bed.

A review of the resident's clinical record indicated that staff were also not checking the resident hourly for safety to ensure that the restraint was secured as directed in the plan of care.

It was confirmed by the DOC that the resident should have two full bed rails while in bed and that staff should have been checking the restraint hourly as specified in the plan of care.

6. 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 change or care set out in the plan was no longer necessary.

A) A review of resident #100's quarterly Minimum Data Set (MDS) coding for section I. Disease Diagnoses in January 2015, indicated that the resident was coded as having an infection. A review of the resident's clinical record confirmed that the resident was

exhibiting symptoms of an infection and was prescribed an antibiotic to be taken daily for seven days. A review of the resident's written plan of care indicated that there was no plan to address the resident's infection including any goals or interventions to manage and treat the infection. An interview with the DOC and registered staff confirmed that the resident's plan of care was not reviewed and revised when the resident's care needs changed.

B) Resident #107 had a change in condition in early 2015, and had symptoms of an infection. The resident required medication and other treatments to alleviate these symptoms which were effective. A month later, the resident had another episode of respiratory distress and required treatment. Later that year, the resident continued to decline and treatments that had been implemented for the resident's symptoms were ineffective. The resident was transferred to hospital for further assessment and returned to the home with additional interventions to alleviate these symptoms, however; was deemed palliative. A review of the resident's plan of care indicated that during this time when the resident's condition changed and interventions had been implemented, the plan of care had not been reviewed and revised.

It was confirmed by the registered staff on June 2, 2015, that the resident's plan of care was not reviewed and revised when the resident's care needs changed in March, 2015.

C) A review of resident #406's plan of care identified they had a fall in 2014, and were transferred to hospital, diagnosed with a fracture and returned from hospital six days later. Upon return from hospital resident #406 was identified to have had a significant change and required an increase in Activities of Daily Living (ADL) support provided by staff. During review of the bed mobility, toileting, transferring and mobility interventions it was identified that the care plan interventions were revised six days after being transferred back to the home. The interventions for the resident's mobility, transferring and toileting had changed due to their fracture. During a staff interview with the RPN and Physiotherapist, it was confirmed that the care plan was not revised when the resident's care needs changed.

D) A review of resident #406's quarterly review assessments completed in April, 2015, physiotherapy assessments completed between January to June, 2015, and care plan interventions in place in June, 2015, were completed. Through a review of residents #406's plan of care and during interviews with the RPN, PSW and Physiotherapist it was confirmed that the resident had a change in condition and that the plan of care for toileting, transferring and mobility had not been revised when the resident's condition had

changed.

E) A review of the continence plan of care for resident #105 identified a goal that the resident would not have injury secondary to manipulation of their appliance or removal and an intervention directed staff to check patency of appliance and urinary output every shift. In an interview with the resident and an interview with registered nursing staff on June 9, 2015 it was confirmed resident #105 did not have an appliance in place and that the care plan had not been revised.

F) A review of the plan of care was completed for resident #105. A Physiotherapy assessment completed in June, 2015 identified resident #105 could be a one person assist transfer to and from bed to wheelchair and for toileting, with adequate cues and safety precautions. The transfer care plan was reviewed after the Physiotherapist conducted the assessment and still directed staff to provide two person total assistance with sit to stand lift for transfers in and out of bed and two person transfer with grab bar for toileting onto the commode. In an interview with registered nursing staff on June 8, 2015 it was confirmed that resident #105's care plan was not updated after new direction was provide by the Physiotherapist.

G) A review of resident #113's current written plan of care indicated under the urinary incontinence focus, that the resident was incontinent of urine/catheter characterized by the inability to control urination. The written plan of care under risk for fluid output exceeding intake indicated under the interventions that the resident had an indwelling catheter for accurate measurement of urinary output. A review of the physician's orders for this resident indicated that their catheter was discontinued.

An interview with the DOC confirmed that the plan of care was not reviewed and revised when care set out in the plan was no longer necessary. (214) [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance , to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not assess all residents who used bed rails in accordance with prevailing practices to minimize risk to the resident.

Prevailing practices for bed rail assessments includes but is not limited to a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Drug and Food Administration.

During a previous inspection conducted on January 21, 2015, an order was issued for failure to complete resident assessments with respect to bed rail use in accordance with the above noted prevailing practices. During this inspection, seven residents were selected to determine if they were assessed for bed rail use after observing them sleeping in bed on June 4, 2015 with at least one bed rail elevated. An assessment questionnaire titled "Welland Bed Rail Utilization Assessment" and each resident's plan of care were reviewed on the licensee's electronic record keeping database.

A) The Bed Rail Utilization Assessment form used by registered staff in the home did not change since the inspection in January 2015. The licensee was required to amend the form according to the guidance document noted above to include additional questions to guide the assessors towards a conclusion that is comprehensive, consistent and offers the safest solution for the resident while in bed. The questions were developed for a "yes" or "no" response with little guidance towards various options. The guidance

document identifies questions related to sleep patterns and alternatives trialled before choosing a bed rail for any particular reason. It also includes the need for an interdisciplinary team to review the residents sleep and mobility patterns which would be reviewed over several nights, how many rails were needed and on which side of the bed, the size of the rail and why. These types of conclusions were not included in 5 out of the 7 assessment records for residents. In addition, none of the assessments included whether a resident's bed was a risk for entrapment and the necessary interventions necessary to mitigate those risks. Six of the identified residents were on therapeutic air mattresses which are a high risk for entrapment without any bed accessories (gap fillers, bolsters, rail pads etc.)

B) Numerous beds throughout the home where observed to have at least one bed rail elevated on unoccupied b. The plan of care for the residents occupying these rooms required that one or more bed rails be applied when the resident is in bed for "safety or for "turning or repositioning". No direction was given to leave rails elevated during the day when the bed was not occupied. Application of bed rails when not planned for may increase the risk of resident injury. This issue was previously identified during the inspection in January 21, 2015.

C) Confirmation was made with the Director of Care that staff did not receive any formal education or training with respect to bed rail use hazards or how to complete appropriate assessments. The requirement for staff education was included in the previous order. [s. 15. (1) (a)]

2. The licensee did not ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The licensee commissioned a company to complete an entrapment assessment of all resident bed systems on September 4, 2014. The results of the audit however could not be used to establish conclusive results as to whether the beds were measured accurately or fully in accordance with Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008. In addition, since September 2014, the beds in the home had been relocated, different beds introduced that were not on the original assessment and mattresses swapped around. The home did not have their own measurement tool and did not complete any re-tests or measurements when changes were made since September 4, 2014. No updates on the status of the beds could be provided during the inspection on June 4, 2015. The Administrator reported that a different evaluator or consultant was retained to return to

the home to complete another audit of the beds for entrapment in June 2015.

The entrapment assessment results from September 4, 2014 identified that 12 beds with a therapeutic air mattress were tested and documented as having passed zones 2-4 (areas between the mattress and bed rail). However, according to Health Canada Guidelines, therapeutic air mattresses cannot be evaluated for zones 2-4 due to their design of being compressible and very flexible. The evaluator concluded that "there was no way to accurately test these gaps as they will change with each cycle, however we test them to simply ensure the mattress, rail and bed frame work together". Unfortunately, the licensee was therefore not appropriately guided to ensure that risks associated with therapeutic surfaces were managed and mitigated. Discussions were held during a follow-up visit on January 21, 2015 that all therapeutic air mattresses were high risk for entrapment and required some type of accessory to mitigate zone 2 and 3 risks. An order was served on the licensee on February 2, 2015 requiring that risks to residents sleeping on therapeutic mattresses be mitigated. During the follow up inspection on June 4, 2015, residents were observed to be lying on therapeutic air mattresses with both full or 3/4 rails elevated in rooms 11, 28, 18, 19, 120. None of the residents had an accessory located between the air mattress and their bed side rails to mitigate zone 2 or 3 risks.

The entrapment assessment results from September 4, 2014 identified that 11 resident beds with a foam mattress failed zone 2 (under the rail and the side of the mattress) and/or zone 3 (between the bed rail and the side of the mattress). During an inspection on January 21, 2015, a review of these beds was conducted to determine if risk mitigating strategies were in place. For the failed beds with a foam mattress and where bed rails were used by the resident, the licensee responded by inserting a bed rail pad on 7 of the beds and had documented their actions on a form titled "Bed Safety and Entrapment Action Sheet - ECU and ILTC" dated October 14, 2014. However, when these 7 beds were reviewed for verification by the employee who completed the form and had inserted the pads, none of the 7 resident beds had any bed rail pads on the rails. The employee confirmed that since October 14, 2014, no monitoring to ensure that the beds remained safe was implemented. During the follow up inspection on June 4, 2015, the entrapment status of the beds could not be verified by the licensee. Concerns that some of the beds remained unsafe were made based on observations of the physical characteristics of the beds during the inspection (i.e. room 11). Based on Health Canada guidelines, beds without mattress keepers (to keep the mattress from moving around), a soft mattress and an elevated bed rail would not typically pass entrapment zones 2-4. The bed in room 11 did not have mattress keepers, had an elevated full bed rail, and

when the mattress was compressed by hand, a large gap emerged beneath the bottom of the bed rail and top of the mattress (zone 2). [s. 15. (1) (b)]

Additional Required Actions:

CO # - 002, 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds were reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

A) Resident #200 had altered skin integrity. A review of the resident's clinical record indicated that the resident's wound was being reassessed but not weekly by registered nursing staff. The resident's wound was reassessed on two dates in September, two dates in October, and only once in December, 2014. In January the resident's wound was reassessed five times, however; there were gaps of nine to ten days in between these assessments.

The resident's wound was not reassessed at all in the month of November, 2014. The Director of Care confirmed during an interview on June 3, 2015, that the resident's wound was not reassessed weekly by a member of the registered staff.

B) Resident #116 was admitted to the home in 2014. A skin assessment had been conducted upon admission which indicated that the resident's skin was clear. Ten days later the staff reassessed the resident's skin and indicated that the resident had a reddened area. The resident was not reassessed again until over a month later, which had identified an open.
The following month, the resident's wound was reassessed and registered staff indicated that the wound had deteriorated further. The resident's wound was not reassessed again until 12 days later.

C) Resident #103 was admitted to the home in 2014, with a wound. A review of the resident's clinical record indicated that the resident's wound was not reassessed by registered staff until two months later.

It was confirmed by the Director of Care that these residents had not been reassessed at least weekly by a member of the registered staff, when clinically indicated. [s. 50. (2) (b) (iv)]

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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee did not ensure that schedules and procedures were in place for routine, preventive and remedial maintenance.

During a previous inspection of the home conducted on January 20 and 21, 2015, observations were made regarding the poor condition of the flooring material, fixtures, furnishings, walls and beds. At that time, the Administrator and Facility Services Supervisor were aware of the issues, but were not able to provide a schedule for the remedial work to correct the issues. A review of the home's policies and procedures revealed that no procedures were in place for the preventive maintenance checks of floors, walls, doors, windows, fixtures, beds, furnishings, lights, ceilings, toilets, sinks, grab bars and other common surfaces/items of the home. As a result, an Order was issued on February 2, 2015 requiring that the licensee develop procedures and schedules to address the disrepair. During this inspection completed on June 4, 2015, the Administrator was able to provide a completed audit of the status or condition of the various interior surfaces and furnishings and a plan to address their findings. However, no procedures had been developed. [s. 90. (1) (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 O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

A) On June 4, 2015, at 1240 hours, a medication cart was observed in the Extendicare Unit (ECU) west hallway outside of room #21 to be unattended and the medication cart drawers unlocked. The door to this resident's room was observed to be closed. A resident, who was sitting approximately 3 feet away, informed the Inspector that the nurse was inside of room #21. An interview was conducted with the nurse upon exiting from room #21 who confirmed that the medication cart was not locked and was left unattended and that the expectation is that the medication cart is to be locked when left unattended. The DOC was informed immediately and confirmed that this was an unacceptable practice and took action of posting a memo to ensure that the medication cart is kept locked when not in attendance.

B) On June 10, 2015, at 1410 hours, a medication cart was observed to be parked in the hallway outside of the ECU nurses station. The medication cart was observed to be unlocked and unattended. Several residents were sitting approximately 4 feet away from this medication cart and two visitors were observed to have walked down the hallway past this medication cart. The DOC was informed immediately and confirmed that the medication cart was unlocked and unattended and proceeded to lock the medication cart. The DOC confirmed that this was an unacceptable practice. (214) [s. 129. (1) (a)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents had the right to live in a safe and clean environment.

Resident #110 was incontinent of urine and also required the use of a wheelchair. Resident #110 was observed by the Inspector in bed on June 5, 2015. An odour that resembled the smell of urine was identified coming from the cushion of the resident's wheelchair.

On June 9, 2015, it was observed by the Inspector in the presence of the DOC and the Program Manager that the resident's wheelchair cushion had a strong odour that resembled urine. A review of the cleaning schedule for the resident's wheelchair and cushion indicated that the resident's wheelchair and cushion were to be cleaned once a month.

The DOC indicated during an interview on June 9, 2015, that residents identified as incontinent and require more frequent cleaning of their personal equipment should have their personal equipment cleaned more frequently or as required.

It was confirmed by the DOC and the Program Manager on June 9, 2015, that resident #110's right to live in a clean environment was not fully respected and promoted. [s. 3. (1) 5.]

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 rights of residents are fully respected and promoted, to be implemented voluntarily.

WN #7: 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:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene.

A family interview conducted for resident #101 indicated that the family was unsure if the resident received oral care. A review of the resident's current written plan of care, indicated under care deficit pertaining to the teeth or oral cavity that the resident had altered oral mucous membrane; problem with dentures/teeth/gums related to poor oral hygiene with interventions to refer to the dentist/hygienist for evaluation/ recommendations. Staff were to provide oral hygiene twice daily. An interview with the DOC confirmed that the resident was assessed by the dentist in 2014, however; the results of this assessment could not be located by the home. An interview with the DOC

confirmed that the home does not complete oral assessments and that an interdisciplinary assessment of resident #101's oral status, including oral hygiene, had not been completed. [s. 26. (3) 12.]

2. The plan of care was not based on, at a a minimum an interdisciplinary assessment of special treatments and interventions with respect to the resident.

On May 27, 2015, during on observation of the lunch service resident #402, #403, #404, and #405 received special adaptive cups to drink their beverages. Direction to provide adaptive cups was documented on a seating chart which staff referenced to set the tables. On May 3, 2015 through an observation of the afternoon snack cart service and through an interview with the PSW's it was identified that adaptive cups were not used for the snack service. The PSW's shared that resident #402, #403, #404, and #405 were able to drink with a large styrofoam cup with lid and straw. A review of the snack cart diet list did not identify that adaptive cups were required. A review of the plan of care for resident #402, #403, #404, and #405 did not contain direction to provide special adaptive cups and there was not an interdisciplinary assessment of the resident's requirement for eating aids/assistive devices required to eat and drink as comfortably and independently as possible. In an interview with the RD and the FSS on June 4, 2015, it was confirmed that the plan of care was not based on, at a a minimum an interdisciplinary assessment of special treatments and interventions with respect to each of the residents. [s. 26. (3) 18.]

3. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's special treatments and interventions.

A review of resident #109's current written plan of care indicated that they were currently using a tabletop that was affixed to their wheelchair that was being used as a personal assistance services device (PASD) that also limited or inhibited their movement. An interview with the DOC confirmed that no assessments had been completed for the use of their tabletop and that their plan of care was not based on an interdisciplinary assessment of the resident's special treatments or interventions. [s. 26. (3) 18.]

4. The licensee failed to ensure the plan of care was based on, at a minimum, interdisciplinary assessment of residents sleep patterns and preferences.

In an interview with resident #103 and resident #400 on May 28 and June 3, 2015 it was shared that their preference was to get up between 0700 to 0730 hours. Resident #103

and #400 required staff assistance to get in and out of bed and shared staff helped them get up at approximately 0900hrs on May 28 and June 3, 2015. During a review of the plan of care for resident #103 and #400 it was identified that there was not an interdisciplinary assessment of the the resident's sleep patterns and preferences and the preferred time they liked to get up out of bed in the morning was not identified. In an interview with registered staff it was confirmed resident #103's and #400's plan of care was not based on an interdisciplinary assessment of sleep patterns and preferences. [s. 26. (3) 21.]

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 requirements in r.26 are met with respect to every plan of care, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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 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 resident #113's kardex indicated that the resident required oral care twice daily. A review of the Daily Flow Sheets that staff use to document the provision of care was reviewed from May – June, 2015 and indicated that on four dates in May, 2015, no documentation had been included that mouth care at bedtime (HS) was provided. An interview with front line nursing staff and the DOC confirmed that the care was provided; however; these actions were not documented. (214)

B) A review of the plan of care for resident #105 identified they were on a restorative walking program which included walking to and from the dining room three times a day with a walker and staff assistance. A review of the restorative flow sheets for June, 2015 did not contain clear documentation as to whether resident #105 completed their walking program before and after each meal and what the resident's responses were. In an interview with the restorative program lead on June 9, 2015 it was confirmed that the flow sheets were not set up to at the times and intervals required for staff to accurately record if the resident completed their restorative walking and that documentation was missing daily for nine days in June, 2015. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provided direct care to residents received as a condition of continuing to have contact with residents annual retraining in accordance with O. Reg. 79/10, s. 219(1) in the area of staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices in accordance with O. Reg. 79/10, s. 221(1)5; and in the area of staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs in accordance with O. Reg.79/10, s. 221(1)6, in relation to the following: [76(7) 6]

An interview with the RN who is also responsible for staff education confirmed that a total of 62 out of 84 direct care staff received training in the above areas and that not all staff who provided direct care received this training in 2014. [s. 76. (7) 6.]

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 all staff who provide direct care to residents receive as a condition of continuing to have contract with residents annual retraining in accordance with O. Reg. 79/10, s. 219(1)in the area of staff, who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices in accordance with O. Reg.79/10, s. 221(1)5; and in the area of staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs in accordance with O. Reg.79/10, s. 221(1)6, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow up action required.

A) Resident #110's family member identified that the resident's personal belongings were missing on an unidentified date in 2015, and reported this to registered staff working that day. A review of the resident's clinical record indicated that this concern had been documented when it was brought to the staff's attention; however, actions taken and the follow up action required had not been documented.

It was confirmed by the Administrator on June 9, 2015, that the actions taken and the follow up action required had not been documented.

B) Resident #115 reported that an item of clothing had not been returned from the laundry during the stage one interview. An interview with three staff working in the laundry department on June 9 and 10, 2015, indicated that lost or missing items are documented when they are reported missing and posted in the laundry room. Laundry staff will look for identified missing items while processing the resident's laundry and any clothing that can not be identified by the resident's name is placed on another rack located in the laundry room.

Staff had not documented the actions taken and the follow up required related to the resident's missing clothing.

It was confirmed by staff on June 10, 2015, that the actions taken and follow up required had not been documented. [s. 101. (2) (c)]

2. The licensee failed to ensure that a documented record was kept in the home that included the final resolution of each verbal or written complaint.

In an interview with resident #108 on May 28, 2015, it was shared that their wallet containing money had recently went missing and had not been found. The progress note documentation completed identified the home was aware and briefly searched for the wallet in the resident's room, the resident was upset and that further action would be taken later that day. No further documentation was in the plan of care related to the missing item. In an interview with the DOC on June 4, 2015, it was identified that a concerns form had not been completed for resident #108's missing wallet and that management was unaware of resident #108's missing item.

It was confirmed the final resolution of the verbal compliant was not documented. [s. 101. (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 a documented record is kept in the home that includes the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any following up action required, to be implemented voluntarily.

WN #11: 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 following requirements were 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.

On May 25, 2015, resident #300 was observed sitting in their wheelchair with a front fastening seat belt applied. The device was loose enough that at least a five finger width spread between the device and the resident's abdomen was present. The resident was unable to undo their seat belt device when asked. A review of the manufacturer's directions for this physical device indicated that the seat belt was to be applied so you can fit only two fingers between the seatbelt and the patient's body. An interview with the Programs Manager who was present at this time confirmed that the front fastening seat belt device used for this resident was a physical restraint and was not applied according to the manufacturer's instructions. [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 with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act that staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including the following: A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

On June 8, 2015, the Inspector requested the monthly audits that were undertaken of the daily count sheets of controlled substances for the period of March – May 2015. The DOC and Administrator indicated that the home does not have these audits and would obtain them from their pharmacy provided. Pharmacy audits that were conducted on a form titled, "Narcotic and Controlled Medications Audits" were only able to be located for the months of December 2014, January and February 2015. A review of these audits completed by the Pharmacy Liason indicated that on all three monthly audits the following question was audited by the pharmacy, "At minimum, a monthly audit of the daily narcotic and controlled substances count sheets is being completed by the home". The answer by the Pharmacy Liason to this question for all three monthly audits was "No". The DOC confirmed the comments on the sheet and indicated that the completion of these audits was to be completed by the home and had not been. (214) [s. 130. 3.]

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 steps are taken to ensure the security of the drug supply, including a monthly audit to be undertaken of the daily count sheets of controlled substances to determine if there is any discrepancies and that immediate action is taken if any discrepancies are discovered, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff were provided training in skin and wound care.

During this inspection attendance records were reviewed related to staff training for skin and wound care. A review of the attendance records for training for Pressure Ulcer Staging and Wound Assessment indicated that only 22% of the direct care staff received the training.

It was confirmed by the Nurse Educator on June 4, 2015, that only 22% of the direct care staff received wound care training. [s. 221. (1) 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 all direct care staff are provided training in skin and wound, to be implemented voluntarily.

WN #14: 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 failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program.

It was observed on June 3, 2015, that resident #101 had their uncovered toothbrush stored in their blue K-basin along with a plastic coloured necklace. An interview with front line nursing staff confirmed that the uncovered toothbrush should not be stored with the necklace. [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 all staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.

WN #15: 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 not served a meal until someone was available to provide the assistance required by the resident.

During an observation of supper service on June 2, 2015, resident #401 was served their main entree. A time period greater than 10 minutes had gone by and the resident was observed to have not received any assistance from staff. Inspector #583 requested the Food Service Supervisor (FSS) to observe the dining service. In an interview with the FSS it was confirmed that resident #401 required total assistance with feeding per their plan of care and that their meal had been served before someone was available to provide the assistance required by the resident. (#583) [s. 73. (2) (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed of an outbreak of a reportable disease as defined in the Health Protection and Promotion Act.

An enteric outbreak was declared by Public Health on March 11, 2015, at the home. The outbreak was declared over on April 6, 2015, and the Director was not notified of the enteric outbreak until April 13, 2015.

It was confirmed by the Administrator that the Director was not notified until a week after the outbreak was declared over. [s. 107. (1) 5.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act was undertaken on a monthly basis.

A request to review the home's records for the analysis of the restraining of residents by use of a physical device for the months of March, April and May 2015, indicated that no records containing this information could be located. An interview with the Programs Manager on June 9, 2015, confirmed that an analysis of the restraining of residents by use of a physical device had not been completed on a monthly basis. [s. 113. (a)]

2. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements were required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this Regulation.

An interview with the Programs Manager on June 9, 2015, confirmed that the home had not completed an evaluation in 2014 with regards to determining the effectiveness of the licensee's policy under section 29 of the Act including what changes and improvements were required to minimize restraining and ensuring that any restraining that was necessary was done in accordance with the Act and this Regulation. [s. 113. (b)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that he annual evaluation of the medication management system was undertaken using an assessment instrument designed specifically for this purpose.

An interview with the Administrator on June 8, 2015, indicated that the home had conducted an annual evaluation of their medication management system in 2014; however; the evaluation was not undertaken using an assessment instrument designed specifically for this purpose. (214) [s. 116. (3)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 118. Information in every resident home area or unit
Every licensee of a long-term care home shall ensure that the following are available in every resident home area or unit in the home:
1. Recent and relevant drug reference materials.
2. The pharmacy service provider's contact information.
3. The contact information for at least one poison control centre or similar body.
O. Reg. 79/10, s. 118.

Findings/Faits saillants :

1. The licensee failed to ensure that the following were available in every resident home area or unit in the home: The contact information for at least one poison control centre or similar body.

On June 5, 2015, an interview conducted with registered staff on the Interim Long Term Care (ILTC) unit indicated that no contact information for at least one poison control centre or similar body could be located. The unit clerk was also unable to locate this contact information and did take action to locate and post this information at the unit. Following this action, an interview with the registered staff on the Extendicare Unit (ECU) was conducted and registered staff indicated that the contact information for the poison control centre had just been posted. (214) [s. 118.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 128. Every licensee of a long-term care home shall ensure that a policy is developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern the sending of a drug that has been prescribed for a resident with him or her when he or she leaves the home on a temporary basis or is discharged. O. Reg. 79/10, s. 128.

Findings/Faits saillants :

1. The licensee failed to ensure that a policy was developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern the sending of a drug that had been prescribed for a resident with him or her when he or she leaves the home on a temporary basis or is discharged.

A review of the pharmacy's policies on June 8, 2015, indicated that no policy was developed to govern the sending of a drug that had been prescribed for a resident when the resident was discharged from the home. An interview with the Administrator and DOC confirmed that the home did not have a policy that identified this information. (214) [s. 128.]

Issued on this 3rd day of September, 2015

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) :	ROSEANNE WESTERN (508), BERNADETTE SUSNIK (120), CATHY FEDIASH (214), KELLY HAYES (583)
Inspection No. / No de l'inspection :	2015_247508_0010
Log No. / Registre no:	H-002398-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 20, 2015
Licensee / Titulaire de permis :	NIAGARA HEALTH SYSTEM 63 THIRD STREET, WELLAND HOSPITAL SITE, WELLAND, ON, L3B-4W6
LTC Home / Foyer de SLD :	NIAGARA HEALTH SYSTEM, WELLAND HOSPITAL SITE, EXTENDED CARE UNIT 155 Ontario Street, St. Catharines, ON, L2R-5K3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	HELEN FERLEY

To NIAGARA HEALTH SYSTEM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_191107_0009, CO #003;

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 complete the following:

1. Review the plan of care for all residents, identify plans containing conflicting information/unclear direction, and update these plans to provide clear directions to staff and others who provide direct care to the resident.

2. Implement a process that ensures that when the resident's care plans are developed or revised that the entire plan of care is reviewed ensuring that it identifies the current needs of the resident and there are clear directions for staff and others who provide direct resident care on how to provide care to meet the resident's current needs.

Grounds / Motifs :

1. Previously issued as a compliance order in May, 2014.

The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

Resident #110 was a high risk for falls and had multiple falls in the first quarter of 2015. The resident's plan of care had indicated that the resident was to have one full bed rail up while the resident was in bed.

In May, 2015, two full bed rails were implemented to minimize the resident's risk of falls.

A review of the resident's current plan of care that staff refer to for direction in providing care to residents had two different directions. Under the restraint focus the care plan indicated that two full bed rails were to be up while the resident was in bed.

Under the falls focus, the resident's plan of care still directed staff to use only one full bed rail up while the resident was in bed.

It was confirmed by the DOC on June 9, 2015, that the plan of care did not set out clear directions to staff and others who provide direct care to the resident. (508)

2. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

B) A review of resident #112's current plan of care, indicated that they required one person constant supervision and extensive physical assistance for safety to transfer on and off the toilet and complete all parts of the task. In the same plan of care under the focus for urinary incontinence, it indicated that the resident is not a candidate for routine toileting/toileting program. They do not want to be toileted for urine and do not know when they need to void and are unaware when voiding. An interview with front line nursing staff indicated that the resident is transferred on and off the toilet for voiding with the assistance of two staff.

An interview with the DOC confirmed that the written plan of care did not set out clear directions to staff and others who provide direct care to the resident.

(214)

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 : Sep 15, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_189120_0009, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

1. Where bed rails are used, mitigate immediately 2-4 entrapment zones for residents residing on all therapeutic air mattresses. Mitigate immediately 2-4 entrapment zones for residents residing on foam mattress where the bed was previously identified as failing entrapment zone 2-4.

2. Have all beds re-measured/re-assessed for entrapment zones 2-4 using Health Canada's guidelines titled "Adult Hospital Bed: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards", March 2008.

3. Accurately document the results of the bed assessments and continuously maintain the document when changes to the bed system occur (i.e. mattress changed, rail replaced).

4. Educate all health care staff who care for residents with respect to entrapment zones, bed safety and rail use hazards using the following document as a guide "Adult Hospital Bed: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ".

Grounds / Motifs :

1. Previously issued as a compliance order in February, 2015.

The licensee did not ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The licensee commissioned a company to complete an entrapment assessment of all resident bed systems on September 4, 2014. The results of the audit however could not be used to establish conclusive results as to whether the beds were measured accurately or fully in accordance with Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008. In addition, since September 2014, the beds in the home had been relocated, different beds introduced that were not on the original assessment and mattresses swapped around. The home did not have their own measurement tool and did not complete any re-tests or measurements when changes were made since September 4, 2014. No updates on the status of the beds could be provided during the inspection on June 4, 2015. The Administrator reported that a different evaluator or consultant was retained to return to the home to complete another audit of the beds for entrapment in June 2015.

The entrapment assessment results from September 4, 2014 identified that 12 beds with a therapeutic air mattress were tested and documented as having passed zones 2-4 (areas between the mattress and bed rail). However, according to Health Canada Guidelines, therapeutic air mattresses cannot be evaluated for zones 2-4 due to their design of being compressible and very flexible. The evaluator concluded that "there was no way to accurately test these gaps as they will change with each cycle, however we test them to simply ensure the mattress, rail and bed frame work together". Unfortunately, the licensee was therefore not appropriately guided to ensure that risks associated with therapeutic surfaces were managed and mitigated. Discussions were held during a follow-up visit on January 21, 2015 that all therapeutic air mattresses were high risk for entrapment and required some type of accessory to mitigate zone 2 and 3 risks. An order was served on the licensee on February 2, 2015 requiring that risks to residents sleeping on therapeutic mattresses be mitigated. During the follow up inspection on June 4, 2015, residents were observed to be lying on therapeutic air mattresses with both full or 3/4 rails elevated. None of the residents had an accessory located between the air mattress and their bed side rails to mitigate zone 2 or 3 risks.

The entrapment assessment results from September 4, 2014 identified that 11 resident beds with a foam mattress failed zone 2 (under the rail and the side of the mattress) and/or zone 3 (between the bed rail and the side of the mattress). During an inspection on January 21, 2015, a review of these beds was conducted to determine if risk mitigating strategies were in place. For the failed beds with a foam mattress and where bed rails were used by the resident, the licensee responded by inserting a bed rail pad on 7 of the beds and had documented their actions on a form titled "Bed Safety and Entrapment Action Sheet - ECU and ILTC" dated October 14, 2014. However, when these 7 beds were reviewed for verification by the employee who completed the form and had inserted the pads, none of the 7 resident beds had any bed rail pads on the rails. The employee confirmed that since October 14, 2014, no monitoring to ensure that the beds remained safe was implemented. During the follow up inspection on June 4, 2015, the entrapment status of the beds could not be verified by the licensee. Concerns that some of the beds remained unsafe were made based on observations of the physical characteristics of the beds during the inspection (i.e. room 11). Based on Health Canada guidelines, beds without mattress keepers (to keep the mattress from moving around), a soft mattress and an elevated bed rail would not typically pass entrapment zones 2-4. The bed in room 11 did not have mattress keepers, had an elevated full bed rail, and when the mattress was compressed by hand, a large gap emerged beneath the bottom of the bed rail and top of the mattress (zone 2).
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2015

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2015_189120_0009, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following:

1. Develop a comprehensive bed safety assessment tool using the US Federal Drug and Food Administration document as a guide titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".

2. An interdisciplinary team shall assess all residents using the bed safety assessment tool and document the results and recommendations.

3. Update all resident health care records (plan of care) to include why bed rails are being used, how many, which side of the bed and any accessories that are required to mitigate any identified entrapment risks.

4. Health care staff shall be provided with and follow directions related to each resident's bed rail use requirements.

5. Institute a monitoring program that will ensure that residents who require accessories to reduce entrapment zones will continue to be provided with those accessories.

Grounds / Motifs :

1. Previously issued as a compliance order in February, 2015.

The licensee did not assess all residents who used bed rails in accordance with prevailing practices to minimize risk to the resident.

Prevailing practices for bed rail assessments includes but is not limited to a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Drug and Food Administration.

During a previous inspection conducted on January 21, 2015, an order was issued for failure to complete resident assessments with respect to bed rail use in accordance with the above noted prevailing practices. During this inspection, seven residents were selected to determine if they were assessed for bed rail use after observing them sleeping in bed on June 4, 2015 with at least one bed rail elevated. An assessment questionnaire titled "Welland Bed Rail Utilization

Assessment" and each resident's plan of care were reviewed on the licensee's electronic record keeping database.

A) The Bed Rail Utilization Assessment form used by registered staff in the home did not change since the inspection in January 2015. The licensee was required to amend the form according to the guidance document noted above to include additional questions to guide the assessors towards a conclusion that is comprehensive, consistent and offers the safest solution for the resident while in bed. The questions were developed for a "yes" or "no" response with little guidance towards various options. The guidance document identifies questions related to sleep patterns and alternatives trialled before choosing a bed rail for any particular reason. It also includes the need for an interdisciplinary team to review the residents sleep and mobility patterns which would be reviewed over several nights, how many rails were needed and on which side of the bed, the size of the rail and why. These types of conclusions were not included in 5 out of the 7 assessment records for residents. In addition, none of the assessments included whether a resident's bed was a risk for entrapment and the necessary interventions necessary to mitigate those risks. Six of the identified residents were on therapeutic air mattresses which are a high risk for entrapment without any bed accessories (gap fillers, bolsters, rail pads etc.)
B) Numerous beds throughout the home where observed to have at least one bed rail elevated on unoccupied beds. The plan of care for the residents occupying these rooms required that one or more bed rails be applied when the resident is in bed for "safety or for "turning or repositioning". No direction was given to leave rails elevated during the day when the bed was not occupied. Application of bed rails when not planned for may increase the risk of resident injury. This issue was previously identified during the inspection in January 21, 2015.
C) Confirmation was made with the Director of Care that staff did not receive any formal education or training with respect to bed rail use hazards or how to complete appropriate assessments. The requirement for staff education was included in the previous order.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2015

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2014_191107_0009, CO #009;

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 complete the following:

1. Ensure that all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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 weekly.

2. Ensure that all nursing staff receives training related to the assessment of skin and wounds and on the home's Skin and Wound Policy.

Grounds / Motifs :

1. Previously issued as a compliance order in May, 2014.

The licensee has failed to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds were reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

Resident #103 was admitted to the home in 2014, with a wound. A review of the resident's clinical record indicated that the resident's wound was not reassessed by registered staff until two months later.

It was confirmed by the Director of Care that resident #103 had not been reassessed at least weekly by a member of the registered staff, when clinically indicated. (508)

2. The licensee has failed to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds were reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

Resident #116 was admitted to the home in 2014. A skin assessment had been conducted upon admission which indicated that the resident's skin was clear. Ten days later the staff reassessed the resident's skin and indicated that the resident had a reddened area. The resident was not reassessed again until over a month later, which had identified an open area.

In September, 2014, the resident's wound was reassessed and registered staff

indicated that the wound had deteriorated further. The resident's wound was not reassessed again until 12 days later.

(508)

3. The licensee has failed to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds were reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

Resident #200 had altered skin integrity. A review of the resident's clinical record indicated that the resident's wound was being reassessed but not weekly by registered nursing staff. The resident's wound was reassessed on two dates in September, two dates in October, and only once in December, 2014. The resident's wound was reassessed five times in January, however; there were gaps of nine to ten days in between these assessments.

The resident's wound was not reassessed at all in the month of November, 2014. The Director of Care confirmed during an interview on June 3, 2015, that the resident's wound was not reassessed weekly by a member of the registered staff.

(508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2015

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2015_189120_0008, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee shall complete the following:

1. Develop guidelines and procedures for completing interior maintenance audits, who will complete the audit, describe the acceptable conditions for the surfaces, furnishings and fixtures and the expected course of action to be taken when identified to be non-compliant.
2. Develop a schedule as to how often the maintenance audits will be completed and by whom.

Grounds / Motifs :

1. Previously issued as a compliance order in February, 2015.

The licensee did not ensure that schedules and procedures were in place for routine, preventive and remedial maintenance.

During a previous inspection of the home conducted on January 20 and 21, 2015, observations were made regarding the poor condition of the flooring material, fixtures, furnishings, walls and beds. At that time, the Administrator and Facility Services Supervisor were aware of the issues, but were not able to provide a schedule for the remedial work to correct the issues. A review of the home's policies and procedures revealed that no procedures were in place for the preventive maintenance checks of floors, walls, doors, windows, fixtures, beds, furnishings, lights, ceilings, toilets, sinks, grab bars and other common surfaces/items of the home. As a result, an Order was issued on February 2, 2015 requiring that the licensee develop procedures and schedules to address the disrepair. During this inspection completed on June 4, 2015, the Administrator was able to provide a completed audit of the status or condition of the various interior surfaces and furnishings and a plan to address their findings. However, no procedures had been developed. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2015

Order # / Ordre no : 006

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

Linked to Existing Order / Lien vers ordre existant: 2014_191107_0009, CO #008;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

The licensee shall ensure that drugs are stored in an area or a medication cart that is secured and locked.

Grounds / Motifs :

1. Previously issued as a compliance order in May, 2014.

The licensee failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

A) On June 4, 2015, at 1240 hours, a medication cart was observed in the Extendicare Unit (ECU) west hallway outside of room #21 to be unattended and the medication cart drawers unlocked. The door to this resident's room was observed to be closed. A resident, who was sitting approximately 3 feet away, informed the inspector that the nurse was inside of room #21. An interview was conducted with the nurse upon exiting from room #21 who confirmed that the medication cart was not locked and was left unattended and that the expectation is that the medication cart is to be locked when left unattended. The DOC was informed immediately and confirmed that this was an unacceptable practice and took action of posting a memo to ensure that the medication cart is kept locked when not in attendance.

B) On June 10, 2015, at 1410 hours, a medication cart was observed to be parked in the hallway outside of the ECU nurses station. The medication cart was observed to be unlocked and unattended. Several residents were sitting approximately 4 feet away from this medication cart and two visitors were observed to have walked down the hallway past this medication cart. The DOC was informed immediately and confirmed that the medication cart was unlocked and unattended and proceeded to lock the medication cart. The DOC confirmed that this was an unacceptable practice. (214)
(214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2015

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 20th day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Roseanne Western

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