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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 13, 2018	2018_716554_0007	008086-18	Resident Quality Inspection

Licensee/Titulaire de permis

Medlaw Corporation Limited
42 Elgin Street Thornhill ON L3T 1W4

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

Pinecrest Nursing Home (Bobcaygeon)
3418 County Road 36, R.R. #2 BOBCAYGEON ON K0M 1A0

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

KELLY BURNS (554), LYNDA BROWN (111), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 17-18, May 22-25, May 28-June 01, and June 04-06, 2018

Resident Quality Inspection Intake #008086-18. The following concurrent intakes were inspected, #020502-17, #003420-18, #003422-18, #003423-18, #003424-18, #003426-18, #007253-18, #007527-18, #009448-18 and #011625-18.

Summary of Intakes:
1) #020502-17 - Critical Incident Report (CIR) - related to declared outbreak;

2) #003420-18 - Follow Up Inspection - Compliance Order (CO) #001 - Pursuant to LTCHA, s. 15 (2) (c) - Accommodation Maintenance, compliance due by February 28, 2018;
3) #003422-18 - Follow Up Inspection - CO #003 - Pursuant to O. Reg. 79/10, s. 245 - Resident Charges, compliance due by December 31, 2017;
4) #003423-18 - Follow Up Inspection - CO #004 - Pursuant to O. Reg. 79/10, s 90 (2) - Heating Ventilation and Air Conditioning (HVAC), heat generating equipment, hot water holding tanks inspected or servicing, compliance due by February 28, 2018;
5) #003424-18 - Follow Up Inspection - CO #005 - Pursuant to O. Reg. 79/10, s. 53 (4) (c) - Responsive Behaviours, compliance due by January 31, 2018;
6) #003426-18 - Follow Up Inspection - CO #007 - Pursuant to O. Reg. 79/10, s. 51 (2) - Continence care and bowel care management, compliance due by January 31, 2018;
7) #007253-18 - Complaint - alleged staff to resident abuse and or neglect;
8) #007527-18 - CIR - related to declared outbreak;
9) #009448-18 - Complaint - related to resident's plan of care not being followed;
10) #011625-18 - Follow Up Inspection - CO #001 - Pursuant to LTCHA, s. 6 (7) - Plan of care not provided, compliance due by May 31, 2018.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Nursing Clerk, Food Service Supervisor, Activation Assistant, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Workers, Activity Aides, Housekeeping Aides, Maintenance Staff, Registered Dietitian, Physiotherapist, Physiotherapist Assistant, Pharmacy Consultant, Resident Council President, Families, and residents.

During the course of the inspection, the inspectors toured the long-term care home, observed dining and nutritional care services, observed staff to resident interactions, resident to resident interactions, reviewed clinical health records, licensee investigations specific to inspections, maintenance request log binder, maintenance invoices, Resident Council meeting minutes, identified training records, Behaviour Support (BSO) meetings, identified accommodation billing and invoices and reviewed licensee policies, specifically Preventative Maintenance Program/Policies, Routine Maintenance, HVAC Inspection Compliance, Maintenance Water Temperatures, Odour Elimination, Outbreak Management Unit Cleaning, Housekeeping Daily Routine, Personal Aids and Equipment, Abuse and Neglect, Managing Responsive Behaviours, Discharge of a Resident, and Infection Prevention and Control Program.

During this inspection, the licensee was identified as having an outstanding Compliance Order (CO) under LTCHA, 2007, s. 6 (7). CO #001 had been issued under Inspection Report #2018_643111_0008. The licensee was to be in compliance by May 31, 2018. During this inspection, Inspector #623, found the licensee compliant with LTCHA, s. 6 (7).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 245.	CO #003	2017_673554_0023	554
O.Reg 79/10 s. 51. (2)	CO #007	2017_673554_0023	111
O.Reg 79/10 s. 53. (4)	CO #005	2017_673554_0023	554

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	Légende 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. 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 failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

During the initial tour of the long-term care home, on an identified date, the following was observed by Inspector #554:

Tub-Shower room-moist black debris was observed present along the wall ledge and along the wall ledge caulking, adjacent to the stationary tub. Similar debris was also observed on the floor under the stationary tub, along the air vent to the right of the stationary tub (vent closet to the floor) and the adjacent the floor drain. The moist black debris was able to be loosened when Inspector #554 scraped at it with a pen.

The same moist black debris was observed, by Inspector #554, during observations on four identified dates.

Personal Support Worker (PSW) #103 indicated, to Inspector #554 that the black debris is always observed present under the stationary tub, and is frequently present along the wall ledge and caulking. PSW #103 indicated that the Maintenance Staff (MS) and the ADM are aware of the debris.

Housekeeper (HSK) #104 indicated, to Inspector #554, that the tub room flooring is cleaned nightly by Dietary Staff, and indicated that the tub-shower room is cleaned on an identified date weekly by housekeeping staff. HSK #104 indicated that the tub-shower room walls are washed down, and the floors are wet mopped. HSK #104 indicated that they do not have access to a steamer, and do not routinely scrape at debris or grout when cleaning the tub-shower room. HSK #104 indicated being aware of the black debris

in the tub-shower room, and indicated that MS use a special cleaner to remove the black debris in the tub-shower room. HSK #104 indicated that both the MS and the ADM are aware of the black debris in the room.

MS indicated, to Inspector #554, being aware that at times debris builds up along the walls, and along the wall ledge in the tub-shower room. MS indicated that they clean the black debris when told by staff it is again present. MS indicated that there is no scheduled cleaning of this debris.

The ADM indicated, to Inspector #554, that the debris identified is "dirt". The ADM indicated that the tub-shower room is cleaned on an identified shift by the Dietary Staff, and weekly on a specified day by housekeeping staff. The ADM indicated that the black debris, in the tub-shower room, should not be present and should have been identified and cleaned at a specified time of the day, as well as on a specific day weekly. The ADM indicated that cleaning procedures will need to be reviewed with both dietary and housekeeping staff.

The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary, specifically the tub-shower room.

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

During the initial tour of the long-term care home, Inspector #554 observed the following:

- Tub - located in an identified room, the acrylic finish, outer surface of the tub was observed to have areas of damage. Inspector #554 observed that there were approximately eight-ten areas, each measuring 1.5 centimetres (cm) to 10 cm that were chipped or gouged. The gouged or chipped areas are porous in nature, and discoloured (greyish). This tub was observed to be in use by nursing staff;

- Disinfectant Hose/Sprayer on tub-located in an identified room, the yellow disinfectant hose/sprayer was observed lying in a basin of unknown fluid on the floor beside the tub. There was no bracket/holder observed on the tub for the disinfectant hose/sprayer;

- Water Spout of the Tub (older stationary)-was observed chipped/gouged in areas surrounding the water spout, within the same area a greenish discolouration and film were observed surrounding the water spout. This tub was observed to have been used

on three identified dates during this inspection;

- Bath Chair-the identified bath chair, located in the tub room, was observed to have areas of corrosion on the frame, specifically the frame's legs. The largest areas of corrosion measured an area of approximately 15-20 cm (irregular).

Upon further observations on identified dates, the following was observed by Inspector #554:

- Windows-the windows in eight identified resident rooms were observed open approximately ½ to 1 inch. The windows would not close when attempted by the Inspector. (Note: this was an identified area of non-compliance in the Resident Quality Inspection the previous year).

- Window Crank-there was no window crank handle observed on the window in of an identified resident room, the casement for the window crank was observed broken and lying on the window ledge; the crank mechanism was exposed.

- Window casement-the paint on the wooden casement/frame of the windows on identified resident rooms were observed chipped and peeling. (Note: this was an identified area of non-compliance in the Resident Quality Inspection the previous year).

The maintenance binder was reviewed by Inspector #554, for an identified time period. The above identified areas of maintenance disrepair were not identified in the maintenance binder for repair, and or replacement by the MS, or the Licensee.

PSW's #115, #130 and #134, HSK #104, and #108, as well as Registered Nurse (RN) #122, and 129, indicated to Inspector #554 during interviews on separate identified dates, that maintenance concerns when identified by staff are placed into the maintenance binder for review and follow up by the MS. PSW's #115 and #134 indicated that the disinfectant hose/sprayer had been lying on the floor in a basin for an identified time period; both PSW's indicated that there is no bracket/holder for the disinfectant hose/sprayer, indicating it broke off and it hasn't been repaired. PSW #115 and #134 indicated that the disinfectant hose/sprayer leaks and the fluid in the basin is disinfectant which has leaked from the hose/sprayer into the basin. Both PSW's indicated that the MS and ADM are aware that the hose/sprayer leaks and that there was no bracket/holder to hold it. PSW #115 indicated that the chipped/gouged areas on the acrylic finish of the tub had been present for a while. PSW indicated not being aware if the MS knew that the

finish on the tub was chipped/gouged.

PSW's #131, and #134, HSK #104, and #108, and RN #122 indicated that the windows in the long term care have been a long-standing concern, all indicated that the windows in some resident rooms will not open and or close. PSW #134, RN #122, and HSK #104 indicated that staff have to go outside to close the windows. All staff interviewed indicated that MS and the ADM were aware of the windows not opening and or closing.

The MS indicated, to Inspector #554, that the maintenance binder is reviewed on specified times weekly. The MS indicated being aware of the identified areas of disrepair in the long-term care home. The MS indicated the following:

- Tub-the chipped/gouged areas (acrylic finish) are from wear and tear. MS indicated that there is currently no plan to repair the chipped/gouged areas on the tub surface.

- Disinfectant Hose/Sprayer of the tub- 'the staff keep breaking it (bracket/holder) off the tub, it takes a lot to repair it'. The MS indicated that they could repair the bracket/holder if needed but that there were currently no parts in the long-term care home to fix it. The MS indicated 'putting hose/sprayer in the basin on the floor was an easy fix to the problem'.

- Windows- 'the windows are old, they are the original windows'. The MS indicated that the windows all have wooden frames; indicating that 'staff leave the windows open and don't close them, and when it rains the window frame gets wet, and swells causing the window not to close'. MS indicated 'it's not a new problem'. The MS indicated that adjustments have been made to windows when told by staff that there is a problem with the window closing. The MS indicated 'some adjustments can be made but on most occasions now adjustments to most of the windows cannot be made. The windows need replacement'. The MS indicated both the ADM and the Licensee are aware of the windows being a concern.

- Window Crank-indicated being aware that the window crank and mechanism were broken in an identified resident room. MS indicated that both are broken and can't be repaired and indicated that the ADM and Licensee are aware.

The ADM indicated, to Inspector #554, that they were aware that there remains areas in the long-term care home needing repair and or replacement, specifically the windows. The ADM indicated being aware that there are some windows in the home that won't open and or close. ADM further indicated being aware that window crank in an identified

room was broken. The ADM indicated 'the owner did have someone (contractor) in to look at an identified number of windows in the home, and provide a quote for those windows to be replaced'. The ADM indicated being aware that the Licensee has been provided a quote for the window replacement. The ADM indicated that 'as of today (date during this inspection) the quote had not been approved' by the Licensee. The ADM indicated not being aware that there were chipped/gouged area areas on both tubs, but indicated that the tubs were older, and most likely the areas the Inspector identified were due to daily use by staff and residents. ADM indicated being aware that the disinfectant hose/sprayer was on the floor in a basin, indicating belief that the hose/sprayer leaked and it was being placed in the basin to prevent fluid (disinfectant) from spilling onto the floor. The ADM indicated not being aware that the identified bath chair had areas of corrosion on the frame.

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

The severity of this issue was determined to be a level 2 as there is minimal harm to residents. The scope of the issue was level 3 - widespread, as during this inspection many areas within the LTCH, were identified by inspector #554. The licensee had a level 4 compliance history as despite MOH action, ongoing non-compliance has continued pursuant to LTCHA, s.15 (2) that included, a Voluntary Plan of Correction (VPC) issued August 07, 2015, Resident Quality Inspection (RQI) #2015_291552_0020; Compliance Order (CO) issued October 04, 2017, RQI #2017_673554_0023. The licensee was to be compliant with LTCHA, s. 15 (2) as of February 28, 2018. [s. 15. (2) (c)] (554)

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that the resident-staff communication and response system can be easily seen, accessed, and used by residents, staff and visitors at all times.

On an identified date and time, resident #054 was relocated, by nursing staff, from one identified room to another identified room due to a change in resident's health condition. Resident #54 was observed, by Inspector #554, in the identified room where the resident was relocated. Resident #054 was observed to have no access to the resident-staff communication and response system, as the resident-staff communication and response system for this room is located on the wall, a distance from where the resident was placed. There were no other resident-staff communication and response systems observed present in the room or accessible to resident #054.

Resident #054 was observed in this same room on a later identified date. The resident was observed to be alone at times.

PSW #112 indicated, to Inspector #554, that resident #054 would not be able to access the resident-staff communication and response system due to its location in the room. PSW #112 indicated that resident #054 would have to rely on staff entering the room for

assistance. PSW #112 indicated that resident #054 would normally be checked upon every one to two hours.

The DOC and the ADM indicated that they were in agreement that resident #054 did not have access to a resident-staff communication and response system, during an identified period.

The licensee has failed to ensure that the resident-staff communication and response system can be easily seen, accessed, and used by residents, staff and visitors at all times, specifically for resident #054. [s. 17. (1) (a)] (554)

2. The licensee failed to ensure that there is a resident-staff communication and response system available in every area accessible by residents.

During the initial tour of the long-term care home, Inspector #554 observed that there was no resident-staff communication and response system available in the following areas:

- main foyer lounge
- patio located at the front of the home
- secured patio area at the back of the home, area off of the activity room / small dining room

The DOC indicated, to Inspector #554, that the main foyer lounge, and patios at the front and the back of the long-term care home are considered resident accessible areas. The DOC indicated being aware that there was no resident-staff communication and response system available in the three identified areas. The DOC indicated being aware that a contracted alarm company was to install a resident-staff communication and response system in the main foyer lounge and both patio areas on an identified date. The DOC indicated that if a resident needed assistance from staff when in the main foyer lounge they could wait for staff to come by, or yell for assistance. The DOC indicated if outdoors, a resident would have to come in for assistance.

The ADM indicated, to Inspector #554, being aware that the main foyer lounge and the two patios areas not having a resident-staff communication and response system available. The ADM indicated that the home is small enough and residents could call out for help if they needed staff. The ADM confirmed that a contracted service provider, was scheduled to install a communication and response system in the three identified areas

on an identified date, but had yet to arrive to install it.

As of an identified date during this inspection, there was no resident-staff communication and response system available or accessible by residents in the main foyer lounge and patio areas, located at the front of the home and at the back of the home.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 2 as a pattern in outside resident spaces and as needed palliative room. The home had a level 4 compliance history as they had on-going non-compliance pursuant to O. Reg. 79/10, s. 17 (1) that included, a VPC issued October 04, 2017, RQI #2017_673554_0023. [s. 17. (1) (e)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that the hot water temperature serving all bathtubs and showers used by residents were maintained at a temperature of a least 40 degree's Celsius (C).

The licensee's policy, Maintenance Water Temperatures directs that water temperatures in resident areas will be monitored in order to maintain a temperature that meets the requirement of Regulation 79/10, s. 90 (2), including (i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degree's Celsius.

Charge Nurse Responsibilities:
- Charge Nurse shall ensure the water temperatures are taken once per shift in random locations where residents have access to hot water.
- Temperatures are documented on the Shift Report with the time, location and initials of the person taking the temperatures.
- Water temperatures should be at least 40 C, but must not exceed 49 C.
- If the water temperature is outside the acceptable range staff should do the following, immediately notify Maintenance staff in the building, write a note in the maintenance book at the nursing station requesting the temperature be adjusted, notify all nursing staff of the temperature and direct them to take precautions when using the water, as well as notify and supervise residents that may use the water independently.

Maintenance Staff Responsibilities:
- When notified of an unacceptable temperature reading, Maintenance Staff will adjust the hot water heater thermostat accordingly and recheck the temperature in 1-2 hours to ensure it has reached an acceptable level.

On identified dates, the shower head from the shower stall, adjacent to the tub (stationary), was observed, by Inspector #554, draped over the side of the tub, in the tub/shower room.

PSW's #131 and #134 indicated to Inspector #554 that the shower head from the shower stall is being used to add hot water to the tub. PSW #131 and #134 indicated that the tub (stationary) has had 'no hot water coming from it for sometime'.

On an identified date and hour, with the faucet turned on, the faucet dial turned to hot, and the water running five minutes, Inspector #554 took the temperature of the water, with a thermometer provided to the Inspector by the ADM. The temperature of the water, coming from the faucet of the tub (stationary) was 35.7 degree's Celsius.

RN #122 indicated to Inspector #554, that water temperatures for the tub is taken, by

registered nursing staff, during an identified shift. RN #122 indicated that the water temperature for the tub is to be recorded in the 'shift report' book.

The Shift Report book was reviewed, by Inspector #554, for an identified period. The Shift Report book directs that the tub temperature is to be taken by staff on an identified shift. The following water temperatures, for the tub, were documented as follows:

In an identified month:

- Water Temperatures taken were documented as below 40 degree's Celsius on six occasions during this month;
- No water temperature were documented on 24 dates during this month.

In an identified month:

- Water Temperatures taken were documented as below 40 degree's Celsius on five occasions during this month;
- No water temperature were documented on on 18 dates during this month.

PSW #115 indicated to Inspector #554, that the water temperature (for the tub) should be at least 97-98 degree's Fahrenheit (F).

PSW #130 indicated to Inspector #554, that the water temperature (for the tub) should be 94 F.

Both PSW #115 and #130 indicated that they were not aware if the licensee had a policy with regards taking of water temperatures, and when to report water temperatures being out of range. Both PSW's indicated that registered nursing staff are responsible for taking water temperatures, which would include tub water temperatures, in the long-term care home.

RN #122 indicated that the taking and recording of water temperatures is the responsibility of registered nursing staff. RN #122 indicated not being familiar with what the water temperature range was to be and unaware of the licensee having a policy regarding taking of or reporting water temperatures.

The DOC indicated to Inspector #554, that the Charge Nurse is to take and record water temperatures on all shifts, and indicated that the tub temperature is taken and recorded

by the identified shift, and recorded in the Shift Report book.

The MS indicated to Inspector #554, not notified of water temperatures serving tubs and showers to be below 40 C in the identified two months. The MS indicated being unaware of what the acceptable water temperature range was to be. The MS indicated being told, by the ADM, that the 'source' water temperature was to be 48 C. The MS indicated being unaware if the licensee had a policy regarding the taking, recording and reporting of water temperatures. The MS indicated having never adjusted the water temperature in the long-term care home as it exceeds their qualifications.

The licensee has failed to ensure that procedures were implemented to ensure that the hot water temperature serving all bathtubs and showers used by residents were maintained at a temperature of a least 40 degree's Celsius (C). [s. 90. (2) (i)]

2. The licensee failed to ensure that procedures are developed and implemented to ensure that, if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water.

The licensee's policy, Maintenance Water Temperatures directs that water temperatures in resident areas will be monitored in order to maintain a temperature that meets the requirement of Regulation 79/10, s. 90 (2), including (i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius.

Charge Nurse Responsibilities:
- Charge Nurse shall ensure the water temperatures are taken once per shift in random locations where residents have access to hot water.
- Temperatures are documented on the Shift Report with the time, location and initials of the person taking the temperatures.
- Water temperatures should be at least 40 C, but must not exceed 49 C.
- If the water temperature is outside the acceptable range staff should do the following, immediately notify Maintenance staff in the building, write a note in the maintenance book at the nursing station requesting the temperature be adjusted, notify all nursing staff of the temperature and direct them to take precautions when using the water, as well as notify and supervise residents that may use the water independently.

Maintenance Staff Responsibilities:

- When notified of an unacceptable temperature reading, Maintenance Staff will adjust the hot water heater thermostat accordingly and recheck the temperature in 1-2 hours to ensure it has reached an acceptable level.

The MS indicated to Inspector #554, that the long-term care home does not use a computerized system for monitoring water temperatures. The MS indicated assuming that the nursing department take the water temperatures.

RN #122 indicated to Inspector #554, that water temperatures are taken and documented by registered nursing staff working an identified shift. RN #122 indicated that the water temperature taken, by Registered Nurse, is to be recorded in the 24 hour Shift Report book.

The 24 hour Shift Report book was reviewed, by Inspector #554, for an identified period. The Shift Report book directs that water temperature is to be taken by all shifts. The Shift Report book indicates that identified staff take the 'source' temperature, plus a room water temperature; that next shift's RN take a room and the tub water temperature; and the next shift's RN takes a room water temperature.

The Shift Report book provided the following:

In an identified month:

- No water temperatures in random locations were documented as taken, during the day or evening shift, on 26 dates during this month, as well as no evening water temperatures taken on three dates and no water temps taken on any shift on three dates during the month.

In an identified month:
- water temperatures were inconsistently taken and or documented on identified shifts during this month.

RN #101 indicated to Inspector #554, that water temperatures are to be taken by registered nursing staff on all shifts, and recorded in the 24 hour Shift Report book. RN #101 indicated being unfamiliar with the water temperature policy.

The MS indicated being unaware of any policy related to monitoring of water

temperatures.

The DOC indicated to Inspector #554, that the water temperatures are to be taken on all shifts by the registered nursing staff and recorded in the 24 hour Shift Report book. DOC indicated being unaware that water temperature had not been taken consistently on all shifts during the identified two months. DOC indicated having reviewed the 24 hour Shift Report book daily but did not notice water temperatures had not been taken.

The ADM indicated to Inspector #554, that registered nursing staff are responsible to take water temperatures on all shifts, record readings and report abnormal temperatures to both DOC and MS. The ADM indicated that the DOC is responsible for reviewing the 24 hour Shift Report book for areas of concern. The ADM indicated being unaware that water temperatures had not been taken consistency during the identified period.

The licensee has failed to ensure that procedures are implemented to ensure that, if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. [s. 90. (2) (k)]

The severity of this issue was determined to be a level 2 as there was a potential for actual harm to residents. The scope of the issue was level 3 - widespread, as the home has only one tub-shower room for all of its residents. The licensee had a level 4 compliance history as despite MOH action, ongoing non-compliance has continued pursuant to O. Reg. 79/10. s. 90 (2) that included, a CO issued October 04, 2017, RQI #2017_673554_0023. The licensee was to be compliant with O. Reg. 79/10, s. 90 (2) as of February 28, 2018.

Additional Required Actions:

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

WN #4: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident related to skin and wounds.

As a result the staff interviews and review of the resident clinical record, it was identified that resident #023 had altered skin integrity as identified. An inspection was initiated.

A review of the clinical records for resident #023 indicated that on an identified date the resident had identified areas of altered skin integrity.

Review of the plan of care in place at the time of the inspection for resident #023 identified the following:

Skin care - Follow facility protocol for treating alterations in skin integrity/pressure ulcers for an identified skin issue on an identified location of resident #023's body as per physician orders.

The written plan of care did not identify all of the altered skin integrity.

During an interview with Inspector #623, RPN #121 indicated that they do not update the plan of care in Point Click Care (PCC) when a new alteration in skin is discovered. RPN #121 was uncertain who would be responsible to update the plan of care.

During an interview with Inspector #623, the DOC indicated that when a new alteration in skin integrity is identified, the licensee's expectation is that an assessment will be completed using the skin and wound assessment form (paper), a progress notes will be written, and the plan of care will be updated to identify the skin problem and their locations and interventions to be taken such as the treatment. The DOC confirmed that the written plan of care for resident #023 only identified a specific area of altered skin integrity for resident #023.

The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident related to skin and wounds. The plan of care for resident #023 failed to identify all areas of identified altered skin integrity that the resident currently had. [s. 6. (1) (c)] (623)

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 there is a process in place and monitored ensuring that the plan of care sets out clear directions to staff and others who provide direct care to the resident related to skin and wounds, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The licensee's policy, 'Abuse and Neglect Policy 2017' indicates that Pinecrest Nursing Home has a zero tolerance policy regarding abuse and neglect of our residents. The Abuse and Neglect Policy indicates that 'we are committed to providing a safe home to all of our residents'. The Abuse and Neglect Policy indicates that staff must report all alleged, suspected or witnessed incidents of abuse or a resident by anyone.

The Abuse and Neglect Policy indicates the following:
- The terms 'abuse' and 'neglect' have the same meaning as those terms in the Long-Term Care Home Act, 2007 (LTCHA);
- Staff must report all alleged, suspected or witnessed incidents of abuse of a resident by anyone;
- There are two distinctly different procedures for reporting all alleged, suspected or witnessed abuse, one for reporting and investigating internally, and another procedure

for reporting to Ministry of Health and Long-Term Care (MOHLTC). The policy indicates that there are defined procedures for long-term care homes (LTCH) to file reports to MOHLTC using the Critical Incident Reporting System.

All Staff will report:
- Staff must immediately report every alleged, suspected or witnessed incident of abuse to the Charge Nurse on duty.

The Registered Nurse will:
- Complete the Resident Incident Investigation Form for every report of alleged, suspected or witnessed incident of abuse or neglect of a resident by a Pinecrest staff member, as well as every incident of inappropriate sexual behaviour directed toward anyone, or verbal or physical aggression. If during business hours or if reportable to the MOHLTC, notify the Director of Care or Administrator.

The licensee's Abuse and Neglect Policy includes the following definition of 'sexual abuse' as the following:
- Any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Related to Resident #048:

The health record for resident #048 was reviewed by Inspector #554. Documentation in the health record, specifically a progress note, dated for an identified date, written by RPN #100, provided details of the incident:
- Resident #048 was walking along side resident #024. Resident #024 reached out and inappropriately touched resident #048. Resident #048 was removed from the area.

RPN #100 indicated, to Inspector #554, the incident involving resident #048 and #024 was witnessed and reported by PSW #138. RPN #100 indicated documenting exactly what PSW #138 reported witnessing. RPN #100 indicated that abuse is defined as 'inappropriate touching of a resident by anyone, and that the touching is non-consensual'. RPN indicated being aware of the licensee's Abuse and Neglect Policy.

RPN #100 indicated being unable to recall if the Charge Nurse was notified of the identified incident. RPN #100 indicated no recall of who the Charge Nurse-RN was on shift that date. RPN #100 indicated that the incident was not immediately reported to the

DOC or the ADM. RPN #100 indicated that 'normally' only incidents that are considered 'major' in nature, such as staff to resident incidents, are immediately reported to the DOC or ADM. RPN #100 indicated that the 'Resident Incident Investigation Form' was not completed for the identified incident. RPN #100 further indicated that the alleged abuse incident was not reported to the Director, indicating that the DOC reports these incidents not registered nursing staff.

RPN #100 indicated not following the licensee's Abuse and Neglect policy for identified incident, as at the time of the incident. RPN #100 indicated that resident #024 has a known responsive behaviours towards other residents; RPN #100 further indicated that resident #048 was unable to give consent.

The DOC indicated to Inspector #554, not being made aware of the alleged abuse incident between resident #024 and resident #048. The DOC indicated becoming aware of the incident on return to the long-term care home on the next business day. The DOC indicated that all staff have been provided training specific to the licensee's Abuse and Neglect Policy.

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, specifically not complied with by RPN #100. [s. 20. (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 there is a process in place and monitored ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #6: 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 failed to ensure that residents have their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within forty-eight hours of admission and in the case of new items, of acquiring.

During the initial tour of the long-term care home, a used razor was observed in the tub-shower room. The razor was used, and was observed to be unlabelled.

Further observations, by Inspector's #554 and #623 on identified dates the following was identified:

- Resident Room (identified) – a denture cup containing a cloudy liquid was observed sitting on the counter-top vanity in the washroom. The denture cup was unlabelled. This washroom is shared by four residents. Residents #007 and #009 were both unable to identify who the denture cup belonged to.

- Resident Room (identified) – a urinal containing fluid was observed on the toilet handrails in the washroom. The urinal was unlabelled. This washroom is shared by four residents. Residents #13 and #14 were unable to identify who the urinal belonged to.

- Resident Room (identified) – a bar of soap in a ceramic dish was observed on the counter-top vanity in the washroom. The bar soap and or ceramic dish were unlabelled. This washroom is shared by two residents.

- Resident Room (identified) – a k-basin, a basin and two bars of soap were observed in the washroom. All items were unlabelled. This washroom is shared by two residents.

- Resident Room (identified) – a hairbrush, a wash basin, and a urinal were observed in

the washroom. All items were unlabelled. This washroom is shared by four residents.

- Resident Room (identified) – a basin was observed in the sink, and a urinal was observed on the toileting safety handrail in the washroom. Both items were unlabelled. This washroom is shared by four residents.

- Resident Room (identified) – two toothbrushes, shaving cream and a bottle of mouthwash was observed on the counter-top vanity in the washroom. All items were unlabelled. This washroom is shared by two residents.

- Resident Room (identified) – a toothbrush, toothpaste and a brush were observed in a washroom. The toothbrush and toothpaste were unlabelled. The brush was labelled with a first name only, both residents residing in this room had the same first name. This is a shared resident washroom.

PSW #120 indicated to Inspector #554, that all personal care items are to be labelled.

The DOC indicated to Inspector #554, that all personal care items are labelled on admission and as residents receive a new personal care item. DOC indicated that all personal care items, including basins, k-basins and urinals are to be labelled for individual resident use.

The licensee has failed to ensure that residents have their personal items labelled within forty-eight hours of admission and in the case of new items, of acquiring [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 there is a process in place and monitored ensuring that residents have their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within forty-eight hours of admission and in the case of new items, of acquiring, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

As a result the staff interviews and review of the resident clinical record, it was identified that resident #023 had altered skin integrity as identified. An inspection was initiated.

Review of the progress notes for resident #023 for an identified period, identified the following:

On an identified date, RPN #126 documented - resident #023 had an identified area of altered skin integrity on identified location of the body. The RPN treated the skin.

The next day, the DOC documented a dietary referral for the new identified altered skin integrity was made. In addition, a separate identified intervention was initiated for treatment.

The same day, on an identified date, RPN #105 documented a weekly assessment for all areas of skin integrity alterations including an identified location of resident #023's body.

A review of the Head to Toe skin assessments in Point Click Care, as well as the Skin and Wound Assessment Form (paper) indicated that an assessment of the newly identified area of altered skin integrity using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, was not completed by RPN #117 until a specific date after the initial discovery of the altered skin integrity for resident #023.

During an interview with Inspector #623, RPN #117 indicated that an assessment was completed for resident #023's identified area of altered skin integrity, as soon as they became aware of the new issue. RPN #117 indicated that with every newly identified area of altered skin integrity, a skin and wound assessment form is to be completed as well as a progress note.

During an interview with Inspector #632, the DOC indicated that when new areas of altered skin integrity are identified, the expectation is that an assessment will be completed using the skin and wound assessment form (paper), a progress note will be written, a referral to the Dietitian is completed, the physician is notified and the SDM is also notified of any change in skin condition. A treatment will be entered into the electronic treatment administration record (eTAR) as well as a weekly skin and wound assessments.

The licensee failed to ensure that when resident #023 exhibited a new alteration in skin integrity as identified on a identified location of their body on an identified date, that resident #023 received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments. [s. 50. (2) (b) (i)] (623)

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, have been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

As a result the staff interviews and review of the resident clinical record, it was identified that resident #031 had altered skin integrity as identified. An inspection was initiated.

Review of the progress notes for resident #023 indicated the following:

Review of the Pinecrest Nursing Home – Skin and Wound Assessment form for resident

#031 from an identified date
- indicated that weekly wound assessments were completed on identified dates over an identified period
- Review of the progress notes from an identified period, indicated that a skin and wound note was completed on identified dates in addition to the dates of the weekly wound assessment.

During an interview, with Inspector #623, RPN #105 indicated that resident's with identified skin and wound issues that require treatment, have a weekly skin and wound assessment that is scheduled in PCC. RPN #105 indicated that they don't always remember to document the assessment when it is completed, but that the treatment is completed as ordered. RPN #105 indicated that on identified dates, the treatments were signed as completed, but the weekly assessment was not documented in the progress notes or the weekly skin and wound assessment form for resident #031. RPN #105 indicated that they could not recall if an assessment was completed.

During an interview with Inspector #623, RPN #121 indicated that on identified dates, the treatments for resident #031 were signed as completed but the scheduled weekly skin and wound assessment was not completed. RPN #121 indicated that they do not complete weekly skin wound assessments despite being aware that they are scheduled and required. RPN #121 indicated that if a wound assessment was completed, they would document this in the progress notes.

During an interview with Inspector #623, the DOC indicated that all resident's with new or altered skin integrity require a baseline assessment to be completed on the skin and wound assessment form in the skin and wound care book, as well as a progress note. The DOC indicated that the expectation of the licensee is that all identified alterations in skin will be assessed at least weekly using the wound assessment form as well as documentation in the progress notes under a skin and wound note. The DOC indicated that the Skin and Wound Committee meets monthly. It was identified at a meeting on a specified date that weekly skin and wound assessments and documentation is not consistently being done for all residents with altered skin integrity.

The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, have been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)] (623)

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, have been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

As a result the staff interviews and review of the resident clinical record, it was identified that resident #023 had altered skin integrity as identified. An inspection was initiated.

A review of the clinical records for resident #023 indicated that the resident had been identified as having areas of altered skin integrity.

Review of the progress notes for an identified period, as well as the Pinecrest skin and wound assessment forms for resident #023, indicated that weekly wound assessments were not documented for resident #023 on the following dates:
- on identified dates- RPN #105
- on an identified date- RPN #121
- on an identified date - RPN #116

During an interview, with Inspector #623, RPN #105 indicated that resident's with identified skin and wound issues that require an identified treatment, have a weekly skin and wound assessment that is scheduled in PCC. RPN #105 indicated that they don't always remember to document the assessment when it is completed, but that the treatments are completed as ordered. RPN #105 indicated that on identified dates, the treatments were signed as completed, but the weekly assessment was not documented in the progress notes or the weekly skin and wound assessment form for resident #023. RPN #105 indicated that they could not recall if an assessment had been completed.

During an interview with Inspector #623, RPN #121 indicated that on an identified date, the treatments for resident #023 were signed as completed but the scheduled weekly skin and wound assessment was not completed. RPN #121 indicated that they do not complete weekly wound assessments despite being aware that they are scheduled and required. RPN #121 indicated that if a skin and wound assessment was completed, it would be documented in the progress notes.

During an interview with Inspector #623, the DOC indicated that all residents with new or altered skin integrity require a baseline assessment to be completed on the wound assessment form in the wound care book, as well as a progress note. The DOC indicated that the expectation of the licensee is that all identified alterations of skin would be assessed at least weekly using the skin and wound assessment form as well as

documentation in the progress notes under a skin and wound note. The DOC indicated that the Skin and Wound Committee meets monthly, it was identified at a meeting held on an identified date, that this is not consistently being done for all residents with altered skin integrity.

The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, have been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)] (623)

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 there is a process in place and monitored ensuring that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment; and that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, have been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #8: 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 failed to respond in writing within 10 days of receiving Resident's Council

advice related to concerns and recommendations.

The Resident Council meeting minutes, for an identified period, were reviewed by Inspector #554. The following concerns and or recommendations of the Resident's Council were forwarded to the licensee. There is no documented response, by the licensee, given to the Resident's Council.

Resident Council meeting minutes and responses:

Meeting Minutes for an identified date documented the following concerns:
- resident #053 indicated their seating arrangement in the dining room is very cold
- why there is so little bacon on the BLT (bacon, lettuce, and tomato sandwiches)
- tea is always weak and barely lukewarm

The ADM responded to the Resident Council meeting minutes, for the identified date and indicated in the response that the Resident Council's food concerns had been forwarded to the Food Services Supervisor (FSS).

There is no documentation of a response by the FSS in relation to the concerns of the Resident Council specific to the BLT sandwiches and the tea. There is no documented response related to an area in the dining room being cold, as voiced by resident #053 in the identified Resident Council meeting minutes.

Activity Aide (AA) indicated to Inspector #554 that if a response was not documented in the Council meeting minutes, regarding the dining room being cold, and or food and beverage concerns, then it would assume that a response was not received by the Council. The AA indicated having no documented record of a response.

The ADM indicated to Inspector #554, that all responses to concerns of the Resident Council are to be in writing and forwarded to the Resident Council within 10 days of receipt of the concern or recommendation. The ADM indicated being unaware if FSS had responded in writing, indicating having no documentation of the FSS response to the identified concerns and indicated there had been no follow up on if responses had been provided to the Resident's Council.

Resident #031 indicated to Inspector #554, that there is no documentation response from the FSS and or Licensee regarding concerns forwarded to the licensee at the identified Council meeting. Resident #031 indicated that tea served remains lukewarm.

The licensee has failed to respond in writing within 10 days of receiving Resident's Council advice related to concerns and recommendations.

2. Resident #031 indicated to Inspector #554, that there are three concerns which have been forwarded by the Council to the ADM that remain outstanding; resident #031 indicated that the concerns that remain outstanding are related to the current Satisfaction Survey questions, the resident owned coffee maker going missing and the cleaning of privacy curtains post isolation.

The Resident Council meeting minutes, for an identified period, were reviewed by Inspector #554. The following concerns and or recommendations of the Council were forwarded to the licensee according to the Resident Council minutes.

Resident Council meeting minutes and responses:

- On an identified date – Resident Satisfaction Survey was reviewed and suggestions sent to the ADM. There was no documentation in the meeting minutes regarding the suggestions by the Council.

On a specified date, the ADM indicated in the response that the Satisfaction Survey is a specific consumer survey. The survey is a standardized way to evaluate and improve quality of health care services. While it is tempting to make changes to the way the survey is set up and administered, we would lose our ability to compare results with past results'.

- On an identified date – Concerns documented include: 1) Council would still like the questions in the Satisfaction Survey changed as they do not feel that the survey allows a good enough representation of how resident's feel. 2) Residents would like to know what happened to the resident owned Keurig coffee maker.

On a specified date, the ADM indicated in a response, 1) Satisfaction Survey:The ADM indicated in the response that the survey was only one way that they (the licensee) collect information from residents. The ADM indicated the intent of the survey was not to create a list of everyone's issues and concerns into a 'to-do list for management'. The purpose of the survey is to get an overall feel for where we are at, and compare 'the feel a year ago'. 2) coffee maker: 'Pinecrest is limited in the equipment they can put in public spaces. We are looking at ways to offer the coffee maker at certain times, but it cannot

be left out 24/7'. The ADM indicated that the AA is developing a coffee cart program where the coffee maker will be available in the Activity Room some mornings.

- On an identified date – Residents asked about Infection Control Procedures for washing privacy curtains after another resident in a shared room had been sick and or coughing on the curtains.

On a specified date, the ADM indicated in a response that housekeeping staff are notified by registered nursing staff when a resident is no longer in isolation and indicated that housekeeping staff do a complete clean of the resident's space, including the removal of the privacy curtains and having the privacy curtains washed.

Resident #031 indicated, to Inspector #554 that Council's concerns, specific to the current Satisfaction Survey, the coffee maker and the cleaning of the privacy curtains, in resident shared rooms remain an outstanding. Resident #031 indicated that the Resident's Council does not feel that the ADM's response is to their satisfaction and does not answer their concerns.

The ADM indicated, to Inspector #554 being 'aware that resident #031 is not satisfied with her response to the Council's concerns' specifically the Satisfaction Survey and coffee maker. The ADM indicated that the concerns are specific to resident #031 versus the Resident Council as a whole. The ADM indicated there has been no further response and or discussions with the Resident's Council regarding the Satisfaction Survey and or the coffee maker. The ADM indicated being unaware that the Council had further concerns about the cleaning of privacy curtains until today.

The licensee has failed to respond in writing within 10 days of receiving Resident's Council advice related to concerns and recommendations. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored ensuring that the licensee responds in writing within 10 days of receiving Resident's Council advice related to concerns and recommendations, and that the response is provided to the Resident's Council, to be implemented voluntarily.

WN #9: 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. (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 failed to ensure that the Satisfaction Survey results were made available to the Resident's Council in order to seek the advice of the Council about the survey.

The previous year's Satisfaction Survey was completed, for both residents and family. Documentation reviewed by Inspector #554 indicated that the previous year's Satisfaction Survey was completed during an identified month and results were received by the Administrator, on a specified date.

The Resident Council meeting minutes, for an identified period, were reviewed by Inspector #554. There is no documentation that the previous year's Satisfaction Survey Results were made available to the Resident's Council, nor is there documentation that advice of the Council had been sought by the licensee regarding the survey results.

Resident #031 indicated to Inspector #554, that the results of the previous year's Satisfaction Survey were not made available to the Resident's Council, nor did the licensee seek the advice of the Council in relation to the survey results. Resident #031 indicated being unaware of the results of the previous year and or current year's Satisfaction Survey results.

AA #132 indicated to Inspector #554, being aware that the Satisfaction Survey results are to be shared with the Resident's Council, and that the licensee is to seek advice of the Council regarding the results of the survey. AA #132 indicated being unable to recall the results of the previous year's Satisfaction Survey being shared with the Resident's Council. AA #132 reviewed the Council meeting minutes for an eleven month period and indicated, to Inspector #554, that there is no documentation in the meeting minutes where the previous year's Satisfaction Survey results were shared with the Resident's Council.

The ADM indicated to Inspector #554, no recall of sharing the previous year's Satisfaction Survey results with the Resident's Council, but indicated the results were posted on the Quality Improvement board in the hallway. The ADM indicated that the advice of the Resident Council is not sought, regarding the outcome of the survey, as the licensee's Quality Improvement Plan must be submitted to Health Canada by an identified date, each year. The ADM indicated that the current year's Satisfaction Survey results have been received, and indicated that the 'raw data' is being inputted (into a spreadsheet) by the AA. The ED indicated not yet seeing the results of the current year's survey.

The licensee has failed to ensure that the Satisfaction Survey results were made available to the Resident's Council in order to seek the advice of the Council about the identified year's Satisfaction Survey. [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 there is a process in place and monitored ensuring that the Satisfaction Survey results are made available to the Resident's Council in order to seek the advice of the Council about the survey, to be implemented voluntarily.

WN #10: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are implemented for addressing incidents of lingering offensive odours.

The licensee's policy 'Odour Elimination' indicates that air quality in the environment can profoundly affect the health, comfort and productivity of the building users. The policy indicates that efforts must be taken to eliminate offensive odours from the home. The Odour Elimination policy indicates that a short-term fix, an odour maintenance program can begin with the consistent use of air fresheners. The policy indicates that the housekeeping staff have two products for use for eliminating odours.

The Odour Elimination policy directs the following:
- In areas where odours are chronic, bathrooms for example, a solid air freshening product is available. The product is good for sixty days. When opened and placed in a room, staff should write the date on the container, so that it can be replaced as required.
- Staff also use a non-aerosol air freshener; it is not to be sprayed on plastic or painted surfaces.
Routine procedures to minimize offensive odours include:

- Wiping up spills and cleaning promptly;
- Emptying garbage's regularly;
- Keeping garbage pails covered with tightly fitting lids;
- Complete cleaning, sanitizing and disinfecting to help eliminate bacteria that produces odours;

On an identified dates during this inspection, Inspector #623 identified lingering offensive odours in two identified resident rooms.

On an identified date, Inspector #554 detected lingering offensive odours to be present in identified resident rooms, during specific hours. These odours were detected again on subsequent dates. The lingering offensive odour in the identified resident rooms resembled a strong urine-like odour. The identified resident rooms are shared resident rooms.

There were solid air fresheners observed in the washrooms of identified resident rooms but neither were dated. There was no solid air freshener observed in a specific resident room identified as having odours.

HSK #104 and HSK #108 indicated to Inspector #554 that odours in the long-term care home are at times a concern. Both HSK's indicated that procedures are in place for daily cleaning of resident rooms. HSK #104 and HSK #108 indicated that there are air fresheners for use, both the aerosol spray and solid (pucks), but such are a temporary measure. HSK #104 indicated that the solid air freshener is to be dated when initiated. HSK #104 indicated that lingering offensive odours in resident rooms are a concern, but that odours are usually related to resident's needing care, urine being left on resident floors until housekeeping can attend to it or from toilets not being consistently flushed. HSK #104 and #108 indicated that odour in a specific resident room is an ongoing issue and is related to resident's assigned equipment leaking onto the floor. HSK #104 indicated that the odour in another room is from a specific resident and care related issues. HSK #104 indicated that the odour issues have been addressed with both the DOC and the ADM on more than one occasion. Both HSK's indicated that all they can do is continued to use the air fresheners, and indicated that lingering offensive odours remain a challenge in some resident rooms.

PSW #120 indicated, to Inspector #554, that lingering offensive odours are present in specific resident rooms. PSW #120 indicated that the odour in an identified room is from a resident's assigned equipment. PSW #120 was not aware of odours in the other

identified rooms.

The DOC and the ADM indicated that there should be no lingering offensive odours in the long-term care home, both indicated not being aware of any lingering offensive odours in the long-term care home.

The licensee has failed to ensure that procedures are implemented for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place, communicated to staff and monitored ensuring that procedures are implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming

aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Related to Resident #048:

The health record for resident #048 was reviewed by Inspector #554. Documentation in the health record, specifically an identified progress note, written by RPN #100, provided the following details:

- Resident #048 was walking along side resident #024. Resident #024 reached out and inappropriately touched resident #048. Resident #048 was removed from the area.

RPN #100 indicated to Inspector #554, that the witnessed incident involving resident #24 inappropriately touching resident #048 was witnessed by PSW #138, and reported that same day. Registered Practical Nurse #100 indicated reporting the incident to the Charge Nurse-RN on shift. RPN indicated no recall who the Charge Nurse-RN was on the identified date. RPN #100 indicated that the SDM for resident #048 had not been notified.

Nursing Clerk indicated to Inspector #554, that RN #139 was the assigned Charge Nurse during the shift on the identified date.

RN #139 was not available for an interview during the time of this inspection.

The health record for resident #048 fails to provide documentation that the witnessed incident was reported to resident #048's SDM.

The DOC indicated to Inspector #554, that all staff, specifically registered nursing staff, have been provided training related to notification of resident's SDM in incidence of alleged, suspected or witnessed abuse.

The licensee has failed to ensure that the resident #048's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse of resident #048. [s. 97. (1) (b)]

2. The licensee failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the

resident.

Related to Intake #011120-18:

The DOC submitted a CIR to the Director on an identified date, specific to an allegation of abuse/neglect reported by resident #009 to Inspector #554 on an identified date.

Resident #009 indicated to Inspector #554, that there had been occasions were PSW #141 had refused to provide continence care during an identified shift. Resident #009 further indicated that PSW #141 had been rude and rough. Resident #009 was unable to provide dates related to the allegations. Resident #009 indicated being upset that PSW #141 had refused to provide identified care during the identified shifts.

The health record for resident #009 was reviewed by Inspector #554, the health record indicates that resident #009 has a designated and active SDM. The health record provides documentation that the SDM for resident #009 had been called for care decisions.

The health record fails to identify that resident #009's SDM was notified of the allegation of abuse/neglect, by resident #009 to Inspector #554, until an identified date.

The DOC indicated to Inspector #554, being aware that resident's SDM are to be notified within 12 hours of alleged, witnessed and suspected abuse/neglect of a resident. The DOC indicated that resident #009's SDM had not been notified of the allegation until an identified date.

The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of resident #009. [s. 97. (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 there is a process in place and monitored ensuring that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident are notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On an indicated date the following was observed by Inspector #554:

- At an identified time, an identified medication, which was approximately a quarter full, was observed sitting on top of a medication cart, there was no lid on the identified medication. The medication cart was observed unlocked, and in the main dining room.

There were residents seated in the dining room, one resident seated in a mobility aid adjacent to the medication cart, and residents walking past the medication cart. There were no staff present during this observation. Seven minutes after the identified time, a staff, later determined to be RPN #121, approached the medication cart, locked it and proceeded to assist residents in the dining room to be seated, and approximately one to two minutes later exited the dining room. The identified medication remained uncapped and on top of the medication cart.

- Nine minutes after RPN #121 locked the cart, a PSW approached RPN #121 and conversed, both staff left the dining room, with RPN #121 taking the medication cart with them. RPN #121 was observed walking down the an identified hallway with the medication cart, stopped outside of an identified resident room, entered the room and shut the door. The medication cart, with the identified medication remained on top of the medication cart, outside of the identified resident room. Residents, including resident #048 was observed walking or wheeling past the medication cart. RPN #121 was observed exiting the identified room approximately three to five minutes later.

RPN #121 indicated to Inspector #554, being aware that medications are not to be left unattended and indicated being aware that the medication cart is to be locked when registered nursing staff are not present. RPN #121 indicated 'forgetting that the identified medication was on the top of the cart', and indicated morning medication pass is busy. RPN #121 indicated that resident #048 potentially could have ingested the unattended medication which was left on the medication cart.

The DOC indicated to Inspector #554, that medications are never to be left unattended, and that medication carts are to be locked when not in the presence of registered nursing staff. The DOC indicated that all registered nursing staff are aware of this requirement.

The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked. [s. 129. (1) (a) (ii)] (554)

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 there is a process in place and monitored to ensure that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #13: 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 ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Review of the medication incidents for an identified period indicated on an identified date and time, resident #046 was found to be administered the incorrect dosage of an identified medication on previous identified dates

Review of the health care record for resident #046 showed:
-the physician's ordered an identified medication, dose and time of administration
-the electronic Medication Administration Record (eMAR) for an identified month, indicated on an identified date, RPN #117 signed the eMAR indicating that the doctors ordered specific to the identified medication for resident #046 had been followed. On a separate identified date, RPN #105 signed the eMAR indicating that the doctors order specific to the identified medication for resident #046 had been followed.

Interview with RPN #116 by Inspector #111 indicated, on an identified date and time, the RPN noted that a medication incident had occurred related to the identified medication for resident #046. The RPN indicated they followed the physician's order re:

administration of the identified medication for resident #046 and then left a note for the physician regarding the medication incident.

Interview with RPN #105 by Inspector #111 confirmed that they had made a medication incident for the identified medication for resident #046 on an identified date.

Interview with RPN #117 indicated recalling the medication incident involving resident #046 and indicated they were unaware how the incident occurred. The RPN indicated the potential for an incident during administration for the identified medication related to the possibility that all registered staff were not aware of the correct way to document administration of the identified medication.

Interview with the DOC by Inspector #111 indicated, they spoke to RPN #117 and confirmed that RPN #117 did not follow the physician's orders specific to the identified medication for resident #046. The DOC confirmed that RPN #105 was not spoken to.

Review of the medication incidents for an identified period indicated on an identified date and time, resident #043 received the incorrect dose of an identified medication. Review of the health care record for resident #043 showed:
-the physician's order for the identified medication including dose and times of administration
-the electronic Medication Administration Record (eMAR) on an identified date showed that RN #107 signed the eMAR indicating that the identified medication and dose had been given to resident #043.

Interview with RN #107 by Inspector #111 indicated, the medication incident involving resident #043 did not directly involve the RN. The RN indicated the identified medication was given by the RPN but could not recall which RPN. The RN confirmed the RN signed for the drug as given. The RN confirmed this was not an appropriate practice. The RN indicated that they did not realize the dosage given of the identified medication was incorrect. The RN indicated the resident was assessed and the resident appeared "fine" but confirmed the assessment was not documented.

Interview with the DOC by Inspector #111 indicated, the medication incident involving resident #043 involved RN #107 who was following instructions on the bottle of medication rather than the MAR. The DOC confirmed they were not aware that the medication incident actually involved an RPN and RN #107.

The licensee failed to ensure that drugs were administered to resident #043 and #046 in accordance with the directions for use specified by the prescriber. [s. 131. (2)] (111)

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 there is a process in place and monitored ensuring drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending

physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Interview with DOC on by Inspector #111 indicated that last Interdisciplinary Team meeting was held on an identified date and reviewed the medication incidents for a identified three month period.

Review of the medication incidents for an identified period indicated the following:

-on an identified date and time, resident #014 did not receive an identified medication as prescribed. Review of the health care record indicated no documented evidence the resident was assessed or to indicate the physician/Medical Director (MD) or SDM was notified. Review of the electronic Medication Administration Record (eMAR) indicated RN #101 was involved in the incident.
- Interview with the DOC by Inspector #111 indicated they spoke to RN #101 and confirmed the physician/MD and SDM were not informed of the medication incident.
- on an identified date and time, resident #043 received the incorrect dose of an identified medication. The progress notes indicated RN #107 documented, the resident asked for an identified medication, but had no physician order for the specified medication. The RN indicated the resident was given the mediation and a note was left for the physician in the communication book to get a physician's order the following day. An identified time period later, RN #106 documented, the resident was assessed for receiving an identified medication in error. There was no documented evidence the physician/MD or SDM was notified.
-on an identified date and time, resident #044 was admitted to the home and did not receive their medications on identified dates as the physician orders were not obtained until specific day after resident #044 was admitted and the medication was not received from the pharmacy until the day after the orders were received. In addition, identified medications were given without a physician order. Review of the resident's health record indicated there was no documented evidence the resident was assessed and the SDM was notified of the incident. The progress notes indicated that the resident was administered identified medications without physician orders as the staff were awaiting orders from the physician. The physician indicated that unfortunately staff faxed a request for orders for resident #044 to the physician's office on a day that the physician does not work in the office and has not worked for the previous identified years. Nor did staff attempt to reach the physician by cell phone until the next day.
-on an identified date, for resident #046, a medication incident was discovered to have occurred on separate days related to an identified medication and dosage. There was no

documented evidence the resident was assessed when the medication incident was discovered or to indicate the resident's SDM and physician/MD was notified.

Interview RPN #116 by Inspector #111 indicated on an identified day, when the medication errors were discovered for resident #046, the physician was notified but not the family. The RPN indicated the physician was notified by leaving a note for the physician communication book. The RPN confirmed a medication incident on an identified date. The RPN indicated awareness that the identified medication is a high risk drug. The RPN indicated awareness that they should have completed a progress notes regarding the assessment of the resident and who was notified. The RPN confirmed the medication incident report included the resident's vital signs were monitored but confirmed there was no documented evidence in the resident's health record to indicate vital signs were obtained.

Interview with RN #107 by Inspector #111 indicated, the medication incident involving resident #043 did not directly involve the RN. The RN indicated the identified medication was administered by the RPN and then the RN signed for the drug as given. The RN indicated they did not think it was an incident, despite not having a physician's order. The RN confirmed the resident, the resident's SDM and the physician was not informed of the medication incident and confirmed a physician order should have been obtained. The RN indicated the resident was assessed and the resident appeared "fine" but confirmed the assessment was not documented.

The licensee failed to ensure that every medication incident involving a resident was documented, with a record of the immediate actions taken to assess and maintain the resident's health and reported to the resident, the resident's SDM, if any, the Medical Director and the prescriber of the drug. [s. 135. (1)] (111)

2. The licensee failed to ensure that:
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b).

Interview with DOC by Inspector #111 indicated that last Interdisciplinary Team meeting was held on an identified date and they reviewed the medication incidents for an identified period.

Review of the medication incidents for the identified period indicated the following:
-on an identified date and time, resident #014 did not receive an identified medication as prescribed. Review of the Medication Administration Record (MAR) indicated RN #101 was involved in the incident.

Interview with the DOC by Inspector #111 indicated they spoke to RN #101 and confirmed there was no documented evidence when they spoke to the RN or what corrective actions were taken.

On an identified date and time, resident #043 was administered an identified medication and dosage without a physician's order.

Review of the health care record for resident #043 indicated RN #107 documented, the resident asked for an identified medication, but had no physician order for the specified medication. The RN indicated the resident was given the medication and a note was left for the physician in the communication book to get a physician's order the following day. An identified number of hours later, RN #106 documented, the resident was assessed for receiving an identified medication in error.

Interview with RN #107 by Inspector #111 indicated, the medication incident involving resident #043 did not directly involve the RN. The RN indicated the identified medication was administered by the RPN and then the RN signed for the drug as given. The RN confirmed this was not an appropriate practice. The RN indicated that they did not think it was an error until reported to the oncoming shift. The RN confirmed the resident, the resident's SDM and the physician were not informed of the medication incident. The RN indicated the resident was assessed and the resident appeared "fine" but confirmed the assessment was not documented.

Interview with the DOC by Inspector #111 indicated, the medication incident involving resident #043 involved RN #107 who was following the directions on the bottle of identified medication instead of following the directions on the electronic medication administration record (eMAR). The DOC indicated the error was discovered at shift report. The DOC was not aware that the resident, resident's SDM and the physician were not informed of the medication incident and that the medication incident actually involved a RPN and RN #107. The DOC confirmed no documented evidence to indicate when any of the nursing staff involved were interviewed or corrective actions taken.

On an identified date, resident #044 did not receive their medications for an identified

number of days due to waiting for physician's order and for the medication to be delivered from pharmacy. In addition, identified medications were given without a physician order.

Interview with the DOC by Inspector #111 indicated she informed the SDM of resident #044 of the delay in medications after the incident was resolved but had not documented this on the resident's health record. The DOC confirmed there was no documented evidence to demonstrate corrective actions taken. The DOC indicated the expectation would be that if the physician had not responded to a fax request to order medications, then the staff are expected to call the on call physician and then inform the pharmacy for medications to be ordered with any changes.

On an identified date, a medication incident was discovered for resident #046 occurring on identified days regarding an identified medication. There was no documented evidence the resident was assessed when the medication incident was discovered or to indicate the physician was notified.

Interview with RPN #116 by Inspector #111 indicated that when the medication incident was discovered on an identified date, the physician was notified but not the family or resident #046. The RPN indicated the physician was notified by leaving a note for the physician. The RPN confirmed knowing the identified medication is a high risk drug. The RPN indicated awareness that a progress note should have been completed regarding the assessment of the resident and who was notified. The RPN confirmed the medication incident report indicated the resident's vital signs were monitored but confirmed there was no documented evidence in the resident's health record to indicate vital signs were obtained. The RPN indicated the DOC spoke to the RPN only to inquire what had occurred.

Interview with the DOC by Inspector #111 indicated the DOC spoke to RPN #117 who was the staff member who signed for the identified medication for resident #046 on an identified date. The DOC indicated no awareness when the RPN was spoken to and had no documented evidence to support same. The DOC indicated not speaking to any other registered staff who may have been involved in the medication error. The DOC indicated no documented evidence to indicate any corrective actions taken to prevent a recurrence.

The licensee failed to ensure that a written record was kept of all medication incidents that occurred for an identified period, to demonstrate they were analyzed and corrective

actions were taken, especially related to an identified resident who receives a high risk drug, a resident receiving an identified amount more than the prescribed dose and a resident not receiving all medications as prescribed for identified dates. [s. 135. (2)] (111)

3. The licensee failed to ensure that:
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have
occurred in the home since the time of the last review in order to reduce and prevent medication
incidents and adverse drug reactions,
(b) any changes and improvements identified in the review are implemented, and
(c) a written record is kept of everything provided for in clause (a) and (b).

Interview with the DOC by Inspector #111 indicated that all medication incidents were reviewed at the quarterly Interdisciplinary Team meeting and the Professional Advisory Committee (PAC) meetings that occurred on an identified date. The DOC indicated the review demonstrated that the medication incidents reviewed were for an identified period. The DOC confirmed there was no written record of any changes or improvements identified to reduce and prevent medication incidents.

Review of the Interdisciplinary Team Medication Management Evaluation and the PAC meeting minutes for the identified date indicated that all medication incidents for the identified period were reviewed. There was no written record to indicate any changes and improvements that were identified in the review to reduce and prevent medication incidents.

The licensee failed to ensure that when the quarterly review was taken of all medication incidents that occurred in the home since the last review, that a written record was kept of any changes or improvements identified to reduce and prevent medication incidents. [s. 135. (3)] (111)

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 there is a process in place and monitored ensuring that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider; that all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary, and that a written record is kept of everything required; and that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review are implemented, and that a written record is kept of everything provided for in clause (a) and (b), to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements, specifically (3) failed to communicate, to the Resident's Council, improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents.

Pursuant to LTCHA 2007, s. 84 - Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home.

The floor plan which was provided by the ADM, and indicated that there is a lounge located at the end of the identified hall.

On an identified date, Inspector #554 observed that resident #054, the resident's bed

and beside table had been relocated to the identified lounge. Resident #054 was observed in this room and being provided care, by nursing staff, in this room on an identified date, and as per the resident's health record the next day as well.

PSW #112 indicated to Inspector #554, that the lounge, located at the end of the identified hall, is a resident space. PSW #112 indicated that the lounge is used by a least two to three residents on a routine basis, for reading, watching television, and or visits with their families. PSW #112 indicated that, at times, identified residents are moved into the room and cared for in this room. PSW #112 indicated being aware that some residents voice displeasure when room is occupied by identified resident as then they can't access the room. PSW #112 indicated that lounge space, for residents for quiet time and or family visits is limited in the home.

During Stage 1 of the Resident Quality Inspection the following comments were made from residents, to Inspector #623:
- Resident #031 indicated that the identified lounge is not always available for visits with family or resident use. Resident #031 indicated having had booked the identified lounge for personal use, but was told by nursing staff that the room was no longer available due to it being used to care for an identified resident. Resident #031 indicated being aware that the home is limited with space, but indicated frustration with the identified lounge being used as a room for identified resident care when it is intended for use by all residents.
- Resident #038 indicated frustration with the identified lounge being used for identified resident care, when it is a resident lounge.

Resident #031 indicated that there has been no discussion with the Resident's Council as to the identified lounge being used for identified resident care on a as need basis. Resident #031 indicated that the lounge is a resident space, and indicated that quiet space is very limited in the home for residents as is. Resident #031 indicated that there are 2 to 3 residents in the home that use the lounge on a consistent basis, and indicated when the room is being used for identified resident care purposes this upsets residents who are used to using the room and can't for days or longer.

Resident #022 indicated, to Inspector #554, that the Administrator and or others have never spoke with the Resident's Council as to the identified lounge being used for identified care.

The ADM indicated to Inspector #554, that the identified lounge is occasionally used for

care for identified residents, due to the home no longer having another specific care room. The ADM indicated being aware that two to three residents use the identified lounge on a daily basis, and indicated being aware that the residents, who use the room routinely, get upset when they cannot use the lounge. The ADM indicated that there had been no discussion with Resident Council as to the use of the identified lounge as a room to care for identified residents.

The licensee failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements, specifically failed to communicate, to the Resident's Council, improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents, related to the identified lounge. [s. 228. 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored ensuring that the quality improvement and utilization review system required under section 84 of the Act complies with the all requirements indicated, specifically the licensee is to communicate, to the Resident's Council, improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During dates of this inspection, the following was observed by Inspector's #554 and #623:

- Resident Room (identified) – a urinal containing fluid was observed on the toileting handrails in the washroom. This washroom is shared by four residents.
- Resident Room (identified) – a k-basin, and a basin were observed on the floor, adjacent to the toilet. This washroom is shared by two residents.
- Resident Room (identified) – a urinal containing fluid was observed hanging on the toileting handrails in the washroom. This washroom is shared by four residents.
- Resident Room (identified) – a soiled basin was observed in the sink, a soiled towel was observed on the floor, and a urinal was observed on the toileting safety handrails in the washroom. This washroom is shared by four residents.
- Resident Room (identified)– a urinal containing fluid was observed on the back of the toilet in the washroom. This washroom is shared by four residents.

PSW #120 indicated to Inspector #554, that basins, bedpans and urinals are to be cleaned following resident use. PSW indicated that linens are not to be placed on the floor but into laundry hampers.

The DOC, who is the lead for the Infection Prevention and Control Program indicated, to Inspector #554, that personal care items are not to be stored in shared washrooms and or on floors. DOC indicated that k-basins, basins, and urinals are to be cleaned following resident use and stored in the resident's bedside table. DOC indicate that linens are not to be placed on floors but disposed of in appropriate laundry hampers.

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

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

Provincial Infectious Diseases Advisory (PIDAC) document, 'Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings' indicates the following:

Definitions: (page 15)

- Environment of the client/patient/resident: The immediate space around a

client/patient/resident that may be touched by the client/patient/resident and may also be touched by the health care provider when providing care. The client/patient/resident environment includes equipment, medical devices, furniture (e.g., bed, chair, bedside table), telephone, privacy curtains, personal belongings (e.g., clothes, books) and the bathroom that the client/patient/resident uses. In a multi-bed room, the client/patient/resident environment is the area inside the individual's curtain.

Routine Practices: (page 46)

- The principle of Routine Practices is that all clients/patients/residents may carry harmful microorganisms regardless of their isolation status or diagnosis. Routine Practices are essential practices that must be followed by all staff working in clinical areas and are intended to prevent the transmission of organisms and to protect both staff and clients/patients/residents.

Environmental service workers must adhere to Routine Practices when working in the care environment. Routine Practices include: hand hygiene; use of personal protective equipment when indicated; safe management of sharps; cleaning and disinfection of equipment that moves from client/patient/resident to client/patient/resident; and environmental cleaning.

The licensee's 'Outbreak Management Unit Cleaning – After Isolation Has Ended' indicates that privacy curtains will be taken down, washed and replaced.

Resident #031 indicated to Inspector #554, that the privacy curtains are not being properly cleaned following an outbreak. Resident indicated residing in a room shared by three other residents, and indicated that two residents in the room were ill with outbreak symptoms recently, once the symptoms resolved, only the privacy curtain partially surrounding the ill resident was taken down, washed and replaced. Resident #031 indicated that the privacy curtain between the beds were not washed. Resident #031 indicated that concern was voiced to HSK #104 and the MS, but indicated the curtain was still not removed. Resident #031 indicated being concerned with staff not following proper infection control practices. Resident #031 indicated that concerns have been brought this to the attention of the DOC on more than one occasion.

HSK #104 indicated to Inspector #554, that following an outbreak the practice has been only takes down the privacy curtain that extends from the one side of the affected resident's bed, in a identified accommodation room, to the end of the affected resident's

bed. HSK #104 indicated the practice has not been to remove the privacy curtain between the two residents bed's, HSK #104 indicated the belief is that privacy curtain belongs to the unaffected resident. HSK #104 indicated being aware that cleaning technique specific to cleaning of privacy curtains post isolation is a concern of some residents. HSK #104 indicated taking down the privacy curtain between the two residents bed's use to be the practice, but HSK #104 indicated that belief that this practice changed but unsure when and at who directed the change.

The DOC, who is the lead for the Infection Prevention and Control Program, indicated to Inspector #554, that all staff have been provided training on infection prevention and control, and that they follow PIDAC best practice guidelines. DOC indicated that the following an outbreak the privacy curtains surrounding the affected resident's bed is to be taken down, washed and replaced. DOC indicated that the curtain that is between two resident's beds in a shared room is to be taken down and washed. DOC indicated that the privacy curtain between the two beds most likely has been coughed on or touched by the affected resident and or staff making this curtain contaminated. DOC indicated that this discussion has already taken place in the past with housekeeping staff, due to concerns brought forth by resident #031.

The DOC indicated that the practice surrounding cleaning of privacy curtains post isolation had not changed.

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program, specifically related to environmental cleaning post isolation. [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 there is a process in place and monitored ensuring that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Specifically failed to comply with the following:

s. 305. (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home. O. Reg. 79/10, s. 305 (3).
2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents. O. Reg. 79/10, s. 305 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that alterations, additions or renovations to the home did not commence without first receiving approval of the Director.

The floor plan which was provided by the Administrator and it indicated that there is a lounge located at the end of the south hall.

On an identified date, Inspector #554 observed that resident #054, the resident's bed and beside table had been relocated to the south-end lounge. Resident #054 was observed in this room and being provided care, by nursing staff, in this room on an identified date and as per the resident's health record the next day as well.

The ADM indicated to Inspector #554, that the approved floor plan for the long-term care home indicated that there is a lounge located at the end of the south hallway. The ADM indicated that the lounge is a resident space. The ADM indicated that the south-end lounge is occasionally used for care of identified residents. The ADM indicated being aware that two to three residents use the south-end lounge on a daily basis and indicated being aware that the residents, who use the room routinely, get upset when they cannot use the lounge. The ADM indicated that there had been no approval by the Director to alter the approved floor plan of the home.

The licensee failed to ensure that alterations, additions or renovations to the home did not commence without first receiving approval of the Director, specifically use of a resident lounge for use as a palliative care room. [s. 305. (3) 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 there is a process in place and monitored ensuring that alterations, additions or renovations to the home did not commence without first receiving approval of the Director, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

. The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone had occurred or may occur, must immediately report the suspicion and information upon which it was based to the Director.

Pursuant to O. Reg. 79/10, s. 2 (1), for the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, (a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual

exploitation directed towards a resident by a person other than a licensee or staff member.

Related to Resident #048:

The health record for resident #048 was reviewed by Inspector #554. Documentation in the health record, specifically a progress note, for an identified date, written by RPN #100 , provided the following details:
- Resident #048 was walking along side resident #024. Resident #024 reached out and inappropriately touched resident #048. Resident #048 was removed from the area.

RPN #100 indicated to Inspector #554, that the identified incident involving resident #048 and #024 was witnessed by PSW #138, and was reported by PSW the same day. RPN #100 indicated reporting the incident to the Charge Nurse-RN on shift that day, RPN indicated being unable to recall who the Charge Nurse-RN was on the identified date. RPN #100 indicated not documenting who the CN was that the incident was reported to.

Nursing Clerk indicated to Inspector #554, that RN #139 was the assigned Charge Nurse during the shift on the date of the incident.

RN #139 was not available for an interview during the time of this inspection.

The DOC indicated to Inspector #554, being unaware of the incident until the next business day. The DOC indicated the witnessed incident of resident #024 inappropriately touching resident #048 was not reported to the Director on date which it occurred, nor had the incident been reported to date.

The DOC indicated that incident was 'non-consensual'. The DOC indicated that resident #048 is unable to consent. The DOC indicated that being aware of reporting requirements under section 24 of the Act.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone had occurred or may occur, must immediately report the suspicion and information upon which it was based to the Director. [s. 24. (1)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 64. A licensee of a long-term care home shall attend a meeting of the Residents' Council or the Family Council only if invited, and shall ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of either Council only if invited. 2007, c. 8, s. 64.

Findings/Faits saillants :

1. The licensee failed to ensure that Administrator and staff only attend the Resident's Council meetings when invited.

The Resident Council meeting minutes, dated for a identified period, were reviewed by Inspector #554. The Resident Council meeting minutes provided documentation that the FSS attended the Resident Council meeting on identified dates and that the RD attended the meeting on an identified date.

Resident #031 indicated to Inspector #554, that "management appear at the Resident's Council meetings without prior invite from the Resident's Council". Resident #031 indicated that the FSS and the RD have appeared at the Resident Council meetings at two occasions without an invitation from the Resident Council.

AA #132 indicated to Inspector #554, being aware that the ADM and staff must be invited to attend the Resident's Council meeting. AA #132 indicated that recall of an occasion when management, specifically the FSS, had attended the Resident Council meeting without being invited by the Resident's Council. AA #132 indicated that on at an occasion they had invited the FSS to attend the meeting without discussion with the Resident's Council members.

The licensee failed has failed to ensure that the ADM and staff only attend the Resident's Council meeting when invited. [s. 64.]

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 12th day of December, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY BURNS (554), LYNDA BROWN (111), SARAH GILLIS (623)
Inspection No. / No de l'inspection :	2018_716554_0007
Log No. / No de registre :	008086-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 13, 2018
Licensee / Titulaire de permis :	Medlaw Corporation Limited 42 Elgin Street, Thornhill, ON, L3T-1W4
LTC Home / Foyer de SLD :	Pinecrest Nursing Home (Bobcaygeon) 3418 County Road 36, R.R. #2, BOBCAYGEON, ON, K0M-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mary Carr

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To Medlaw Corporation Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_673554_0023, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;

(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and

(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).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s. 15 (2).

Specifically, the licensee shall ensure that the home, furnishings and equipment is kept clean and sanitary, especially the tub-shower room.

The licensee shall further ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, specifically ensuring:
- the tub's acrylic finish has been repaired;
- the disinfectant hose/sprayer on the tub has been repaired and a bracket or holder for the disinfectant hose/sprayer has been affixed to the tub;
- the water spout (older stationary tub) has been repaired and or replaced;
- corrosion on lifts, transfer devices and bath chairs has been removed and the frame of the lift, transfer device or bath chairs refinished;
- all windows in the long-term care home are to be repaired or replaced ensuring that windows that made to open and close do so, without difficulty, from the inside by residents, staff and visitors;
- all window casement or frames are to be free of chipping, peeling or damage.

The licensee shall ensure that all maintenance concerns needing repair and or replacement are to be documented, prioritized and completed in a timely manner. Any repairs and or replacement awaiting parts and or contracted service providers arrival are to be dated and an expected date of repair documented and to be kept on-site at the home.

Grounds / Motifs :

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

During the initial tour of the long-term care home, on an identified date, the following was observed by Inspector #554:

Tub-Shower room-moist black debris was observed present along the wall ledge and along the wall ledge caulking, adjacent to the stationary tub. Similar debris was also observed on the floor under the stationary tub, along the air vent to the right of the stationary tub (vent closet to the floor) and the adjacent the floor drain. The moist black debris was able to be loosened when Inspector #554

scraped at it with a pen.

The same moist black debris was observed, by Inspector #554, during observations on four identified dates.

Personal Support Worker (PSW) #103 indicated, to Inspector #554 that the black debris is always observed present under the stationary tub, and is frequently present along the wall ledge and caulking. PSW #103 indicated that the Maintenance Staff (MS) and the ADM are aware of the debris.

Housekeeper (HSK) #104 indicated, to Inspector #554, that the tub room flooring is cleaned nightly by Dietary Staff, and indicated that the tub-shower room is cleaned on an identified date weekly by housekeeping staff. HSK #104 indicated that the tub-shower room walls are washed down, and the floors are wet mopped. HSK #104 indicated that they do not have access to a steamer, and do not routinely scrape at debris or grout when cleaning the tub-shower room. HSK #104 indicated being aware of the black debris in the tub-shower room, and indicated that MS use a special cleaner to remove the black debris in the tub-shower room. HSK #104 indicated that both the MS and the ADM are aware of the black debris in the room.

MS indicated, to Inspector #554, being aware that at times debris builds up along the walls, and along the wall ledge in the tub-shower room. MS indicated that they clean the black debris when told by staff it is again present. MS indicated that there is no scheduled cleaning of this debris.

The ADM indicated, to Inspector #554, that the debris identified is "dirt". The ADM indicated that the tub-shower room is cleaned on an identified shift by the Dietary Staff, and weekly on a specified day by housekeeping staff. The ADM indicated that the black debris, in the tub-shower room, should not be present and should have been identified and cleaned at a specified time of the day, as well as on a specific day weekly. The ADM indicated that cleaning procedures will need to be reviewed with both dietary and housekeeping staff.

The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary, specifically the tub-shower room. (554)

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

During the initial tour of the long-term care home, Inspector #554 observed the following:

- Tub - located in an identified room, the acrylic finish, outer surface of the tub was observed to have areas of damage. Inspector #554 observed that there were approximately eight-ten areas, each measuring 1.5 centimetres (cm) to 10 cm that were chipped or gouged. The gouged or chipped areas are porous in nature, and discoloured (greyish). This tub was observed to be in use by nursing staff;

- Disinfectant Hose/Sprayer on tub-located in an identified room, the yellow disinfectant hose/sprayer was observed lying in a basin of unknown fluid on the floor beside the tub. There was no bracket/holder observed on the tub for the disinfectant hose/sprayer;

- Water Spout of the Tub (older stationary)-was observed chipped/gouged in areas surrounding the water spout, within the same area a greenish discolouration and film were observed surrounding the water spout. This tub was observed to have been used on three identified dates during this inspection;

- Bath Chair-the identified bath chair, located in the tub room, was observed to have areas of corrosion on the frame, specifically the frame's legs. The largest areas of corrosion measured an area of approximately 15-20 cm (irregular).

Upon further observations on identified dates, the following was observed by Inspector #554:

- Windows-the windows in eight identified resident rooms were observed open approximately ½ to 1 inch. The windows would not close when attempted by the Inspector. (Note: this was an identified area of non-compliance in the Resident Quality Inspection the previous year).

- Window Crank-there was no window crank handle observed on the window in of an identified resident room, the casement for the window crank was observed

broken and lying on the window ledge; the crank mechanism was exposed.

- Window casement-the paint on the wooden casement/frame of the windows on identified resident rooms were observed chipped and peeling. (Note: this was an identified area of non-compliance in the Resident Quality Inspection the previous year).

The maintenance binder was reviewed by Inspector #554, for an identified time period. The above identified areas of maintenance disrepair were not identified in the maintenance binder for repair, and or replacement by the MS, or the Licensee.

PSW's #115, #130 and #134, HSK #104, and #108, as well as Registered Nurse (RN) #122, and 129, indicated to Inspector #554 during interviews on separate identified dates, that maintenance concerns when identified by staff are placed into the maintenance binder for review and follow up by the MS. PSW's #115 and #134 indicated that the disinfectant hose/sprayer had been lying on the floor in a basin for an identified time period; both PSW's indicated that there is no bracket/holder for the disinfectant hose/sprayer, indicating it broke off and it hasn't been repaired. PSW #115 and #134 indicated that the disinfectant hose/sprayer leaks and the fluid in the basin is disinfectant which has leaked from the hose/sprayer into the basin. Both PSW's indicated that the MS and ADM are aware that the hose/sprayer leaks and that there was no bracket/holder to hold it. PSW #115 indicated that the chipped/gouged areas on the acrylic finish of the tub had been present for a while. PSW indicated not being aware if the MS knew that the finish on the tub was chipped/gouged.

PSW's #131, and #134, HSK #104, and #108, and RN #122 indicated that the windows in the long term care have been a long-standing concern, all indicated that the windows in some resident rooms will not open and or close. PSW #134, RN #122, and HSK #104 indicated that staff have to go outside to close the windows. All staff interviewed indicated that MS and the ADM were aware of the windows not opening and or closing.

The MS indicated, to Inspector #554, that the maintenance binder is reviewed on specified times weekly. The MS indicated being aware of the identified areas of disrepair in the long-term care home. The MS indicated the following:

- Tub-the chipped/gouged areas (acrylic finish) are from wear and tear. MS indicated that there is currently no plan to repair the chipped/gouged areas on the tub surface.

- Disinfectant Hose/Sprayer of the tub- 'the staff keep breaking it (bracket/holder) off the tub, it takes a lot to repair it'. The MS indicated that they could repair the bracket/holder if needed but that there were currently no parts in the long-term care home to fix it. The MS indicated 'putting hose/sprayer in the basin on the floor was an easy fix to the problem'.

- Windows- 'the windows are old, they are the original windows'. The MS indicated that the windows all have wooden frames; indicating that 'staff leave the windows open and don't close them, and when it rains the window frame gets wet, and swells causing the window not to close'. MS indicated 'it's not a new problem'. The MS indicated that adjustments have been made to windows when told by staff that there is a problem with the window closing. The MS indicated 'some adjustments can be made but on most occasions now adjustments to most of the windows cannot be made. The windows need replacement'. The MS indicated both the ADM and the Licensee are aware of the windows being a concern.

- Window Crank-indicated being aware that the window crank and mechanism were broken in an identified resident room. MS indicated that both are broken and can't be repaired and indicated that the ADM and Licensee are aware.

The ADM indicated, to Inspector #554, that they were aware that there remains areas in the long-term care home needing repair and or replacement, specifically the windows. The ADM indicated being aware that there are some windows in the home that won't open and or close. ADM further indicated being aware that window crank in an identified room was broken. The ADM indicated 'the owner did have someone (contractor) in to look at an identified number of windows in the home, and provide a quote for those windows to be replaced'. The ADM indicated being aware that the Licensee has been provided a quote for the window replacement. The ADM indicated that 'as of today (date during this inspection) the quote had not been approved' by the Licensee. The ADM indicated not being aware that there were chipped/gouged area areas on both

tubs, but indicated that the tubs were older, and most likely the areas the Inspector identified were due to daily use by staff and residents. ADM indicated being aware that the disinfectant hose/sprayer was on the floor in a basin, indicating belief that the hose/sprayer leaked and it was being placed in the basin to prevent fluid (disinfectant) from spilling onto the floor. The ADM indicated not being aware that the identified bath chair had areas of corrosion on the frame.

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

The severity of this issue was determined to be a level 2 as there is minimal harm to residents. The scope of the issue was level 3 - widespread, as during this inspection many areas within the LTCH, were identified by inspector #554. The licensee had a level 4 compliance history as despite MOH action, ongoing non-compliance has continued pursuant to LTCHA, s.15 (2) that included, a Voluntary Plan of Correction (VPC) issued August 07, 2015, Resident Quality Inspection (RQI) #2015_291552_0020; Compliance Order (CO) issued October 04, 2017, RQI #2017_673554_0023. The licensee was to be compliant with LTCHA, s. 15 (2) as of February 28, 2018. [s. 15. (2) (c)] (554) (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 21, 2018

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 17 (1).

Specifically the licensee shall ensure that:
- there is a resident-staff communication and response system in every area accessible by residents and will further ensure that the resident-staff communication and response system is easily seen, accessed and used by residents, staff and visitors at all times.

Grounds / Motifs :

1. 1. The licensee failed to ensure that the resident-staff communication and response system can be easily seen, accessed, and used by residents, staff and visitors at all times.

On an identified date and time, resident #054 was relocated, by nursing staff, from one identified room to another identified room due to a change in resident's health condition. Resident #54 was observed, by Inspector #554, in the identified room where the resident was relocated. Resident #054 was observed to have no access to the resident-staff communication and response system, as

the resident-staff communication and response system for this room is located on the wall, a distance from where the resident was placed. There were no other resident-staff communication and response systems observed present in the room or accessible to resident #054.

Resident #054 was observed in this same room on a later identified date. The resident was observed to be alone at times.

PSW #112 indicated, to Inspector #554, that resident #054 would not be able to access the resident-staff communication and response system due to its location in the room. PSW #112 indicated that resident #054 would have to rely on staff entering the room for assistance. PSW #112 indicated that resident #054 would normally be checked upon every one to two hours.

The DOC and the ADM indicated that they were in agreement that resident #054 did not have access to a resident-staff communication and response system, during an identified period.

The licensee has failed to ensure that the resident-staff communication and response system can be easily seen, accessed, and used by residents, staff and visitors at all times, specifically for resident #054. [s. 17. (1) (a)] (554) (554)

2. 2. The licensee failed to ensure that there is a resident-staff communication and response system available in every area accessible by residents.

During the initial tour of the long-term care home, Inspector #554 observed that there was no resident-staff communication and response system available in the following areas:

- main foyer lounge
- patio located at the front of the home
- secured patio area at the back of the home, area off of the activity room / small dining room

The DOC indicated, to Inspector #554, that the main foyer lounge, and patios at the front and the back of the long-term care home are considered resident accessible areas. The DOC indicated being aware that there was no resident-

staff communication and response system available in the three identified areas. The DOC indicated being aware that a contracted alarm company was to install a resident-staff communication and response system in the main foyer lounge and both patio areas on an identified date. The DOC indicated that if a resident needed assistance from staff when in the main foyer lounge they could wait for staff to come by, or yell for assistance. The DOC indicated if outdoors, a resident would have to come in for assistance.

The ADM indicated, to Inspector #554, being aware that the main foyer lounge and the two patios areas not having a resident-staff communication and response system available. The ADM indicated that the home is small enough and residents could call out for help if they needed staff. The ADM confirmed that a contracted service provider, was scheduled to install a communication and response system in the three identified areas on an identified date, but had yet to arrive to install it.

As of an identified date during this inspection, there was no resident-staff communication and response system available or accessible by residents in the main foyer lounge and patio areas, located at the front of the home and at the back of the home.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 2 as a pattern in outside resident spaces and as needed palliative room. The home had a level 4 compliance history as they had on-going non-compliance pursuant to O. Reg. 79/10, s. 17 (1) that included, a VPC issued October 04, 2017, RQI #2017_673554_0023. [s. 17. (1) (e)] (554)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2018

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant: 2017_673554_0023, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 90.

Specifically, the licensee shall:
1. Ensure that the policy 'Maintenance Water Temperatures' meets the requirements under O. Reg. 79/10, s. 90 (2), specifically (i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degree's Celsius; and (k) procedures are developed and implemented to ensure that, if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water;
2. All Registered Nursing Staff, the Maintenance Worker and any other applicable staff receive training on the licensee's policy, Maintenance Water Temperatures. A written record must be kept of this training;
3. Develop a process to ensure that water serving all bathtubs and showers used by residents are monitored and maintained at a temperature of at least 40 C and that water temperature is monitored once per shift in random locations where residents have access to hot water. These temperatures are to be monitored and documented. If the water temperature is recorded as greater or less than 40 C, there is to be clear documentation of action taken and by whom. A written record must be kept of all water temperature monitoring and any action taken to remedy water temperatures greater or less than 40 C.

Grounds / Motifs :

1. 1. The licensee failed to ensure that procedures were developed and implemented to ensure that the hot water temperature serving all bathtubs and showers used by residents were maintained at a temperature of a least 40 degree's Celsius (C).

The licensee's policy, Maintenance Water Temperatures directs that water temperatures in resident areas will be monitored in order to maintain a temperature that meets the requirement of Regulation 79/10, s. 90 (2), including (i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degree's Celsius.

Charge Nurse Responsibilities:

- Charge Nurse shall ensure the water temperatures are taken once per shift in random locations where residents have access to hot water.
- Temperatures are documented on the Shift Report with the time, location and initials of the person taking the temperatures.
- Water temperatures should be at least 40 C, but must not exceed 49 C.
- If the water temperature is outside the acceptable range staff should do the following, immediately notify Maintenance staff in the building, write a note in the maintenance book at the nursing station requesting the temperature be adjusted, notify all nursing staff of the temperature and direct them to take precautions when using the water, as well as notify and supervise residents that may use the water independently.

Maintenance Staff Responsibilities:
- When notified of an unacceptable temperature reading, Maintenance Staff will adjust the hot water heater thermostat accordingly and recheck the temperature in 1-2 hours to ensure it has reached an acceptable level.

On identified dates, the shower head from the shower stall, adjacent to the tub (stationary), was observed, by Inspector #554, draped over the side of the tub, in the tub/shower room.

PSW's #131 and #134 indicated to Inspector #554 that the shower head from the shower stall is being used to add hot water to the tub. PSW #131 and #134 indicated that the tub (stationary) has had 'no hot water coming from it for sometime'.

On an identified date and hour, with the faucet turned on, the faucet dial turned to hot, and the water running five minutes, Inspector #554 took the temperature of the water, with a thermometer provided to the Inspector by the ADM. The temperature of the water, coming from the faucet of the tub (stationary) was 35.7 degree's Celsius.

RN #122 indicated to Inspector #554, that water temperatures for the tub is taken, by registered nursing staff, during an identified shift. RN #122 indicated that the water temperature for the tub is to be recorded in the 'shift report' book.

The Shift Report book was reviewed, by Inspector #554, for an identified period.

The Shift Report book directs that the tub temperature is to be taken by staff on an identified shift. The following water temperatures, for the tub, were documented as follows:

In an identified month:

- Water Temperatures taken were documented as below 40 degree's Celsius on six occasions during this month;
- No water temperature were documented on 24 dates during this month.

In an identified month:

- Water Temperatures taken were documented as below 40 degree's Celsius on five occasions during this month;
- No water temperature were documented on on 18 dates during this month.

PSW #115 indicated to Inspector #554, that the water temperature (for the tub) should be at least 97-98 degree's Fahrenheit (F).

PSW #130 indicated to Inspector #554, that the water temperature (for the tub) should be 94 F.

Both PSW #115 and #130 indicated that they were not aware if the licensee had a policy with regards taking of water temperatures, and when to report water temperatures being out of range. Both PSW's indicated that registered nursing staff are responsible for taking water temperatures, which would include tub water temperatures, in the long-term care home.

RN #122 indicated that the taking and recording of water temperatures is the responsibility of registered nursing staff. RN #122 indicated not being familiar with what the water temperature range was to be and unaware of the licensee having a policy regarding taking of or reporting water temperatures.

The DOC indicated to Inspector #554, that the Charge Nurse is to take and record water temperatures on all shifts, and indicated that the tub temperature is taken and recorded by the identified shift, and recorded in the Shift Report book.

The MS indicated to Inspector #554, not notified of water temperatures serving tubs and showers to be below 40 C in the identified two months. The MS indicated being unaware of what the acceptable water temperature range was to be. The MS indicated being told, by the ADM, that the 'source' water temperature was to be 48 C. The MS indicated being unaware if the licensee had a policy regarding the taking, recording and reporting of water temperatures. The MS indicated having never adjusted the water temperature in the long-term care home as it exceeds their qualifications.

The licensee has failed to ensure that procedures were implemented to ensure that the hot water temperature serving all bathtubs and showers used by residents were maintained at a temperature of a least 40 degree's Celsius (C). [s. 90. (2) (i)] (554)

2. 2. The licensee failed to ensure that procedures are developed and implemented to ensure that, if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water.

The licensee's policy, Maintenance Water Temperatures directs that water temperatures in resident areas will be monitored in order to maintain a temperature that meets the requirement of Regulation 79/10, s. 90 (2), including (i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius.

Charge Nurse Responsibilities:
- Charge Nurse shall ensure the water temperatures are taken once per shift in random locations where residents have access to hot water.
- Temperatures are documented on the Shift Report with the time, location and initials of the person taking the temperatures.
- Water temperatures should be at least 40 C, but must not exceed 49 C.
- If the water temperature is outside the acceptable range staff should do the following, immediately notify Maintenance staff in the building, write a note in the maintenance book at the nursing station requesting the temperature be adjusted, notify all nursing staff of the temperature and direct them to take precautions when using the water, as well as notify and supervise residents that

may use the water independently.

Maintenance Staff Responsibilities:
- When notified of an unacceptable temperature reading, Maintenance Staff will adjust the hot water heater thermostat accordingly and recheck the temperature in 1-2 hours to ensure it has reached an acceptable level.

The MS indicated to Inspector #554, that the long-term care home does not use a computerized system for monitoring water temperatures. The MS indicated assuming that the nursing department take the water temperatures.

RN #122 indicated to Inspector #554, that water temperatures are taken and documented by registered nursing staff working an identified shift. RN #122 indicated that the water temperature taken, by Registered Nurse, is to be recorded in the 24 hour Shift Report book.

The 24 hour Shift Report book was reviewed, by Inspector #554, for an identified period. The Shift Report book directs that water temperature is to be taken by all shifts. The Shift Report book indicates that identified staff take the 'source' temperature, plus a room water temperature; that next shift's RN take a room and the tub water temperature; and the next shift's RN takes a room water temperature.

The Shift Report book provided the following:

In an identified month:

- No water temperatures in random locations were documented as taken, during the day or evening shift, on 26 dates during this month, as well as no evening water temperatures taken on three dates and no water temps taken on any shift on three dates during the month.

In an identified month:
- water temperatures were inconsistently taken and or documented on identified shifts during this month.

RN #101 indicated to Inspector #554, that water temperatures are to be taken by registered nursing staff on all shifts, and recorded in the 24 hour Shift Report book. RN #101 indicated being unfamiliar with the water temperature policy.

The MS indicated being unaware of any policy related to monitoring of water temperatures.

The DOC indicated to Inspector #554, that the water temperatures are to be taken on all shifts by the registered nursing staff and recorded in the 24 hour Shift Report book. DOC indicated being unaware that water temperature had not been taken consistently on all shifts during the identified two months. DOC indicated having reviewed the 24 hour Shift Report book daily but did not notice water temperatures had not been taken.

The ADM indicated to Inspector #554, that registered nursing staff are responsible to take water temperatures on all shifts, record readings and report abnormal temperatures to both DOC and MS. The ADM indicated that the DOC is responsible for reviewing the 24 hour Shift Report book for areas of concern. The ADM indicated being unaware that water temperatures had not been taken consistency during the identified period.

The licensee has failed to ensure that procedures are implemented to ensure that, if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. [s. 90. (2) (k)]

The severity of this issue was determined to be a level 2 as there was a potential for actual harm to residents. The scope of the issue was level 3 - widespread, as the home has only one tub-shower room for all of its residents. The licensee had a level 4 compliance history as despite MOH action, ongoing non-compliance has continued pursuant to O. Reg. 79/10. s. 90 (2) that included, a CO issued October 04, 2017, RQI #2017_673554_0023. The licensee was to be compliant with O. Reg. 79/10, s. 90 (2) as of February 28, 2018. (554)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 30, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 13th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Burns

Service Area Office /
Bureau régional de services : Central East Service Area Office