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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 13, 2016	2016_433625_0010	005681-16	Resident Quality Inspection

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA
1220 Valley Drive KENORA ON P9N 2W7

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

NORTHWOOD LODGE
51 Highway 105 P.O. Box 420 RED LAKE ON P0V 2M0

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

KATHERINE BARCA (625), JENNIFER KOSS (616)

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): July 18 - 22 and July 25 - 29, 2016.

Additional logs inspected during this Resident Quality Inspection were related to:
- a Critical Incident System report submitted regarding a resident's access to an unsafe substance and subsequent treatment;
- a Complaint submitted regarding insufficient staffing and staff qualifications; and
- a Follow-up to an order regarding the plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator, a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping Aides, a Dietary Aide, residents and family members.

The Inspector(s) reviewed resident health care records, various home's policies and procedures, home's investigation files and maintenance records. The Inspector(s) also completed observations of residents, observed the provision of care and services to residents, observed resident and staff interactions, meal services, conducted tours and made observations of resident care areas.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
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

During the course of this inspection, Non-Compliances were issued.
- **21 WN(s)**
- **13 VPC(s)**
- **0 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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2015_246196_0017	616

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to be treated with courtesy and respect and in a way that fully recognized the resident’s individuality and respected the resident’s dignity.

On a particular date, during the inspection in July of 2016, Inspector #625 was at the nursing station and heard Dietary Aide #114 say to resident #015 that they had to eat at their spot at a dining room table and could not eat elsewhere, despite the resident requesting to eat in another location.

Inspector #625 attended the dining room and observed resident #015 seated near the television lounge, where other residents had eaten and were eating their meals.

During an interview with Inspector #625, Dietary Aide #114 stated that the resident was supposed to eat at the table in their spot, that it had been too hot in a specific area of the dining area when an argument had occurred between the residents over the use of a cooling device, and that the resident was expected to return to their seat to eat.

During an interview with Inspector #625, PSW #115 stated that they had told resident #015 that they had to return to their seat to eat as residents were supposed to eat at their assigned seats. When asked if there was a specific reason that resident #015 was required to eat in their assigned seat, the PSW stated that staff would have to clean up any resulting mess from a resident not eating at their assigned seat.

Inspector #625 observed PSW #107 assist resident #015 to an empty table in a screened in dining area. Inspector #625 spoke to resident #015 in this location and the resident stated that they had been too hot to eat a part of their meal in a specific area of the dining room and needed to cool down. The resident stated they would like that part of their meal at that time, and it was brought to the resident to eat in the screened in dining room.

During an interview with Inspector #625 on a particular date during the inspection in July of 2016, the Administrator stated that resident #015 had the right to eat where they had asked to eat, that hot temperatures and the use of a specific cooling device had been an ongoing challenge, and that the resident could eat outside of the dining room to accommodate this. When asked if resident #015's rights had been fully respected and promoted during these interactions with the resident, the Administrator acknowledged that the Residents' Bill of Rights had been violated. [s. 3. (1) 1.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #010 was identified during stage one of the inspection regarding the use of bed

rails.

On a particular date, during the inspection in July of 2016, Inspector #616 observed resident #010 laying in bed with bed rails in use.

The Inspector reviewed the resident's plan of care related to the use of bed rails. Their current care plan did not include any information related to the use of bed rails. A Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment dated a specific date in the winter of 2016, indicated that bed rails were used daily.

During interviews with Personal Support Worker (PSW) #112, PSW #109, and Registered Practical Nurse (RPN) #103 on a specific date during the inspection in July of 2016, the PSWs stated to the Inspector that the bed rails were used to keep resident #010 in their bed. The RPN stated that bed rails were used as a safety measure, but that there was no documentation related to the use of bed rails for the resident.

During an interview with the Inspector on a particular date during the inspection in July of 2016, the Administrator stated that they expected to see the use of bed rails included in the resident's current care plan, but verified that it was not. [s. 6. (1) (a)]

2. 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 other who provided direct care to the resident.

During stage one of the inspection, resident #010 was identified to have had a worsening area of impaired skin integrity between specific dates in the fall of 2015 and spring of 2016.

Inspector #616 reviewed the resident's health record with a focus on skin and wound care. A progress note dated a specific date in the winter of 2016, identified an impairment in skin integrity on a particular area of resident #010's body. The RAI MDS assessment dated a specific date in the spring of 2016, identified that this resident had a worsened area of impaired skin integrity. A nursing intervention on the resident's Treatment Administration Record (TAR) directed staff to check the area daily, and perform a particular treatment, if needed. This intervention was listed monthly for specific months 2016, however, staff initials were documented inconsistently as follows:
- initials were missing on 13 of 20 dates in one specific month, or 65 per cent of the time;
- initials were missing on 18 of 31 dates in one specific month, or 58 per cent of the time;

- initials were missing on 2 of 30 dates in one specific month, or 7 per cent of the time;
- initials were missing on 5 of 31 dates in one specific month, or 16 per cent of the time;
- initials were missing on 6 of 30 dates in one specific month, or 20 per cent of the time; and
- initials were missing on 19 of 27 dates in one specific month, or 70 per cent of the time.

A procedure within the home's policy titled "Skin and Wound Care Program - NUR 035" last revised August of 2012, stated that registered staff were to know how and when interventions and treatments were being carried out for residents at risk for actual or potential skin/wound breakdown.

During an interview with RPN #119 on a particular date during the inspection in July of 2016, the Inspector reviewed this intervention on the resident's TAR. They stated to the Inspector that staff checked a particular location on resident #010's body daily, and only initialed the TAR when the particular treatment was completed. However, on a particular date during the inspection in July of 2016, RPN #103 stated to the Inspector that they initialed the TAR to document that they checked the particular location, and documented in a progress note when they completed a particular treatment.

For clarification, the Inspector interviewed the Administrator on a particular date during the inspection in July of 2016. They stated that there should not have been any blank documentation within the TAR for this treatment. They also stated that the wording of this intervention did not provide clear direction for whether registered staff documented when the particular location was checked, or when the particular treatment was completed, or both. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

During stage one of the inspection, a family interview was conducted by Inspector #616 on a specific date during the inspection in July of 2016, with resident #013's family member #117. Resident #013's family member #117 stated that the last time they had been informed of any changes to the resident's treatments was in the summer of 2015. Family member #117 stated that, in the summer of 2015, they learned of a change in a particular area of the resident's functional status from a person at an external organization that provided services to resident #013. The family member stated that the

home had not notified them of a change in the resident's medication and the change in their functional status at the time that the changes had occurred.

A review of resident #013's health care record by Inspector #625 included the resident's chart and electronic progress notes. The Inspector reviewed the physician's orders and electronic progress notes, which did not include documentation that indicated that the resident's family was notified of the medication changes or had provided consent for any medication changes or changes to the plan of care. The "Annual Care Conference Review" sheet dated a particular date in the spring of 2016, was also reviewed and identified that family member #117 attended the care conference and brought forward no significant concerns.

Inspector #625 reviewed the home's policy "Medication Administration – NUR 070", last revised February 2010, that identified that the RN or RPN was to assess the resident's ability to understand medication therapy, and seek consent to administer medication where incapacity was considered, as well as incorporate the substitute decision-maker's requests/instructions for medication therapy as outlined in the plan of care.

A review of the home's policy "Medication Program – Structure – NUR 085", last revised February 2010, did not identify that staff were to obtain consent from residents, substitute decision-makers or family members when processing physician's orders, but indicated that consent was required when drugs were ordered where there would be a cost incurred by the resident. In that case, the RN/RPN was to speak with the resident or substitute decision-maker to provide information on the drug cost and the reasons that it had been ordered, and then to contact the pharmacy with consent, or lack of consent, for the cost of the drug.

During an interview with Inspector #625 on a particular date during the inspection in July of 2016, the Director of Care (DOC) stated that they believed staff notified families of medication changes but that some may have slipped through the cracks. The DOC acknowledged that consent for the medications changes obtained from families was not being documented by staff but that the expectation was that all substitute decision-makers were notified of any changes to plans of care. [s. 6. (5)]

4. During stage one of the inspection, a family interview was conducted by Inspector #625 on a specific date during the inspection in July of 2016. Resident #011's family member #118 stated that the home had changed the type of medication the resident received for a particular medical condition without notifying the family member. The

family member stated they found out about the change during the resident's care conference in a particular month in 2016 and did not know how long the resident had been receiving the new medication prior to that time.

A review of resident #011's health care record by Inspector #625 included a progress note dated a particular date in the winter of 2016, that indicated the resident's care conference was held and that family member #118 wanted information on the medications the resident was on and wanted to be notified of any future medication changes for the resident. The review also included a "Care Conference" sheet dated a particular date in the winter of 2016, and signed by the DOC, that indicated family member #118 wanted to know about medication changes and any other significant changes that occurred involving resident #011.

During an interview with RPN #119, they stated that the RPN on shift or the DOC should call the family for consent to medication changes and document that the consent was obtained in an electronic medication progress note.

During an interview with Registered Nurse (RN) #104, they stated that the person completing the rounds with the physician should call families with medication changes, that there may have been times where families were not notified, and that a new employee did not know to call the family when accompanying the physician on rounds.

During an interview with Inspector #625 on a particular date during the inspection in July of 2016, the DOC stated that they became aware at resident #011's care conference that the family wanted to be made aware of every medication change that occurred. The DOC stated that it may be problematic for the nurses on the floor and hoped that the nurses contacted family.

During an interview with the Administrator, they stated that about 75 per cent of the home's families did not want to be notified of changes, and that some residents relied on the Public Guardian and Trustee who did not want to know of changes. The Inspector informed the Administrator that they were not able to locate notification of substitute decision-makers for consent to new medications or medication changes in the home's medication policies, even those related to medication order changes, except as it related to consenting to the cost of medications. The Administrator stated that obtaining consent was not something that the home had done across the board and that they would come up with a system to ensure it was done and documented. [s. 6. (5)]

5. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Resident #013 was identified during stage one of the inspection for a weight change as indicated through census record review.

Inspector #616 reviewed the "Nutritional Care" care plan for resident #013 dated a particular date in the summer of 2016. The resident was identified as being at nutritional risk as evidenced by two specific criteria. The care planned interventions included that the PSW observed and documented food and fluid intake on the "Food and Nourishment Daily Record".

The Inspector reviewed resident #013's "Food and Nourishment Daily Record" (FNDR) over a 14 day period from two particular dates in July of 2016. This included a record of food and fluid intake at all meals, and any fluids and/or nourishments taken in the morning, afternoon, and evening. Throughout the period, the following were not documented as per the care plan:
- on one out of 14 days, or seven per cent of the days, fluid intake at breakfast;
- on one out of 14 days, or seven per cent of the days fluid intake at mid-morning nourishment;
- on four out of 14 days, or 29 per cent of the days, fluid intake at lunch;
- on 13 out of 14 days, or 93 per cent of the days, food intake at mid-afternoon nourishment;
- on three out of 14 days, or 21 per cent of the days, fluid intake at mid-afternoon nourishment;
- on two out of 14 days, or 14 per cent of the days, food intake at supper;
- on one out of 14 days, or seven per cent of the days, fluid intake at supper;
- on ten out of 14 days, or 71 per cent of the days, food intake at evening nourishment; and
- on one out of 14 days, or seven per cent of the days, fluid intake at evening nourishment.

From this information, the Inspector noted the number of days that resident #013's total fluid intake was less than 1500 ml/day over the 14 day period. There were six days when fluid intake was insufficient, however the fluid intake documentation at meals and/or nourishment was incomplete, which did not not provide an accurate assessment of fluid intake over 24 hours.

The worksheets used by staff to document the provision of food/fluids to residents taken at the mid-morning, mid-afternoon, and evening nourishment passes were reviewed and cross-referenced with the FNDR for the same 14 day period from the two particular dates in July of 2016. These worksheets were not included in the resident's health record but were obtained from the Administrator, filed in their office. For each of the blanks in the FDNR as noted above, there was documentation that indicated that the resident had refused, was sleeping, or food/fluid amount was recorded. The documentation from the worksheet had not been transferred to the "Food and Nourishment Daily Record" as per the resident's care plan.

The Inspector reviewed the home's policy titled "Nutrition Resident Care - NUR 135" last revised February of 2010, that stated the PSW recorded the resident's intake of food and fluids at each meal and at nourishment on the "Food and Nourishment Daily Record".

In an interview with the Inspector on a particular date in July of 2016, PSW #113 stated to the Inspector that the FNDR was completed by the PSWs after each meal and snacks, leaving no areas blank.

During interviews with the Administrator in July of 2016, and via telephone in August of 2016, they verified to the Inspector that the "Food and Nourishment Daily Record" for meals, fluids, supplements and snacks should have been fully completed by the PSWs as per the home's policy and the resident's plan of care. [s. 6. (9) 1.]

6. Resident #006 was identified during stage one of the inspection for a weight change as indicated through census record review.

Inspector #616 reviewed the "Nutritional Care" care plan for resident #006 dated a particular date in the spring of 2016. The resident was identified as being at nutritional risk as evidenced by one specific criteria. The care planned interventions included that the PSW observed and documented food and fluid intake on the "Food and Nourishment Daily Record".

The Inspector reviewed resident #006's "Food and Nourishment Daily Record" (FNDR) over a 14 day period from two particular dates in July of 2016. This included a record of food and fluid intake at all meals, and any fluids and/or nourishments taken in the morning, afternoon, and evening. Throughout the period, the following were not documented as per care plan:
- on one out of 14 days, or seven per cent of the days, fluid intake at mid-morning

nourishment;
- on 12 out of 13 days, or 86 per cent of the days, food intake at mid-afternoon nourishment;
- on four out of 14 days, or 29 per cent of the days, fluids intake at mid-afternoon nourishment;
- on one out of 14 days, or seven per cent of the days, food intake at supper;
- on one out of 14 days, or seven per cent of the days, fluid intake supper;
- on 12 out of 14 days, or 86 per cent of the days, food intake at evening nourishment; and
- on one out of 14 days, or seven per cent of the days, fluid intake at evening nourishment.

From this information, the Inspector noted the number of days that resident #006's total fluid intake was less than 1500 ml/day over the 14 day period. There were two days when fluid intake was insufficient, however the fluid intake documentation at meals and/or nourishment was incomplete, which did not provide an accurate assessment of fluid intake over 24 hours.

The worksheets used by staff to document the provision of food/fluids to residents taken at the mid-morning, mid-afternoon, and evening nourishment passes were reviewed and cross-referenced with the FNDR for the same 14 day period from the two particular dates in July of 2016. These worksheets were not included in the resident's health record but were obtained from the Administrator, filed in their office. For each of the blanks in the FDNR as noted above, there was documentation that indicated that the resident had refused, was sleeping, or food/fluid amount was recorded. The documentation from the worksheet had not been transferred to the "Food and Nourishment Daily Record" as per the resident's care plan.

During interviews with the Administrator in July of 2016, and via telephone in August of 2016, they verified to the Inspector that the "Food and Nourishment Daily Record" for meals, fluids, supplements and snacks should have been fully completed by the PSWs as per the home's policy and the resident's plan of care. [s. 6. (9) 1.]

7. Resident #012 was identified during stage one of the inspection for a weight change as indicated through census record review.

Inspector #616 reviewed the "Nutritional Care" care plan for resident #012 dated a particular date in the summer of 2016. The resident was identified as being at nutritional

risk as evidenced by three specific criteria. The care planned interventions included that the PSW observed and documented food and fluid intake on the "Food and Nourishment Daily Record".

The Inspector reviewed resident #006’s "Food and Nourishment Daily Record" (FNDR) over a 14 day period from two particular dates in July of 2016. This included record of food and fluid intake at all meals, and any fluids/nourishments taken in the morning, afternoon, and evening. Throughout the period, the following were not documented as per care plan:
- on one out of 14 days, or seven per cent of the days, fluid intake at breakfast;
- on 13 out of 14 days, or 93 per cent of the days, food intake at mid-afternoon nourishment;
- on one out of 14 days, or seven per cent of the days, fluid intake at mid-afternoon nourishment;
- on nine out of 14 days, or 64 per cent of the days, food intake at evening nourishment; and
- on one out of 14 days, or 7 per cent of the days, fluid intake at evening nourishment.

From this information, the Inspector noted the number of days that resident #012’s total fluid intake was less than 1500 ml/day over the 14 day period. There were two days when fluid intake was insufficient, however the fluid intake documentation at meals and/or nourishment was incomplete, which did not provide an accurate assessment of fluid intake over 24 hours.

The worksheets used by staff to document the provision of food/fluids to residents taken at the mid-morning, mid-afternoon, and evening nourishment passes were reviewed and cross-referenced with the FNDR for the same 14 day period from the two particular dates in July of 2016. These worksheets were not included in the resident’s health record but were obtained from the Administrator, filed in their office. For each of the blanks in the FDNR as noted above, there was documentation that indicated that the resident had refused, was sleeping, or food/fluid amount was recorded. The documentation from the worksheet had not been transferred to the "Food and Nourishment Daily Record" as per the resident’s care plan.

During interviews with the Administrator in July of 2016, and via telephone in August of 2016, they verified to the Inspector that the "Food and Nourishment Daily Record" for meals, fluids, supplements and snacks should have been fully completed by the PSWs as per the home's policy and the resident’s plan of care. [s. 6. (9) 1.]

8. Resident #006 was identified as having a potential restraint during stage one of the inspection. On a particular date during the inspection, in July of 2016, the resident was observed by Inspector #616 with a particular type of potential restraint in use.

Inspector #616 reviewed the resident's current relevant care plan dated a particular date in the spring of 2016, which identified a particular type of device to be used with associated criteria for a specific reason.

During interviews with RPN #120 and RPN #103 on a particular date in July of 2016, they stated to the Inspector that the PSWs applied the device, repositioned the resident while the device was being used, and removed the device when appropriate. They both stated that the PSWs documented the use of the device on an hourly monitoring form. They also stated that the registered staff evaluated the applied device on this same form and documented, by their signature, every eight hours.

The Inspector reviewed resident #006's monitoring forms titled "Northwood Lodge Hour Monitoring Record" from the date the physician approved the particular type of device on a specific date in spring of 2016, to a specific date in the summer of 2016. The documentation was incomplete by registered staff on the following day shifts (0700-1500 hours) during the reviewed period in 2016 on one specific date in April, on five specific dates in May, on five specific dates in June, and on two specific dates in July. The documentation was incomplete by registered staff on the following evening shifts (1500-2300 hours) during the reviewed period in 2016 on three specific dates in May.

The Inspector reviewed the home's policy titled "Minimizing Restraint – PASD Use - NUR 400" last revised November of 2015, that stated the registered staff reassessed and monitored the effectiveness of the restraint at least every eight hours, and documented on the "NUR 400 Physical Restraint/PASD Use" form.

During an interview with the RPN #120 on a particular date in July of 2016, they stated to the Inspector that the form in the policy was the hourly monitoring form used by staff.

During an interview with the Administrator on a particular date in July of 2016, they stated to the Inspector that registered staff documented the effectiveness of the device every eight hours and signed the hourly monitoring form. They acknowledge that there were blanks in the registered staff signature section of the monitoring forms in the reviewed period. [s. 6. (9) 1.]

9. During stage one of the inspection, Inspector #625 observed a prescription topical medication for resident #021 kept in the resident's washroom.

During an interview on a particular date in July of 2016, with Inspector #625, the Administrator stated that residents in the home did not administer their own topical medications, but that staff brought the medications to the residents for each application.

A review of resident #021's Medication Administration Record (MAR) for July of 2016 identified that a specific topical medications was to be applied a specific number of times daily. The MAR was signed once, on one specific date in July of 2016, and no other time up to the date of review of the MAR on a specific date in July of 2016.

A review of resident #022's MAR for July of 2016 identified that a specific topical medication was to be applied a specific number of times daily. The MAR was not signed for at a specific time on 20 dates in July of 2016; or at another specific time on three dates in July of 2016. [s. 6. (9) 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: there is a written plan of care for each resident that sets out clear directions to staff and other who provide direct care to the resident; 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; and that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

Ontario Regulation 114. (2) requires the licensee to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

On a particular date during the inspection in July of 2016, at a specific time, Inspector #616 observed RPN #103 administer medication to resident #005 seated in a chair outside of the dining room. During the Inspector's observations, the RPN reviewed the Medication Administration Record (MAR) for the specific medication pass, prepared, and administered the resident's medication using a specific route of administration. The RPN returned to the medication cart, transferred the resident's oral medications from the pharmacy package to a small paper cup, and signed their initials on the MAR. As the resident stood to proceed to the dining room, the Inspector heard the resident ask the RPN for their pills, which the RPN responded that they would bring the pills to their table. The resident proceeded to their seat in the dining room.

As the resident walked away, the RPN stated to the Inspector that the resident was "pretty good" with taking their pills, and often asked to take their medication with their meals. The RPN stated that they had no concerns related to leaving the medications in the close proximity of a cognitively impaired co-resident seated next to resident #005 at the dining table.

The Inspector returned to the dining room 30 minutes after the first observation was made. The Inspector observed resident #005's medications in a paper cup on the table in front of the resident.

The resident was observed leaving the dining room 15 minutes after the Inspector had returned.

The RPN stated to the Inspector that when they went back to check, the resident had reported to them that they had taken their medications.

The Inspector noted that one of the medications listed in the designated medication pass on the MAR was written for administration during two different medication times, not at the time that it was administered.

The Inspector reviewed the procedure in the home's policy titled "Medication Program - Methods and Routes of Administration - NUR 80" last revised February of 2010, which stated that the Registrant must observe that medication was taken as prescribed. Further, medications were never to be left at the bedside, or with a resident unless the Doctor had given specific instructions.

An additional policy reviewed by the Inspector titled "Medication Program - Administration - NUR 070" last revised February 2010, stated that staff ensured that the medication prepared was correct, which included the right time of the medication administration. This policy also stated that medications were recorded immediately after giving them to a resident, not before.

In an interview with the Inspector on a particular date during the inspection in July of 2016, the Administrator stated that the staff were to review the medication to be provided, and sign for the medication administration after they had administered and observed the medication was taken by the resident. [s. 8. (1) (b)]

2. Ontario Regulation s. 68 (2)(e)(i) requires every licensee of a long-term care home to ensure that the nutrition care and hydration programs included a weight monitoring system to measure and record with respect to each resident weight on admission and monthly thereafter.

During a review of residents' weights during a census review, it was noted by Inspectors

#616 and #625 that admission and monthly resident weights were missing from residents' electronic GoldCare records.

A review, by Inspector #625, of the home's policy "Vital Signs/Allergy Recording – NUR 045" last revised February 2010, identified that residents' admission weights and monthly weights were to be recorded in the computer in the vital signs section.

A review, by Inspector #625, of the home's staff meeting minutes from June 29, 2016, identified that, during the meeting, the staff had been directed to ensure monthly resident weights were entered into GoldCare.

Inspector #616 reviewed admission and monthly weights and noted that weights were missing from the vital signs section in GoldCare for residents #006, #009, #012 and #013 in December of 2015, resident #001 in June of 2016, and resident #019's admission weight in a specific month in 2016.

Inspector #625 reviewed admission and monthly weights and noted that weights were missing from the vital signs section in GoldCare for residents #008, #014 and #020 in December of 2015, and resident #004, #008, #017 and #020 in June of 2016.

During an interview with Inspector #625 on a particular date during the inspection in July of 2016, the Administrator stated that residents' weights were to be completed monthly and within 14 days of admission. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and that those doors were kept closed and locked when they were not being supervised by staff.

On July 20, 2016, Inspector #625 observed the storage rooms located beside rooms B11 and B12 to be propped open. The door to the storage room beside room B11 had a sign posted that read "staff only".

On July 21, 2016, Inspector #625 observed the storage room door beside room B11 to be unlocked and the storage room door beside room B12 to be propped opened.

On July 26, 2016, Inspector #625 observed the storage room door beside room B12 to be unlocked. Inspector #625 interviewed RPN #111 about the storage room door. The RPN stated that the door should be locked and that every PSW had a key for the door. On July 29, 2016, at 1040 hours, Inspector again observed the door to the storage room beside room B12 to be unlocked.

On July 26, 2016, the Inspector observed the Clean Utility Room door to be unlocked. Inspector #625 interviewed PSW #107 about the Clean Utility Room door. The PSW stated that the door should be closed and locked as residents should not access the Clean Utility Room.

The Inspector interviewed the Administrator on July 26, 2016, who stated that the doors to the Clean Utility Room should be locked at all times. The Administrator also identified that the doors to the storage rooms located in B hallway, the Dirty Utility Room, the Housekeeping Closet and the Laundry area should all be closed and locked when not supervised by staff.

On July 27, 2016, Inspector #625 observed the Housekeeping Closet door not fully closed and not locked. Two bottles containing concentrated disinfectants were hooked up to the dispenser, including Enviro Solutions 64 Neutral Disinfectant, which had a Workplace Hazardous Materials Information System (WHMIS) symbol that identified the disinfectant was corrosive. During an interview with Inspector #625 about the Housekeeping Closet door, PSW #109 stated that the door should be kept closed and locked.

On July 28, 2016, at 0930 hours, Inspector #625 observed a sign on the conference/staff room door that was dated April 2, 2015, and read "This staff room is for employees of Northwood Lodge only" signed by the Administrator. A second sign posted on the door read "staff only beyond this point". The Inspector noted an exterior door in the conference/staff room leading to the outside that had a key in the lock. RAI Coordinator #102 stated that residents could exit the home from the exterior door, and that the door did not have a wander guard or an alarm to notify staff should that occur. The RAI Coordinator stated that the door to the conference/staff room should be closed and locked when staff were not present so that residents could not get outside without staff knowing.

On July 28, 2016, at 1215 hours, Inspector #625 observed the door to the conference/staff room to be opened, unlocked and unsupervised. PSW #113 stated that the door to the conference/staff room should have been closed and locked when staff were not present to supervise the area. The PSW went up to the exterior door that was accessible to residents when the conference/staff room door was left opened, and stated that it did not have a wander guard system on it, that the door was not alarmed, and that the key in the door permitted anyone to exit through the door to the outside without the staff being aware.

Inspector #625 then interviewed the Administrator who stated that the exterior door in the conference/staff room was not equipped to sound with a wander guard system and did not sound an alarm when opened. The Administrator acknowledged that the door to the conference/staff room should be closed and locked when staff were not present.

Later the same day, on July 28, 2016, Inspector #625 observed resident #011 to be behind the nursing station desk, in the immediate vicinity of the conference/staff room, during the afternoon and the evening. One of resident #011's care plans last updated on a specific date in the summer of 2016, identified that the resident exhibited responsive

behaviours related to wandering and that a device was in place to alert staff of associated behaviours.

On July 28, 2016, at 1815 hours, Inspector #625 observed resident #013 to be behind the nursing station, in the immediate vicinity of the staff/conference room. One of resident #013's care plans last updated on a specific date in the spring of 2016, identified that the resident exhibited responsive behaviours related to wandering and that a device was in place to alert staff of associated behaviours.

During a discussion with the Administrator, they acknowledged the safety risks associated with residents entering the nursing station area and that they had contacted contractors for quotes to install doors on the nursing station as residents should not be accessing that area.

On July 29, 2016, at 0930 hours, the door to the conference/staff room was observed to be opened and unlocked. The key to the exterior door was in the lock and no staff were present. PSW #115 stated that the door should have been closed and locked, and that there was nothing preventing residents from exiting the building without staff being notified. The Administrator stated that the door to the staff/conference room should have been closed and locked and that the Administrator had placed a note in a staff communication binder regarding locking that specific door. The Administrator confirmed that the staff/conference room was a non-residential area and that the exterior door located in the room was not equipped to sound with a wanderguard system, and that residents requiring the wanderguard system could exit the home without the staff being aware.

Inspector #625 reviewed the letter dated July 28, 2016, to "all staff" from the Administrator that read that the staff room door was to remain locked at all times as the outside door in the staff room was not locked and residents could elope through the door.

On July 29, 2016, at 1200, Inspector #625 exited the exterior door in the conference/staff room. The door led to an unmaintained outdoor area that had broken tree limbs and debris on the walking path. The area was enclosed by a fence of approximately three feet in height where, on the other side of the fence, there was a drop of several feet to the ground. An opened gate was present that could not lock or latch closed. [s. 9. (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 doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #5: 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 has failed to ensure that, where bed rails were used, the resident had been assessed and his or her bed system had been evaluated in accordance with evidence-based practice, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

During stage two observations, on a particular date during the inspection in July of 2016, Inspector #625 observed a bed rail in a specific resident room to be loose and move ten centimeters when the rail was in use. On the same date, the Inspector observed a bed rail in a specific resident room to be loose and defective when in use, as it did not remain level if grasped and raised from any location other than the middle.

A review of the home's policy "Bed Entrapment Prevention Program - ADM 470" last

revised May 2014, indicated that the Environmental Services department was to maintain competency in the use of the Dimensional Test Methods and tools for bed systems, assess bed systems on admission and readmission of a resident, following a change in components of a bed system, when there was reason to believe that some components were worn (rails wobble), and when accessories such as therapeutic surfaces were added.

During an interview with Inspector #625 on a particular date during the inspection in July of 2016, the Administrator stated that the bed systems had last been evaluated in April of 2015. Since that time, the Administrator identified that four residents had received new bed systems, one resident had received a therapeutic mattress, and one resident had been recently admitted into the home, and that none of the bed systems had been evaluated. The Administrator confirmed that the Environmental Services department had not assessed the bed systems as required. [s. 15. (1) (a)]

2. The licensee has failed to ensure that, where bed rails were used, other safety issues related to the use of bed rails were addressed, including height and latch reliability.

During stage two observations, on a particular date during the inspection in July of 2016, Inspector #625 observed the a bed rail in a specific resident room to be loose and move ten centimeters from side to side when in use, and a bed rail in a specific resident room to be loose causing the rail to no longer be parallel to the bed system when being raised or lowered.

A review of "Bed Rail Assessment Sheets - NUR 145" for residents #002 and #004, identified that these residents, who resided in the previously identified specific resident rooms, used the bed rails when in bed.

During an interview with Inspector #625 on a particular date during the inspection in July of 2016, PSW #105 stated that they had noted the bed rail to be loose and malfunction when being raised and lowered two weeks prior, and had noted the concern on a "Maintenance Communication/Work Order Sheet".

A review of the home's "Maintenance Communication/Work Order Sheet" dated June of 2016, identified an entry dated June 13, 2016, that identified that maintenance was required to check the left bed rail in one of the specific resident rooms. The entry had not been signed to indicate that the rail had been evaluated or that any maintenance had been performed on the bed rail.

A review of the home's policy "Bed Entrapment Prevention Program - ADM 470" last revised May 2014, identified that the Environmental Services department was required to assess the bed system when there was reason to believe that some components were worn, including wobbling rails and damaged rails.

During an interview with Inspector #625 on a particular date during the inspection in July of 2016, the Administrator attended the two specific resident rooms with Inspector #625 and confirmed that both identified bed rails were loose and required maintenance, that the loose bed rail in one specific resident room had been noted on the "Maintenance Communication/Work Order Sheet" on June 13, 2016, and that no corrective maintenance had been completed on the bed rail. [s. 15. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, where bed rails were used, 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; and that other safety issues related to the use of bed rails were addressed, including height and latch reliability, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the initial tour of the home and stage one inspection observations, the home and furnishings were observed to be in a poor state of repair.

On July 18, 2016, Inspectors #616 and #625 entered the home and observed bricks falling from one of the posts at the front of the home and a crack in the concrete of the wheelchair ramp leading to the main entrance of the home. The crack was approximately one meter in length by ten centimeters in width by five centimeters in depth. Rocks and pebbles were loose in the concrete and were falling out of the crack.

On July 18, 2016, Inspector #616 observed the baseboard closest to the home's main entrance door to be falling off of the wall and gouges in the drywall outside of the main office. On July 20, 2016, Inspector #616 observed wooden trim broken off of the wall by the bed in room A6, wooden trim not fixed to the wall and broken in places behind the headboard in room B1, flooring lifting around the toilet in the washroom of room B1, and damage to drywall behind a reclining chair in room A7. On July 21, 2016, Inspector #616 observed corner drywall near the closet in room B5 to be damaged, and trim behind the head board in room B5 to be damaged with splintered wood.

On July 20, 2016, Inspector #625 observed three areas of paint peeled from the wall above the bed in room C4, wood trim on the wall behind the nightstand in room B10 to be splintered and missing the top of the trim for approximately 45 centimeters, the wall in room B7 to have gouges approximately ten centimeters by 20 centimeters exposing the drywall, and chipped off paint on the wall beside the bedroom door of room B7.

During an interview with Inspector #625 on July 26, 2016, resident #017, who ambulated outdoors with an assistive device, stated that the crack in the concrete ramp was a safety risk to residents.

During an interview with Inspector #625 on July 26, 2016, the Administrator accompanied the Inspector to specific areas of the home observed to be in disrepair by Inspectors #616 and #625. The Administrator acknowledged that peeling baseboards, gouged drywall, lifting flooring, falling bricks and cracked concrete were present and required repair. [s. 15. (2) (c)]

2. During stage one inspection resident observations, bed systems were observed to be in an unsafe condition and a poor state of repair.

On July 25, 2016, Inspector #625 observed the bed systems in one specific resident room to have a gap of greater than 12 centimeters between the end of the mattress and the headboard, and the bed system in another specific resident room to have a gap of greater than 12 centimeters between the end of the mattress and the foot board.

A review of the home's policy "Bed Entrapment Prevention Program - ADM 470" last revised May 2014, indicated that the zone of entrapment between the mattress end and the head or foot board presented a risk of head entrapment and recommended a dimension of less than 12 centimeters.

A review of the "Publication of Final Guidance Document - Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" dated March 17, 2008, by Health Canada identifies using a head breadth dimension of 120 mm (12 cm) as the basis for its dimensional limit recommendations.

During an interview with Inspector #625 on July 25, 2016, the Administrator attended the two specific resident rooms with the Inspector and acknowledged that the zones of entrapment between the mattress edge and the head and/or foot boards in these rooms exceeded 12 centimeters. The Administrator acknowledged that the mattress keepers had been installed incorrectly, and were not holding the mattress in place as the space between the mattress keepers was greater than the length of the mattresses. During a second interview on July 26, 2016, the Administrator stated that the bed systems had been assessed and it was identified that the beds had been incorrectly assembled so that the bed frames were longer than the mattress length of the bed system. [s. 15. (2) (c)]

3. During completion of stage one resident observations on two particular dates during the inspection in July of 2016, Inspector #625 observed resident #007 laying in bed. The resident was observed to be in an unsafe position. The Inspector noted a piece of falls prevention equipment was not lit to indicate that it was on and functioning.

During interviews with PSWs #107 and #112 about the Inspector's observations of resident #007, the PSWs assessed the falls prevention equipment and determined that it was not functioning properly, did not stay turned on and required replacement.

Inspector #625 reviewed resident #007's current relevant care plan last updated on a particular date in the spring of 2016, that listed that the resident was to have the falls prevention equipment on at all times. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by

resident, staff and visitors at all times.

During stage one resident observations, Inspectors #616 and #625 observed call bells that could not be easily seen, accessed or used by residents, staff and visitors at all times.

On a particular date during the inspection in July of 2016, Inspector #616 observed the call bells not to work when pushed in rooms A1 and A4. Inspector #616 notified RN #104 of the broken call bells at the time of the observations. The Inspector also observed the call bell in room B2 to be on the floor under the head of the bed, and not to function until the cord was pulled from the wall.

On a particular date during the inspection in July of 2016, Inspector #625 observed the bedside call bell in room B7 to not light up outside of the room identifying where the call bell was being sounded from. Inspector #625 notified PSW #105 who stated they would notify maintenance of the broken light at the time of the observation.

On a particular date during the inspection in July of 2016, Inspector #625 observed the call bell in room B11 to be clipped to the top of the bed where resident #007 could not reach it. PSWs #107 stated that the resident did not use the call bell but that the resident’s care plan did not indicate that there was a reason why the call bell should be kept out of the resident’s reach.

On a particular date during the inspection in July of 2016, Inspector #625 observed that the call bells in rooms A1, A4 and B7 continued to be broken as previously identified by the Inspectors to the home's staff on July 20, 2016.

On July 26, 2016, Inspector #625 reviewed the maintenance book and found no entries related to non-functioning call bells listed.

On July 26, 2016, Inspector #625 reviewed the home’s "Preventative Maintenance Service Card" that listed maintenance completed from 2009 to present. Testing for nurse call bells/systems was listed and included the checking of cords, outlets, lights in hallways and panels, and that alarms were working. The frequency was listed as monthly but only one entry, dated May 28, 2016, was listed that indicated the preventative maintenance had been completed.

Inspector #625 conducted an interview with the Administrator who attended room A1 and

A4 and confirmed that the call bells were not sounding at the bedsides. The Administrator stated that the cords required replacement and the home was waiting for Maintenance to find replacement cords for the beds. The Administrator also attended room B7 with the Inspector, confirmed that the light outside of the resident's room did not light up when the call bell was on, and acknowledged that it was a safety concern as staff standing directly outside of the room would not know that help was being requested from that room unless they left the area to read the location at the nursing station. [s. 17. (1) (a)]

2. During completion of stage one resident observations on two particular dates in July of 2016, Inspector #625 observed resident #007 laying in bed. The resident was observed to be unsafely positioned. The Inspector noted that the resident's call bell was clipped to the top of the bed where the resident could not reach it.

During interviews with PSWs #107 and #112 about the Inspector's observations of resident #007, the PSWs stated that the resident's care plan did not identify that the call bell should be kept out of the resident's reach, and that the resident's call bell should not be out of their reach.

Inspector #625 reviewed resident #007's current relevant care plan in place last updated on a particular date in the spring of 2016, that identified resident #007 was to have their call bell kept within their reach at all times. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

During the initial tour of the home on July 18, 2016, Inspector #616 observed the following personal care items used, and unlabelled in the tub room:
- one Degree stick antiperspirant;
- three Arrid stick antiperspirant;
- four jars of Infazinc ointment;
- two paddle hairbrushes with hair in the bristles; and
- one small black comb.

The Inspector observed a posted sign on wall above where the personal care items were observed which stated: "No personal care products powders, creams, combs, brushes, personal razors, and deodorants are NOT to be shared between residents. No personal products are to be kept in the tub room. All personal products must be returned to the residents rooms after use. This is an infection control issue and must be followed".

On July 21, 2016, the Inspector noted the same personal care products previously observed three days earlier, with the addition of:
- one Speedstick antiperspirant; and
- two hair clips on the paper towel dispenser.

During an interview with the Inspector on July 21, 2016, PSW #107 verified the personal products and items, including hair brushes, should not have been left in the tub room. The PSW stated items were to be brought in the tub room with the resident and removed when care was completed. They then disposed of the personal care items, and identified

the two hair clips belonged to a resident but stated they should have either been labelled or brought back to their room, not left in the tub room.

The Inspector reviewed the home's policy titled "Admission To A Unit - NUR 010" last revised in February of 2010, which stated that residents were provided with supplies for personal hygiene and comfort. The policy did not reference the labeling of personal items.

During an interview with the Inspector on July 21, 2016, the Administrator verified that the home's current policy did not direct staff to label personal products or items, but stated that their practice and expectation was that residents' personal items would be brought with them during care, and removed when finished. They stated that labeling of personal items and products with the resident's name should have been done but was not. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

During stage one of the inspection, resident #010 was identified to have had a worsening impairment in skin integrity between two particular dates in December of 2015 and June of 2016.

During an interview with Inspector #616 on a particular date during the inspection in July of 2016, RPN #119 stated to the Inspector that resident #010 did not currently have any specific impairments in skin integrity, but had a previous skin integrity impairment to a specific location on their body that staff continued to monitor.

The Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment dated a particular date in March of 2016, identified that this resident had a specific impairment in skin integrity.

To determine the date the specific impairment in skin integrity was first discovered, Inspector #616 reviewed resident #010's progress notes related to skin and wound care.

The first reference to the skin integrity impairment was on a specific date in the winter of 2016, where a specific impairment to the resident's skin integrity on a specific location on the resident's body was identified, and an unidentified substance had been applied. Throughout two consecutive months in 2016, there were multiple progress notes related to the skin integrity with a range of documented severities of skin integrity impairments. None of the reviewed progress notes identified any skin and wound assessment(s) that included a specific clinical criteria for assessing the impairment in skin integrity.

The home’s policy titled “Skin and Wound Care Program - NUR 035" last revised August of 2012, directed that upon discovery of a specific alteration in skin integrity, registered staff would initiate a baseline assessment using a clinically appropriate assessment instrument.

During an interview with the RAI Coordinator and the Administrator on a particular date during the inspection in July of 2016, they verified to the Inspector that the "Healing Chart" for the specific alteration in skin integrity was the clinical tool utilized for specific skin integrity impairment assessments. They both stated that this assessment tool should have been initiated on discovery of the impairment in skin integrity, but was not. [s. 50. (2) (b) (i)]

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

Resident #008 was identified through a staff interview during stage one of the inspection to have had two separate impairments in skin integrity on two specific locations of their body.

Inspector #616 reviewed the home’s policy titled “Skin and Wound Care Program - NUR 035" last revised August of 2012, which indicated that upon discovery of a specific alteration in skin integrity, registered staff were to initiate a baseline assessment using a clinically appropriate assessment instrument, identify the severity of the impairment using specific guidelines, ensure the plan of care was established outlining interventions and treatments, reassess the resident weekly if indicated and revise the care plan accordingly.

The Inspector reviewed resident #008’s plan of care with a focus on skin and wound assessments, care plans, treatment orders and records.

Two "Healing Charts" for the specific alteration in skin integrity were reviewed, one dated a particular date in the winter of 2016, that identified an impairment of skin integrity on a specific location on resident #008's body, and another dated a particular date in the winter of 2016, that identified a second impairment of skin integrity on a second specific location on resident #008's body. The directions on the form indicated that staff were to observe and measure the impaired skin integrity at regular intervals, weekly, using a specific tool. For this area of altered skin integrity, the observations and measurements were documented which included 5 clinical criteria resulting in an overall total score.

The Inspector reviewed the wound assessment dates from discovery of one area of skin impairment on a particular date in the winter of 2016, to the last documented assessment of the area on a particular date in the summer of 2016. Within this time period, the Inspector noted that of the 22 weekly assessments required, 12 weekly assessments, or 55 per cent, had not been documented as completed. On further review, the documentation indicated that this wound had worsened throughout this period as indicated by the assessment scores. There was no documented reference to a specific, relevant criteria of the skin integrity impairment identified on this tool.

The wound assessment dates were also reviewed for the second area of skin impairment from the date of discovery on a particular date in the winter of 2016, to a particular date in the summer of 2016. Within this time period, the Inspector noted that of the 28 weekly assessments required, 17 assessments, or 61 per cent, had not been documented as completed. On further review, the documentation indicated that this impairment to skin integrity had worsened throughout this period as indicated by the assessment scores. There was no documented reference to a specific, relevant criteria of the skin integrity impairment identified on this tool.

The resident's relevant care plan dated a particular date in the spring of 2016, identified a specific impairment to skin integrity on a specific location on resident #008's body with a corresponding intervention for skin assessments related to their potential for particular skin integrity impairments, weekly.

During an interview with the RAI Coodinator and Administrator on a particular date during the inspection in July of 2016, both confirmed to the Inspector that the "Healing Chart" for the specific alteration in skin integrity was the assessment tool where registered staff documented weekly wound assessments.

During an interview with the Inspector on a particular date during the inspection in July of 2016, RPN #120 reviewed the resident's "Healing Charts" for the two areas of impaired skin integrity on two specific locations of the resident's body. They stated to the Inspector that assessments were completed weekly by registered staff on the "Healing Chart" for the specific alteration in skin integrity. They also verified that the required assessments had not been completed weekly on these forms since monitoring was initiated for each area in two particular months in the winter of 2016, and both areas had progressively worsened before beginning to heal. [s. 50. (2) (b) (iv)]

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 resident 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; and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' Council and the Family Council, if any, was sought in developing and carrying out the survey, and in acting on its results.

During Inspector #616's interview with resident #023 (a participant of the Residents' Council) on a particular date during the inspection in July of 2016, they stated that they did not know if the home sought the advice of the Residents' Council related to the development and carrying out the satisfaction survey, and in acting on its results.

The Inspector interviewed the Administrator on the telephone on August 10, 2016. They stated the home had previously used a generic survey, not specifically designed for or by Northwood Lodge residents. They verified the advice from Residents' Council had not been sought in the development and implementation of the satisfaction survey. [s. 85. (3)]

2. The licensee has failed to ensure that the results of the home's satisfaction survey

were documented and made available to the Residents' Council, to seek their advice under subsection (3).

During Inspector #616's interview with resident #023 (a participant of the Residents' Council) on a particular date during the inspection in July of 2016, they stated that they did not know about results of a satisfaction survey.

The Inspector interviewed the Administrator on the telephone on August 10, 2016. They stated the home currently had not documented and made available to the Residents' Council the results of the satisfaction survey for advice about the survey. [s. 85. (4) (a)]

3. The licensee has failed to ensure that the results of the home's satisfaction survey were documented and made available to the Family Council, to seek their advice under subsection (3).

During an interview with Inspector #625 on a particular date during the inspection in July of 2016, when asked about the home's satisfaction survey, Family Council member #116 stated that they were not aware of the home contacting the Family Council with respect to the satisfaction survey or its results.

During an interview with Inspector #625 on a particular date during the inspection in July of 2016, the Administrator stated that one or two satisfaction surveys had been returned to an associated long-term care home for the 2015 year. The Administrator consulted with that home, and then stated that the response from any returned surveys in 2015 could not be shared with the Family Council, as the home did not know where the response from the survey was, or what the results were. [s. 85. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the advice of the Residents' Council and the Family Council, if any, is sought in developing and carrying out the survey, and in acting on its results; and that the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3), to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for cleaning and disinfection of the following in accordance with manufacturer's specifications and used, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs;
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids; and

(iii) contact surfaces.

During stage one resident observations, and during tours of the home, Inspectors #616 and #625 observed a failure to implemented procedures that were developed related to disinfection in accordance with manufacturer's specifications.

On July 20, 2016 at 1145 hours, Inspector #616 noted feces on a raised toilet seat in the washroom of a specific resident room.

On July 21 and 26, 2016, Inspector #625 noted black soiled markings on the hallway door leading into a specific resident room and on the washroom door of another specific resident room.

On July 26, 2016 at 1203 hours, Inspector #625 noted feces on the commode in the washroom of a specific resident room.

During an interview with Inspector #625 on a particular date during the inspection in July of 2016, PSWs #108 and #109 stated that the feces had been in place on the commode in the washroom of the particular resident room since approximately 0720 hours, and that they did not have access to specific cleaning supplies used to clean the commode. The PSWs stated that they could use a paper towel and periwash to clean the feces at the time that it occurred, or tell the Housekeeping Aide that it required cleaning. The PSWs stated that the Housekeeping Aide had not been informed of the feces on the commode, and may not have checked the toilet in that room as the toilet was not always used. PSW #108 stated that the black stains on the doors of a particular resident room were from specific activities the resident engaged in, and were transferred to the doors when the resident opened and closed them.

During an interview with Inspector #625 on a particular date during the inspection in July of 2016, Housekeeping Aide #106 identified that the home used Enviro Solutions 64, a disinfectant cleaner, to wash resident contact surfaces, floors and washrooms. The Housekeeping Aide showed the Inspector the concentrated container of solution which was empty and did not have any solution in the tubing leading to the dispenser. The Housekeeping Aide stated that they were not aware of the how the ratio of disinfecting solution to water measured by the dispenser would be impacted by having an empty container of disinfecting solution attached to the dispenser.

A review of the policy "Housekeeping - Daily Routine" revised December 2014, by

Inspector #625, identified that spot washing, wiping obvious marks from walls and dusting as necessary was to occur daily in resident rooms, that cleaning the toilet inside and out was to be done daily in personal washrooms, that all bottles were to be properly filled in general areas, and that dusting of all surfaces in resident rooms was to occur weekly.

A review of the housekeeping routine schedule by Inspector #625 for July of 2016, identified that a particular resident room had received weekly cleaning on two specific dates in July of 2016, and had received monthly cleaning on one specific date in July of 2016.

During an interview with Inspector #625 on a particular date during the inspection in July of 2016, the Administrator attended a particular resident room with Inspector #625 and observed the feces on the commode. They stated that staff had access to appropriate disinfecting wipes and cleaning solutions and that the feces should have been cleaned immediately when noticed by staff. The Administrator attended another particular resident room with Inspector #625 and observed the doors to the room and washroom soiled with a black film in some areas. The Administrator was able to remove some of the debris with a wet cloth and confirmed that the doors should have been cleaned as per the duties listed in the "Housekeeping - Daily Routine" policy and as was signed off by housekeeping staff in the the weekly cleaning schedule on two specific date in July of 2016, and on the monthly cleaning schedule on one specific date in July of 2016. The Administrator also acknowledged that the Enviro Solutions 64 disinfectant cleaner container should have been replaced by the Housekeeping Aide prior to the low level of disinfectant in the container impacting the dilution ratio of the cleaning solution dispensed. [s. 87. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs;

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids; and
(iii) contact surfaces, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

A Critical Incident System (CIS) report was submitted for an incident that occurred on a particular date during the fall of 2015, where resident #003 had an unsafe interaction with a specfic substance used by the home's staff to address environmental conditions. The report stated that the locks to the Dirty Utility Room door and closet had not been locked at that time.

During an interview with the Administrator about the incident, they stated that resident #003 had a condition that made them vulnerable to inadvertently having an unsafe interaction with the substance, that staff had left the container of the substance in the

resident's room in a location where the resident could have mistaken it for a safe item kept in that location, and that the resident unsafely interacted with the substance thinking it was their safe item.

On a particular date during the inspection in July of 2016, Inspector #625 observed a container of a substance beside resident #007's bed. RN #104 removed the container and stated that it should not have been left at the bedside where it was accessible to residents.

On a particular date during the inspection in July of 2016, Inspector #625 observed a housekeeping cart unattended for five minutes with a chemical solution in the mop bucket and a container on top of the cart. Housekeeper #106 stated that Enviro Solutions 64 Neutral Disinfectant was in both the container and the bucket, and that the cupboard containing chemicals on the housekeeping cart did not lock. Inspector viewed the Enviro Solutions 64 Neutral Disinfectant concentrated source container that had a Workplace Hazardous Materials Information System (WHMIS) symbol identifying the cleaner as corrosive.

On a particular date during the inspection in July of 2016, Inspector #625 observed the Housekeeping room door not fully closed and unlocked. Two concentrated bottles of disinfectants (including Enviro Solutions 64 Neutral Disinfectant) were present, open and hooked up to dispensing machine. PSW #109 stated that the door should have been kept closed.

On a particular date during the inspection in July of 2016, Inspector #625 observed a mop and bucket full of a chemical cleaning solution extending into the hallway where resident #003 used the railing to get to and from their room. Housekeeping Aide #110 stated that resident #003 used the railing and that the mop bucket was not usually left in the hallway.

On a particular date during the inspection in July of 2016, Inspector #625 observed a mop and bucket full of a chemical cleaning solution in the hallway in a location that would be an obstacle for resident #003, who had a characteristic that made them vulnerable. The cart was not visible to Housekeeping Aide #106, who stated that they knew of resident #003's past unsafe interaction with a substance and pulled the bucket into the room they were cleaning. [s. 91.]

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 ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During stage one resident observations, and during tours of the home, Inspector #625 observed the home's staff failing to participate in the implementation of the infection prevention and control program.

On a particular date during the inspection in July of 2016, Inspector #625 observed face and wash clothes hanging on the railings outside of three specific resident rooms and hanging on the window boxes of two specific resident rooms. During an interview with Inspector #625 about this practice, the DOC stated that staff hung the clothes outside of the residents' rooms in this manner to save time, but acknowledged that using the clothes to wash residents would not be in line with expected infection prevention and control practices.

On a particular date during the inspection in July of 2016, Inspector #625 observed a white bucket upside down on a toilet seat in a shared washroom for two particular resident rooms. During an interview with Inspector #625 about this observation, PSWs #108 and #112 stated that the bucket was used collect a specific body fluid from the resident in a particular resident room, and that the resident in another particular resident room used the toilet in the shared washroom. The PSWs acknowledged that the storage of the bucket on top of the toilet seat in this manner was not appropriate.

On a particular date during the inspection in July of 2016, Inspector #625 observed Housekeeping Aide #106 folding clean rags on the nursing station desk with an open interdepartmental binder in contact with the clothes and the hamper that held them. During an interview with Inspector #625 about this observation, the Housekeeping Aide stated that the rags they were folding were used to wash toilets in the home and that they would disinfect the counter when they were done. During an interview with Inspector #625 about this practice, the Administrator stated that the rags were not to be folded on the nursing station desk and acknowledged a potential infection control concern with the observed practice. [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 #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following were satisfied: a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

Resident #010 was identified during stage one of the inspection for use of bed rails as potential restraints.

On a particular date during the inspection in July of 2016, Inspector #616 observed the resident laying in bed with bed rails in use.

The Inspector reviewed the resident's plan of care related to the use of bed rails. Their

current care plan did not include any information related to the use of bed rails. A Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment dated a specific date in the winter of 2016, indicated, under Section P: Restraints, that bed rails were used daily.

During interviews with PSW #112, PSW #109, and RPN #103 on a particular date during the inspection in July of 2016, the PSWs stated to the Inspector that the bed rails were used to keep the resident in their bed. The RPN stated that bed rails were used as a safety measure. They also stated that beyond the nightly checks by staff, there was no specific monitoring or documentation related to the use of the bed rails.

The home's policy titled "Minimizing Restraint - PASD Use - NUR 400" last revised in November of 2015, identified that a resident may be restrained by a physical device if the restraining of the resident was included in the residents' plan of care. The policy included that a physician or a registered nurse in the extended class must have ordered or approved the restraint.

The Inspector reviewed the resident's health chart for a physician's order directing use of the restraint, but found none.

During an interview with the Inspector on a particular date during the inspection in July of 2016, the Administrator stated that they expected to see the bed rails included in the resident's current care plan, but verified that it was not found. They added that as the bed rails prevented the resident from getting out of bed, they functioned as a restraint and as such required a physician's order, which had not been obtained. [s. 31. (2) 4.]

2. The licensee has failed to ensure that the restraining of a resident by a physical device was included in a resident's plan of care only if all of the following were satisfied: the restraining of the resident had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #010 was identified during stage one of the inspection for use of bed rails as potential restraints.

On a particular date during the inspection in July of 2016, Inspector #616 observed the resident laying in bed with bed rails in use.

Inspector #616 reviewed a RAI MDS assessment dated a specific date in the winter of

2016, which indicated, under Section P: Restraints, that bed rails were used daily.

The home's policy titled "Minimizing Restraint - PASD Use - NUR 400" last revised in November of 2015, identified that a resident may be restrained by a physical device if the restraining of the resident was included in the residents' plan of care. The policy identified that consent for the restraint was required by the resident or, if the resident was incapable, the substitute decision-maker of the resident with authority to give the consent.

During Inspector #616's interviews with PSW #112, PSW #109, RPN #103 and the Administrator on a particular date during the inspection in July of 2016, they stated that resident #010's bed rails prevented them from getting out of bed and functioned as a restraint.

This same day, the Inspector and the Administrator reviewed the resident's health chart for a consent obtained for the use of the bed rails as a restraint. No record of the consent was found. The Administrator stated to the Inspector that a consent should have been obtained for the use of bed rails as a restraint. [s. 31. (2) 5.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following was developed to meet the needs of residents with responsive behaviours: written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

During stage one resident observations, on a particular date during the inspection in July of 2016, Inspectors #625 and #616 observed resident #018 with a visitor in the main corridor of the home. Specific parts of the resident's body were exposed.

At this time, Inspector #616 interviewed RN #104 who stated that the resident was known to exhibit responsive behaviours related to their attire and had been covered by staff four times since breakfast on this day.

The Inspector reviewed progress notes from a specific date in the spring of 2016 to a specific date in the summer of 2016, with a focus on behaviours. On two specific dates in the spring and summer of 2016, it was documented that resident #018 had exhibited particular responsive behaviours related to their attire and an item that covered them, was easily redirected, and on a specific date in the spring of 2016, it was documented they exhibited particular responsive behaviours related to their attire.

During the Inspector's interview with resident #023 on a particular date during the inspection in July of 2016, they reported resident #018's behaviour was offensive. They stated there have been many instances when they have been in the presence of this resident who was not dressed appropriately and would exhibit behaviours that resident #023 witnessed. They further stated they had just received information that staff would cover this resident with an item when they exhibited responsive behaviours related to their attire.

The Inspector reviewed a memo to all staff from the Director of Care (DOC) dated a specific date in July of 2016, separate from the resident's health record, which directed staff to dress the resident in specific clothing and provided permission to modify the resident's clothing, if effective. The memo also encouraged any attempt to find a solution to ensure the resident was dressed appropriately.

A review of the home's policy titled "Responsive Behaviour Program - NUR 445" last

revised on January of 2013, defined responsive behaviours as actions that may include a resident exhibiting one or more of physically non-aggressive or protective behaviours and provided examples including the responsive behaviour exhibited by resident #018, as well as socially inappropriate or disruptive actions. The policy also indicated that to minimize triggers or respond effectively for specific residents, the causes and triggers for responsive behaviours and the development of strategies and interventions must be identified.

In an additional interview with RN #104, on a particular date during the inspection in July of 2016, they stated to the Inspector that this resident preferred to be dressed in a specific manner, and had modified their own clothing for physical comfort. They added that this was not a new behaviour, as demonstrated fora specific period of time, and was aware that co-residents found this behaviour offensive. The RN reported an effective strategy by staff was dressing the resident in a specific piece of clothing, or covering them with an item. They further stated they were unsure if this information was in the resident's care plan, but should have been.

A review of the resident's relevant care plan last updated a specific date in the spring of 2016, did not identify any indication of the resident's known responsive behaviour related to their attire.

During an interview with the RAI Coordinator and the Administrator on a particular date during the inspection in July of 2016, they verified resident #018's current care plan did not include identification of this responsive behaviour, triggers, nor interventions to manage the behaviours and should have. [s. 53. (1) 1.]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure a written response was provided to concerns or recommendations received from the Residents' Council within 10 days.

Inspector #616 interviewed resident #023 (a participant of the Residents' Council) on a particular date during the inspection in July of 2016, regarding Residents' Council. During the interview, they stated a concern had been voiced at the council meeting about a month prior, related to a resident who was not dressed appropriately in the common area. They stated at the most recent council meeting they were provided with information on how staff would respond to this resident.

The Inspector reviewed minutes from the meeting held on a specific date in the summer of 2016. The Activation Coordinator #121 had recorded that the residents were upset about the resident sitting in the common area dressed inappropriately. They also had indicated they would follow up with the Administrator for a solution. A memo to the Residents' Council from the Administrator dated July 19, 2016, referred to the council meeting from the specific date in the summer of 2016. In the written response, the Administrator addressed the concerns related to residents who was dressed inappropriately, and advised of the action to be taken by staff in these situations.

In an interview with the Administrator on July 29, 2016, they confirmed to the Inspector that a written response from the home had not been provided to the Residents' Council within 10 days. [s. 57. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle was reviewed by the Residents' Council for the home.

During an interview with resident #023 (a participant of the Residents' Council) on a particular date in July of 2016, they stated to Inspector #616 that they had not reviewed the home's menu cycle.

On August 10, 2016, during a telephone interview, the Administrator stated to the Inspector that the Residents' Council had not reviewed the home's menu cycle. [s. 71. (1) (f)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included a review of the meal and snack times by the Residents' Council.

During an interview with resident #023 (a participant of the Residents' Council) on a particular date during the inspection in July of 2016, they stated to Inspector #616 that they were unable to confirm whether the Residents' Council reviewed meal and snack times.

In the Inspector's telephone interview with the Administrator on August 10, 2016, they stated to the Inspector that they were unable to provide verification that the dining and snack service included Residents' Council review of dining and snack times. [s. 73. (1) 2.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

During stage one of the inspection, on a particular date in July of 2016, Inspector #616 observed the toilet in the washroom of room B1 to be leaking onto the floor, lifting the flooring in that area, and the toilet in room B6 to be missing a toilet seat.

During stage one of the inspection, on July 21, 2016, Inspector #625 observed cracks in the washroom sinks in rooms C1 and C5, and damage to the flooring behind the toilet in the washroom of room C9 where the flooring appeared to be separating and lifting.

During an interview with Inspector #625 on July 26, 2016, PSW #108 stated that the flooring behind the toilet in the washroom of room C9 appeared rotted and needed to be replaced. The PSW stated that they believed the damage to have been caused by the toilet leaking or overflowing, and that it likely occurred one to two years prior.

During an interview with Inspector #625 on July 26, 2016, the Administrator also stated that there appeared to be toilet water damage to the flooring behind the toilet of the washroom for room C9, and confirmed that the damage had been present over one year prior. The Administrator confirmed that repair to the floor behind the toilet should have been identified and completed earlier. The Administrator stated that the home would be implementing a "General Maintenance Room Audit" which included auditing of the resident washrooms for the condition of toilet, sink, faucet, counter top, grab bar and washroom accessories, but confirmed that the home had not been conducting routine audits of the condition of the resident washrooms, which resulted in damage and disrepair to the resident washrooms not being identified and corrected as required. [s. 90. (2) (d)]

WN #20: 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 has failed to ensure that drugs were stored in an area or a medication cart that complied with manufacturer's instructions for the storage of the drugs.

On July 28, 2016, Inspector #616 observed the home's medication supply within the medication room. The Inspector noted six bottles of a specific medication, with an expiry date of June of 2016.

During an interview with the Inspector on this same day, the Administrator stated the expired medication should have been removed for destruction. [s. 129. (1) (a)]

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

During stage one resident observations during the inspection, on a specific date in July of 2016, Inspector #625 observed a prescription topical medication, for resident #021 in the resident's bathroom.

A review of resident #021's Medication Administration Record (MAR) for July of 2016 identified that the prescription topical medication was to be applied a specific number of times per day.

During stage one resident observations during the inspection, on a specific date in July of 2016, Inspector #625 also observed prescription topical medication for resident #017, dated a specific date in winter of 2015, in the resident's bedroom.

A review of resident #017's MAR for July of 2016 identified that the prescription topical medication was not listed as a current prescription for the resident.

During an interview with RN #104, they stated that staff were to apply prescription topical medications when ordered and that resident #017 did not have a current physcian's order for the topical medication found at their bedside.

On July 28, 2016, the Administrator stated that the home's residents did not administer their own topical medications, that staff brought the topical medications to the residents and they were to be locked in the treatment cart until they were used. [s. 129. (1) (a) (ii)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #616 observed the medication administration for resident #005 by RPN #103 on a particular date during the inspection in July of 2016, at a specific time. The resident's Medication Administration Record (MAR) listed a specific medication to be administered at the time observed by the Inspector, with orders to take the medication at two different times of the day.

During an interview with the Inspector, the Administrator stated the administration time of the medication administration on the MAR and the administration time directed in the physician's order was inconsistent. They stated that it was the resident's preference to take this medication at the time observed by the Inspector.

The Inspector and the Administrator reviewed the resident's three month medication review dated a specific date in the summer of 2016, which indicated the same medication administration time inconsistency.

The Inspector reviewed a copy of the physician's order dated a specific date in the spring of 2014, which directed the medication to be taken in at two specific medication times, neither of which were the time the Inspector had observed the medication administered.

The home's policy "Medication Program - Structure - NUR 083" last revised in February of 2010, was reviewed by Inspector #625. The policy stated that specified medication times were 0800, 1200, 1700 and 2100 (or bedtime). The policy identified that the physician or pharmacist could specify alternate times, that all medication passes had a range for delivery of approximately 1 hour before and 1 hour after established times and

that nurses could not change pass times without a Physician/Pharmacist's Order.

The home's policy "Medication Program-Administration - NUR 070" last revised in February of 2010, was reviewed by the Inspectors #616 and #625. The policy stated the registrant was to ensure appropriate transcription of orders to the MAR, that changes in the time of administration were to be authorized only by the attending physician or pharmacist and that no registrant was to arbitrarily alter medication times without appropriate consultation and instruction.

The Administrator verified to Inspector #616 that this particular medication administration time on the MAR was not as per the physician's order. [s. 131. (2)]

Issued on this 30th day of December, 2016

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

Original report signed by the inspector.