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

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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
Mar 28, 2017	2017_584161_0004	000671-17	Resident Quality Inspection

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

PETER D. CLARK CENTRE
9 MERIDIAN PLACE OTTAWA ON K2G 6P8

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

KATHLEEN SMID (161), JOANNE HENRIE (550), MICHELLE JONES (655), RUZICA SUBOTIC-HOWELL (548), SUSAN LUI (178)

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): January 23 - January 27, January 30 - February 3, February 6 - 9, 2017.

During the course of the Resident Quality Inspection, the inspector(s) also conducted 14 concurrent inspections which included:

- One follow-up to a compliance order issued on August 4, 2016 related to plan of care of an identified resident log: #023868-16.

- Two critical incident inspections related to resident injuries: logs #018820-16, #026488-16.

- Four critical incident inspections related to resident falls: logs #016812-16, #019630-16, #021950-16, #032175-16.

- Seven critical incident inspections related to alleged resident abuse: logs #018067 -16, #030099-16, #033977-16, #000555-17, #001071-17, #001597-17, #002427-17.

During the course of the inspection, the inspector(s) conducted a tour of all resident care areas, observed residents' rooms and common areas, observed a medication pass as well as several drug storage areas, a meal service, infection control practices, staff to resident and resident to resident interactions and the delivery of resident care and services.

The inspector(s) reviewed residents' health care records, salient Licensee policies and procedures, posted menus, staff work routines, Resident's Council and Family Council minutes.

During the course of the inspection, the inspector(s) spoke with residents, family members, Administrative Assistant (AA), Activity Coordinator, Housekeeping Attendants, Presidents of the Resident Council and Family Council, Staffing Coordinator, Personal Support Workers (PSW), RAI-MDS Specialist, Facilities Supervisor, Registered Practical Nurses (RPN), Registered Nurses (RN), Manager of Hospitality Services, Program Manager of Personal Care, Manager of Recreation/Leisure/Volunteer Services, Program Manager of Resident Care and the home's Administrator.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **6 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. (10)	CO #001	2016_286547_0017	548

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

This non-compliance is related to log #001071-17, which was based on Critical Incident Report (CIR) which concerned a resident being transferred from wheelchair to bed without appropriate assistance.

Resident #052 was admitted to the home on an identified date in January 2017, is cognitively impaired and requires extensive assistance for activities of daily living.

The CIR submitted by the home on an identified date in January 2017, states that four days prior, PSW staff #157 transferred resident #052 from wheelchair to bed without the assistance of a mechanical lift or another person. The CIR indicates that resident #052 was previously assessed by physiotherapy as requiring a mechanical lift, and that the resident's care plan reflected this need.

During an interview with Inspector #178 on February 7, 2017, resident #052's family member and Substitute Decision Maker indicated that staff member #157 told him approximately one month ago, that she had transferred the resident alone, without the assistance of another person or a mechanical lift.

Review of resident #052's health record indicated that the resident had been assessed on the date of admission, to require transfer using a Maxi Lift with two staff members. The resident's 24 Hour Plan of Care Form indicated that the resident required extensive assistance, two plus persons and a Maxi-Lift for transfer.

The Resident Care Assignment form on resident #052's unit was reviewed by inspector #178. This form provides a brief summary of care requirements of the residents, including transfer assistance required. The form states that resident #052 requires Maxi Lift with two staff for transfers.

During an interview with Inspector #178 on February 8, 2017, PSW staff #157 indicated that on two identified dates in January 2017, she transferred resident #052 from chair to bed by herself, without the assistance of a mechanical lift or another person. Staff #157 indicated that the resident tolerated the transfer without incident or apparent discomfort. Staff #157 indicated that she was unfamiliar with the resident at the time, and that there was no logo posted in the resident's room to indicate what type of assistance the resident needed for transfers. Staff #157 indicated that a logo is normally hung above residents' beds to indicate the level of assistance they require for transfer. Staff #157 indicated that she now knows that resident #052 should have been transferred using the Maxi Lift with two staff, and that because the logo was not present in the resident's room on the two identified dates in January 2017, she should have spoken to the nurse to determine the level of assistance the resident needed. Staff #157 indicated that she could also have found this information on the resident's plan of care, or on a list of residents and their transfer needs, which is kept on the unit.

During observations of resident #052's room by inspector #178 on an identified date in February 2017, a logo indicating mechanical lift with two persons assist was observed above the resident's bed.

During an interview on February 8, 2017, the home's Manager of Resident Care indicated that after the home was made aware that resident #052 had been transferred by one staff member with no other assistance, the home investigated the incidents and concluded that PSW staff #157 had failed to follow proper procedure related to the use of lifts by failing to ensure she was using the correct method of transfer for the resident as indicated in resident #052's plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are transferred from wheelchair to bed as set out in their plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

The licensee has failed to ensure that written policies to promote zero tolerance of abuse and neglect of residents are complied with.

A Critical Incident Report (CIR) was submitted to the Director on an identified date in January 2017 for an incident observed by PSW #145 for alleged sexual abuse by a co-resident's son to resident #044 six days prior. The PSW #145 observed the son to be kissing resident #044, in the resident's room while the resident lay in bed. Resident #044 and the co-resident's son were observed alone in the resident's room at the time.

Resident #044's Cognitive Performance Scale as recorded in the Minimum Data Set on an identified date in December 2016 was assessed to be four and the resident #044 was assessed to be easily distracted, had periods of altered perception and the resident's mental function varied throughout the day.

On February 3, 2017 resident #044 recalled the incident and indicated to Inspector #548 that the kiss was deep and romantic. The resident further explained that there were other instances where the co-resident's son held her/his hand and they kissed. Resident #044 indicated that she/he was acquainted with his mother and he would visit with her/him when he came into visit his mother. The resident also indicated that she/he was not comfortable to tell him not to kiss her/him.

On February 3, 2017 during an interview, PSW #145 explained that although he observed the incident in the resident's room, he was not certain if the situation would be considered an alleged sexual abuse, but remained uncomfortable with what he had witnessed. The PSW#145 returned to work several days later on an identified date in January 2017 and reported the incident to the Manager, Personal Care. [s. 20. (1)]

2. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall:

(a) clearly set out what constitutes abuse in their policy titled ""Abuse - #750.65 revision/review date September 2016."

As per LTCHA, 2007 S.O. 2007, c.8, s.19 (1) every licensee of a long-term care home shall protect residents from abuse by anyone.

On February 3, 2016 the Inspector #548 asked the Program Manager of Resident Care for the licensee's written policy to promote zero tolerance of abuse and neglect of residents. The Program Manager of Resident Care provided Inspector #548 with the licensee's written policy titled "Abuse - #750.65, revision/review date September 2016."

Inspector #161 reviewed the licensee's written policy titled "Abuse - #750.65, revision/review date September 2016" that had been provided to Inspector #548 by the Program Manager of Resident Care on February 3, 2016. The licensee's written policy indicated that residents would not be subjected to any form of abuse from other residents, families, volunteers or employees. Inspector #161 noted that the policy did not

indicate that residents shall be protected from abuse by anyone.

(d) contain an explanation of the duty under section 24 of the Act to make mandatory reports.

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

Inspector #161 reviewed the licensee's written policy titled "Abuse - #750.65, revision/review date September 2016" that had been provided to Inspector #548 by the Program Manager of Resident Care on February 3, 2016. The licensee's written policy did not contain an explanation of the duty under section 24 of the Act to make mandatory reports. [s. 20. (2)]

3. The licensee failed to clearly set out what constitutes neglect in their policy titled Abuse, #750.65 last revision/review date September 2016."

As per O. Reg. 79/10, s. 5:" neglect" means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The licensee's written policy defines neglect as: "includes but is not limited to withholding food and/or health services; deliberately failing to meet a dependent resident's needs; shunning."

Inspector # 548 noted that the licensee's definition of neglect did not clearly set out the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes

the health, safety or well-being of one or more residents. In addition, the policy, does not discriminate between neglect and emotional abuse. The word "shunning" is used as an example for both. [s. 20. (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 the written polices to promote zero tolerance of abuse and neglect of residents are complied with; clearly set out what constitutes abuse and neglect; contain an explanation of the duty under section 24 of the Act to make mandatory reports, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the policy to minimize restraining of residents is complied with.

Pursuant to s. 109 (e) of Ontario Regulation 79/10, every licensee shall ensure that the home's written policy to minimize restraining deals with how consent to the use of PASDs is to be obtained and documented.

Inspector #655 reviewed the licensee's policy document titled "Least Restraint" (#335.10). In the policy document, two purposes for the use of restraining devices on residents of long-term care homes are identified, including the use of a restraining device

as a personal-assistance service device (PASD). In the subsection of the policy, titled "restraints definitions", PASD is included; and in step five under "procedure" it is indicated that consent for use of a restraining device must be both obtained and documented. The "Restraint Consent Form" document was attached to the policy (form #335. 10C- Consent Form).

On an identified date in January 2017, resident #026 was observed by Inspector #655 to be seated in a tilted wheelchair.

During an interview on the identified date in January 2017, resident #026 indicated to Inspector #655 that he/she spends the majority of the time tilted in his/her wheelchair for reasons of positioning and comfort. Resident #026 indicated that when the chair is tilted, it limits his/her movements and prevents him/her from rising from the chair.

During an interview on January 30, 2017, RPN #105 indicated to Inspector #655 that there was no documented consent for the use of the tilted wheelchair for resident #026. During the same interview, RPN #105 indicated that the tilt wheelchair could have the effect of limiting resident #026's movements.

During an interview on January 30, 2017, the Program Manager of Resident Care indicated to Inspector #655 that the tilt wheelchair used by resident #026 is considered a PASD. During interviews on February 6 and February 9, 2017, the Program Manager of Resident Care indicated that the "Restraint Consent Form" is to be completed when restraining devices are used. The Program Manager of Resident Care indicated to Inspector #655, however, that in this case, consent was not documented because resident #026 can verbally express him/herself.

On February 9, 2016, Inspector #161 reviewed the residents’ hard-copy health care record in the presence of RN #140, and was unable to locate any documented consent for the use of a PASD by resident #026.

The licensee has failed to ensure that the licensee's written policy to minimize restraining is complied with. [s. 29. (1) (b)]

2. As per LTCHA, S. O. 2007, s. 29. (1) (a), the licensee is required to have a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations and (b) ensure that the policy is complied with.

The licenses has failed to ensure that their policy to minimize the restraining of residents was complied with.

On two identified dates in January 2017, Inspector #550 observed resident #006 sitting in a wheelchair in the hallway in front of his/her bedroom. The resident had a tray table attached at the back and a front closure lap belt applied. The resident was not physically and cognitively capable of removing the tray table or the lap belt.

During an interview on January 27th, 2017, PSW #160 indicated to the inspector that the resident requires the lap belt to prevent the resident from falling and the tray table as he/she uses it to rest their arms on it. RN #113 indicated to the inspector during an interview on the same day that after the resident fractured his/her hip in 2015, the resident required to have a tray table in place to prevent the resident from getting up and falling but later they had to add a front closure seat belt because as the resident got better, he/he was sliding in the chair under the belt in an attempt to get up. Staff have tried removing the tray table and this increased the resident's agitation as he/she was trying to undo the lap belt constantly because he/she would see it, hence the reason for having both restraints applied at the same time. RN #113 indicated that today the resident has recuperated very well and will attempt to get up on his/her own as he/she forgets that he/she is no longer able to walk and will try to remove the lap belt.

The inspector reviewed resident #006's health care records. The resident's current plan of care on an identified date in January 2017 indicated:

Physical restraints
Use of front closure lap belt with table top tray applied, while up in w/c.
Unsteady gait, unable to ambulate safely on his/her own post right femur fracture in 2015.
Resident believes s he/he can walk unassisted and does not remember that she/he had a femoral fracture.
Has front closure lap belt and table top applied once in w/c.
Monitored for safety and comfort q1hr, while in w/c with restraint applied.
Reposition in w/c using tilt feature of w/c
Document monitoring and repositioning on flow sheets as per p & p.

The document titled ''Restraint Consent Form'' which is the document used to document consent for restraints as per RN#113 was also reviewed. This document was signed in

July 2015 by the resident’s daughter who is also his/her substitute decision maker (SDM), and it referred to the tray table attached at the back; it did not mention the lap belt restraint. RN #113 was unable to find any other signed consent for the lap belt restraint in the resident's healthcare records. The inspector reviewed the ‘’Restraint/PASD Monitoring Form’’ for January 2017 which is the document PSWs use to document the application and the removal of the restraint, the resident’s response to the restraining and the repositioning of the resident as per RN #113. The document indicated at the top left side of the page the following:

Restraint order: table top tray when up in broda.

There was no indication of the lap belt restraint. RN #113 reviewed the ‘’restraint/PASD Monitoring Forms’’ for the past months in the resident’s thinned chart folder and was unable to find any ‘’Restraint/PASD Monitoring Form’’ for the lap belt.

The inspector requested and reviewed the home’s restraint policy. The Program Manager of Resident Care provided a document titled ‘’Least Restraint’’, P & P No: 335.10, with a revision date of January 2017, which she identified as the home’s most current policy. On Page 4 of 7, under procedures, it was documented:

5. Obtain and document consent or refusal on consent form.
13. Every release of the device and all repositioning will be recorded on the restraint/PASD flow sheet.
14. Document all assessments, reassessment and monitoring including the resident's response, as well as the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining.

The licensee did not ensure that their ‘’Least Restraint’’ policy was complied with for resident #006. [s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any restraining that is necessary is done in accordance with this Act and the regulations and ensure that the home's policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

The licensee has failed to ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of the residents.

This is specifically related to the availability of pagers for nursing staff, which are connected to the resident-staff communication and response system, and which directly notifies nursing staff when a call for assistance has been made.

On January 25, 2017, while doing resident room observation for room #111 on bungalow 1 which is a secured unit, Inspector #550 activated the call bell in the room. The light at the bedroom door was activated but the inspector heard no sound. A PSW in an adjacent room indicated to the inspector that the home uses a pager system and that she did not carry a pager as she was working the short shift adding that the PSW working the short shift does not have a pager. Inspector #550 proceeded to the dining room to find a PSW who had a pager and verify its functionality. PSW #159 gave her pager to the inspector. The inspector observed that there was nothing displayed on the PSW's pager although the call bell had not been cancelled. PSW # 159 indicated that she felt her pager vibrate when it was in her pocket but she did not cancel the call or look at which room number was displayed on the pager as she was busy feeding a resident. She added not knowing if there would be a reminder from the pager informing PSWs that the call was not answered until it was cancelled by someone. PSW #159 then activated the emergency

call bell in the dining room and inspector observed that the pager vibrated and that the call was displayed on her pager. After a few moments, the screen on the pager went blank although no one had cancelled the call bell. Inspector asked the PSW how she would know if the call was answered or not and the PSW indicated she was not sure. By this time, a male PSW and a female PSW came from other bungalows to inquire about the call on the pager.

Further verification was done of this specific pager with the assistance of Inspector #548 in the presence of RN #113 and PSW#114. Inspector #548 activated the call bell in room 112. Inspector #550 observed that the pager was activated as it beeped but nothing was displayed on the screen. Inspector #548 then activated the call bell in room #106 and the pager was activated and displayed the room number on the pager. Inspector #548 activated the call bell in room #104, the beeper did not beep and there was nothing displayed on the pager's screen. It was also observed that PSW#114's pager was functioning properly during this verification. Throughout the verification of the pager, it was observed that after a call bell is activated, pagers will beep and display the room number. After a few moments, the pager screen will turn blank, but the pager will beep again approximately every 80 seconds until the call is cancelled in the room, to notify staff that the call was not answered. PSWs can view the room # by pressing on the back arrow button on the pager.

Inspector #550 returned the pager to PSW #159 and informed her that her pager was not working properly, identifying the above noted issues. The PSW did not know what to do with the pager that was not functioning properly and asked what the inspector was going to do to have the pager fixed.

Two days later, on January 27, 2017 during an interview, RN #113 confirmed that PSW #159's pager was not functioning properly. She stated that she had informed the DOC and the maintenance department had ordered more pagers but they were not in yet. RN #113 indicated that she does not have any extra pagers for replacement when a pager is not functioning. Inspector inquired about the PSW who did not have a pager with her on January 25, 2017. The RN indicated that this person was the PSW working the short shift and those PSWs do not have to carry a pager.

During an interview on Friday January 27th, and 31st, 2017, the Program Manager for Personal Care indicated to the inspector that when a pager is not working, PSWs will ask registered staff for new batteries. If the pager is still not working, the registered staff will inform her so she can inform the maintenance department. She indicated they do not

keep any extra pagers in the home to use as a replacement when a pager is not functioning as the pagers are rented and they need to be calibrated for each unit; they are not interchangeable between units. She indicated when a pager is not working, the PSW whose pager is not functioning has to look for the light lit up above a resident's bedroom door to know that a resident has placed a call for assistance or rely on the other PSWs on other units as their system is not audible. The Program Manager of Personal Care indicated that the PSWs on the other units had a pager was sufficient. She further stated that the short shift PSW position has been in place for a few years and she does not know why the home does not supply pagers to these PSWs.

Inspector reviewed the home's Call Bell Response policy #350.25, reviewed October 2015. Page 2 indicated under Numeric pagers:

2. Pagers shall be carried by all Resident Care staff on their person while on duty and if necessary hand to a colleague when on break.

The licensee did not ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of the residents. [s. 44.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's pagers are readily available to resident care staff at the home to meet the nursing and personal care needs of the residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The Licensee failed to ensure that copies of the inspection reports from the past two years is posted in the home.

The home has a designated area outside the main foyer for the posting of required information. On January 23, 2017 it was observed by inspector #548 that six public inspection reports were not posted for the year 2016 and 2015.

During a discussion on January 25, 2016 with inspector #548 the Administrator provided an explanation on the process to post the required information as he was aware that residents' and family members did access the reports from this location. He indicated that he receives the served public reports and delegates the posting of the reports to the Administrative Assistant.

On the same day, during a discussion with the inspector #548 the Administrative Assistant who is responsible to post the information indicated that she was not aware to do so. [s. 79. (3) (k)]

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 copies of the inspection reports from the past two years are posted in the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

On January 27, 2017 Inspector #655 observed a medication cart located in the dining/lounge area on the Maple West unit. RPN #107 was observed to lock the medication cart after dispensing a medication, and then walk away from the cart at 1011. At that time, Inspector #655 was able to open the medication cart drawers, including the bottom drawer, while the medication cart was out of RPN #107s sight. On opening the bottom drawer of the medication cart, Inspector #655 observed that that the lid to the box which contained controlled substances, including narcotics, was closed but unlocked so that the inspector could access the stored narcotics. At 1014, Inspector #655 was still able to open the medication cart drawers which remained unlocked.

At 1139 on the same day, RPN #107 locked the medication cart on the Maple West unit with Inspector 655 present. The medication cart drawers remained unlocked despite the RPNs attempt to lock the cart. RPN #107 acknowledged that there she was aware of a one to two minute delay in the locking mechanism of the medication cart. RPN #107 indicated that an audible "click" can be heard when the medication cart is actually locked. Inspector #655 was able to repeatedly open the medication cart drawers until 1141, when an audible click was heard, at which time the cart became locked.

On January 31, 2017, Inspector #655 observed a medication cart located in the open lounge/dining area on Pine East. At 1158, RPN #117 was observed to dispense a medication, lock the medication cart, and then proceed to leave the area of the medication cart. Between 1158 and 1200, Inspector #655 was able to open the medication cart on multiple attempts before RPN #117 returned to the area of the medication cart at 1201. There were seven residents seated in the lounge area for the duration of this observation.

During an interview on January 31, 2017, RPN #117 indicated to Inspector #655 that she was aware that there was a delay in the locking mechanism of the medication cart, but did not know how long the delay was. RPN #117 trialed the locking mechanism of the medication cart with Inspector #655 present and indicated that the delay was longer than expected.

RN #s 103 and #116 were made aware of the delay in the locking mechanism of the medication carts on their respective units, Maple and Pine.

On February 2, 2017, Inspector #655 observed two medication carts (Maple East and Maple West) located in the dining/lounge area on the Maple East unit to be unlocked while not in use.

On February 6, 2017 Inspector observed RN #103 to close and lock the medication cart located in the dining/lounge area on the Maple West unit at 1218 and then proceed to the Maple East unit. Inspector #655 was able to open the medication cart drawers at 1219, after RN #103 had left the unit and the medication cart was no longer in RPN #103's sight.

At 1139 on the same day, Inspector #655 observed a medication cart located in the dining/lounge area on Maple West to be unlocked and unattended before RPN #152 returned to the cart. At 1434 on the same day, Inspector #655 again observed a medication cart located in the dining/lounge area outside of the nurses' office on Maple East to be unlocked and unattended until RPN #152 returned to the cart and locked it at 1436. There was one resident seated in the area for the duration of this observation.

During interviews with the Program Manager of Personal Care and the Program Manager of Resident Care, it was indicated that medication carts are to be locked when unattended by staff. The Program Manager of Resident Care indicated to Inspector #655

on February 6, 2017, that any staff who were aware of the delay in the locking mechanism of the medication carts would be expected to wait until the lock is fully engaged before leaving the medication cart unattended. It was unknown whether all registered staff were aware of the delay. The Program Manager of Resident Care indicated that the box in the bottom drawer of each medication cart, used for the storage of controlled substances including narcotics, is expected to be locked at all times when not in use.

The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use. [s. 130. 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 all medication carts are kept locked at all times, when not in use, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the PASD that is used to assist resident #026 with a routine activity of living is included in the resident's plan of care.

On an identified date in January 2017, resident #026 was observed by Inspector #655 to be seated in a tilted wheelchair.

Inspector #655 reviewed resident #026's health care record. Resident #026 has a

Cognitive Performance Scale score of 0, meaning the resident is cognitively intact. On review of resident #026s health care record, Inspector #655 was unable to locate any documentation related to the use of a tilted wheelchair for resident #026.

During an interview on the identified date in January 2017, resident #026 indicated to Inspector #655 that he/she spends the majority of his/her time seated in a tilted position when in his/her wheelchair for reasons of comfort and pressure relief. Resident #026 indicated that when the wheelchair is positioned in a tilted position, it prevents him/her from rising out of the chair.

During an interview on January 27, 2017, PSW #112 indicated to Inspector #655 that resident #026 sits in a tilted wheelchair at times; though he/she is to be seated in an upright position most of the time, when not in bed, due to difficulty breathing.

During an interview on January 30, 2017, RPN #105 indicated to Inspector #655 that resident #026 is seated in a tilted wheelchair when he/she is in his/her room for comfort reasons. RPN #105 indicated that there is potential that the wheelchair, when tilted, would have a restraining effect - limiting the residents freedom of movement.

During an interview on January 30, 2017, RN #103 indicated to Inspector #655 that resident #026's wheelchair is tilted at the residents' request for reasons of comfort. RN #103 acknowledged that resident #026 could not release the tilt of the wheelchair independently.

During an interview on January 30, 2017, the Program Manager of Resident Care indicated to Inspector #655 that where a tilt wheelchair is used by a resident for purposes of comfort, it is considered a PASD and is expected to be included in resident #026s plan of care. The Program Manager of Resident Care indicated that if a tilt wheelchair is part of resident #026's plan of care, it should be documented in the care plan.

On January 30, 2017, both the Program Manager of Resident Care and Inspector #655 were unable to locate any information related to the use of a tilt wheelchair in resident #026's current care plan.

The licensee has failed to ensure that the tilted wheelchair (PASD) used by resident #026 is included in the resident's plan of care. [s. 33. (3)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee has failed to ensure that each resident is bathed, at a minimum, twice a week by the method of his or her choice, unless contraindicated by a medical condition.

The Bungalows are a secure units comprised of four resident home areas (Bungalow 1, 2, 3, and 4).

During an interview on January 25, 2017, a family member of resident #002 indicated to Inspector #550 that the home is often short staffed on resident #002s home area, Bungalow 1, and that this affected resident #002s care.

During a follow-up interview on February 2, 2017, the same family member of resident #002 indicated to Inspector #655 that on those days when Bungalow 1 is short staffed, it is usually the four hour PSW who is not present. The family member of resident #002 indicated that he had submitted a complaint to the home on Tuesday, January 31, 2017 related to staffing concerns.

During an interview on February 3, 2017, PSW #159 indicated to Inspector #655 that there are five residents on Bungalow 1 who require assistance from two staff members for activities of daily living, such as bathing and toileting. PSW #159 indicated she cannot bath or shower these five residents without the assistance of another staff member.

During an interview on an identified date in February 2017, RN #s 113 and 135 indicated to Inspector #655 that they are often short-staffed in the Bungalows. According to RN# 135, the Bungalows are expected to be staffed with one PSW for each home area (1, 2, 3, and 4) plus one PSW who works four hours (0700-1100), shared between all four

home areas in the Bungalows. On the day of the interview, RN #135 indicated that the four hour PSW had been pulled to another unit; and as a result, several residents who were scheduled to receive a bath or shower that day did not receive it. RN #135 indicated that two of the affected residents required a mechanical lift for transfers.

On an identified date in February 2017, RN #135 indicated that six out of eight residents who were scheduled to receive their shower during the day shift on an identified date in February 2017 did not receive their showers. Among those six residents were residents #001 and #056. During the same interview, RN#135 indicated that not all residents who reside in the Bungalows receive the required two baths or showers every week. RN #135 indicated that PSW four hour shifts were not filled in the Bungalows on four identified dates in January 2017 and two identified dates in February 2017.

During an interview on February 9, 2017, PSW #133 indicated to Inspector #655 that she is the regular four hour PSW for the Bungalows. PSW #133 confirmed that on the two identified dates in February 2017, she was pulled from the Bungalows to work her shift on another unit in the home. PSW #133 indicated that she is often pulled from the Bungalows, and that this affects many aspects of care for the residents who reside in the Bungalows, including bathing. PSW #133 identified two residents who are particularly affected: resident #001 and resident #005.

Inspector #655 reviewed the bath lists for the day shift in Bungalows 1 and 3.

Resident #001 was scheduled to receive a shower on two identified days of the week, during the day shift. Inspector #655 reviewed the bath record for resident #001 for the months of January and February, 2017. On two identified days of the week where the Bungalows were short-staffed, there was no documentation to indicate that resident #001 had received a shower as scheduled. According to the bath record, resident #001 received one bath during an identified week in January 2017. The last recorded bath on the bath record for resident #001 was on an identified date in early February 2017 and there was no documentation to indicate that the resident had received a second bath for that week.

Resident #005 was scheduled to receive a shower on two identified days of the week during the day shift. Inspector #655 reviewed the bath record. On one of the identified days of the week in January 2017 – when the Bungalows were short-staffed, there was no documentation to indicate that resident #005 had received a shower as scheduled for that day or that the resident had received two showers that week.

Resident #056 was scheduled to receive a shower on two identified days of the week, during the day shift. Inspector #655 reviewed resident #056s bath records. In the space for the identified date in January 2017 – the day that the Bungalows were short-staffed, the documentation reads "n/a" and "short-staffed". For an identified week in January 2017, there was no documentation to indicate that resident #056 had received a second bath for that week.

During an interview on February 9, 2017, PSW #159 indicated that residents #001 and #005 are two residents on Bungalow 1 that require the assistance of two staff members for bathing, adding that resident #001 requires a mechanical lift for transfers and therefore cannot be bathed with only one staff member. PSW #159 indicated that staff are successful in bathing both residents #001 and #005 when they attempt to, and could not recall a time when either resident had refused to be bathed; or, when either resident could not be bathed for behavioural reasons. RN #135 indicated the same. [s. 33. (1)]

Issued on this 28th day of March, 2017

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

Original report signed by the inspector.