Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

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

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 14, 2018 | 2018_669642_0002 | 000628-18 | Resident Quality Inspection |

## Licensee/Titulaire de permis

City of Greater Sudbury
200 Brady Street PO Box 5000 Stn A SUDBURY ON P3A 5P3

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

PIONEER MANOR
960 NOTRE DAME AVENUE SUDBURY ON P3A 2T4

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

AMY GEAUVREAU (642), CHAD CAMPS (609), SHELLEY MURPHY (684)

## 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): January 22-26, 29-31, and February 1-2, 2018.**

**The following intakes were inspected during this Resident Quality Inspection (RQI):**

**-Follow Up intake: related to Compliance Order #001, from inspection report #2017_657681_0006, s. 24 (1) of the Long-Term Care Homes Act (LTCHA),2007, specific to late reporting of abuse to the Director**

**-Five Critical Incidents intakes (CIS): related to critical incident's the home submitted to the Director regarding alleged abuse between, resident to resident, and staff to resident.**

**-One CIS intake: related to a critical incident the home submitted to the Director regarding an injury after a fall.**

**-One Complaint intake: a complaint submitted to the Director which was related to not following the resident's plan of care.**

**During the course of the inspection, the inspector(s) spoke with the Manager of Administration, Manager of Resident Care (MRC), Physician, Physician Liaison, Manager of Therapeutic Services, Program Coordinators, Physical Therapist (PT), Registered Dietitians (RDs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Support Ontario-RPNs, (BSO-RPNs), Nutritional Aid (NA), Health Care Aides (HCAs), Personal Support Workers (PSWs), family members, and residents.**

**The Inspectors also conducted a tour of the resident care areas, reviewed resident care records, home investigation notes, home policies, relevant personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**
**Sufficient Staffing**

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

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

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 24. (1) | CO #001 | 2017_657681_0006 | 642 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 37. Personal items and personal aids**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

a) On a specific date, during a tour of the home, Inspector #609 found a used unlabelled comb and used nail clipper in one of the unit's spa rooms, while in the unit's other spa room a used unlabelled comb was found.

Inspector #609 observed on a specific date, in a Lodge unit's spa room, a used unlabelled comb, used nail clipper and hair dryer.

During an interview with the Program Coordinator (PC) #109, they said the used unlabelled items found in a Lodge unit's spa room should be labelled with the resident's name.

A review of the home's policy titled, "Personal Care Daily Grooming, Dressing, Foot and Nail Care," last revised December 30, 2012, indicated that all nail care equipment was to be labelled with the resident's name.

b) Inspector #684 observed on a specific date, in resident #026's shared bathroom, a slipper bedpan, unlabelled under the vanity. Resident #027's shared bathroom was observed to have, two slipper bedpans one on top of the other, unlabelled. In resident #028's room, there was one unlabelled bed pan.

Inspector #684 observed in resident #026's shared bathroom an unlabelled slipper bedpan. Resident #030's bathroom was noted to have a raised toilet seat on the floor under the vanity not labelled. Resident #031's shared bathroom, was observed to have a wash basin and a urine collection container, under the sink, items were unlabelled.

During an interview with the Manager of Resident Care (MRC), they verified that all residents' personal care items should have been labelled with the resident's name. [s. 37. (1) (a)]

2. The licensee has failed to ensure that the resident’s personal items, including personal aids such as dentures, glasses and hearing aids were cleaned as required.

On a specific date, Inspector #609 observed resident #002 and #004 with significantly soiled wheelchairs. On another specific date, resident #002 and #004's wheelchairs were observed to remain significantly soiled. On another specific date, the two wheelchairs were observed to remain soiled, with the same residue noted initially on the first date.

A review of the home's Family Council meeting minutes found that from a specific month, and up to four months later, members of the council were bringing concerns forward that wheelchairs were not being cleaned on an ongoing basis, with some wheelchairs, "in desperate need of cleaning."

During an interview with the Manager of Therapies, they confirmed that resident #002 and #004's wheelchairs' were significantly soiled and should have been spot cleaned at the time of the spills, as well as monthly, as indicated on the, "Equipment Cleaning List."

A review of a specific time, noted the monthly Equipment Cleaning List found that resident #002's wheelchair was documented by PSW #143 as cleaned, on a specific date, while resident #004's wheelchair was documented as cleaned by PSW #143 on another specific date.

A review of the home' s policy titled, "Equipment Repair Maintenance and Cleaning," last revised April 22, 2014, required all staff to wipe up all spills/dirt as they occurred on wheelchairs and that each staff member was responsible to ensure that their assigned residents equipment were kept in clean, sanitary condition.

During an interview with PSW #143, they verified that they were present and working on two dates in a specific month. They outlined that on night shift on the day stipulated on the Equipment Cleaning List, the resident's ambulatory aid would be brought to the spa room, cleaned, dried and at the end of the shift would be returned to resident's room. However, the PSW acknowledged that when they were pulled from regular duties or if they had a busy shift, the equipment would not always be cleaned, despite documenting that they were on the Equipment Cleaning List. [s. 37. (1) (b)]

***Additional Required Actions:***

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

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

**Specifically failed to comply with the following:**

**s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

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

**Findings/Faits saillants :**

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

A Critical Incident (CI) report, was submitted by the home to the Director on a specific date, which identified alleged sexual abuse between two residents. The CI report indicated that resident #038 and #045 were found by staff, physically touching. Resident #038 was noted to have an injury.

a) On a specific date, Inspector #609 observed resident #045's door, which had a device applied. A review of resident #045's plan of care, found no mention that a device was to be applied to the resident's door.

During an interview with PSW #162, they verified that resident #045 was to have a device applied to their door, and that this had been ongoing for at least three months.

During an interview with a Behavioural Support Ontario (BSO)-Registered Practical Nurse (RPN), #138, they verified that resident #045 had responsive behaviours, that the device was to be applied to the resident's door, and should have been identified in the resident's plan of care.

b) On a specific date, Inspector #684 observed resident #005's door, which had the device applied.

A review of the plan of care for resident #005, found that resident #005's plan of care had not outlined the specific device.

A review of the home's policy titled, "Documentation – Resident Care Plan," last revised May 2, 2013, indicated that the plan of care would reflect the resident's safety and security risks.

During an interview with Program Coordinator (PC) #109, they stated that resident #045 and #005's plan of care should have had the device identified in their written plan's of care if the resident's had them in use. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

On a specific date, Inspector #684 observed resident #011's bed with two bed mobility device's in the engaged position.

Inspector #684 interviewed resident #011, who stated that they had not used the bed

mobility device and had a specific preference related to sleep.

Inspector #684 reviewed the home's policy titled, "Resident Care Plan," last revised on May 2, 2013, which indicated that all residents of Pioneer Manor were to have an individualized resident care plan that reflected their needs and care wishes.

Inspector #684 reviewed resident #011's written plan of care, which failed to indicate the residents sleep related preference.

Inspector #684 interviewed RN #130 and RPN #124 on a specific day, who both stated that resident #011 had a preferred sleep preference.

Inspector #684 interviewed PC #121, who stated that resident #011's written care plan was not reflective of the resident's current preference and it should have reflected that resident #011 sleep preference. [s. 6. (2)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A Critical Incident (CI) report was submitted to the Director on a specific date, related to resident #013, who had a fall which caused an injury.

During a review of resident #013 current care plan at the time of the fall, Inspector #684 noted the care plan stated that resident #013 was ambulatory.

Inspector #684 reviewed the Physical Therapist (PT), Quarterly assessment, which stated, the resident required staff assistance and used a mobility device.

On a specific date, Inspector #684 interviewed RPN #142, and PSW #117, who stated that resident #013 was not ambulatory.

Inspector #684 interviewed PT #145, who stated that resident #013 was not ambulatory. The PT confirmed that the current care plan had not reflected the resident's current mobility status.

Inspector #684 reviewed the policy titled, "Resident Care Plan," last revised May 2, 2013. The policy stated, the resident's plan of care was re-assessed during resident

admission/annual case conferences, and when current status changed and quarterly.

Inspector #684 interviewed the Manager of Therapeutic Services #146, who confirmed that the Falls section of the care plan for resident #013, was not up to date and had not reflected the resident's current care status. [s. 6. (10) (b)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any other time when care set out in the plan had not been effective.

The CI report was submitted by the home to the Director, on a specific date, which alleged resident to resident abuse. The CI report outlined how resident #016 had an altercation with resident #015. When staff arrived resident #016 was found to have received an injury.

Inspector #609 reviewed resident #015's written plan of care and found that on the day of the altercation the plan of care was updated to include, that when the resident was in their room, a device was applied to their door.

On a specific day, resident #015 was observed in their room with no device applied to their door, the hardware, which were meant to hold the device in place were missing as well.

Inspector #609 reviewed 20 residents' plans of care on a specific date from a specific Lodge, and found that resident #015 as well as #016, #020 and #021 were to have the same device applied to their doors. On a specific date, the Inspector found no devices applied to any of the four residents' doors.

During interviews with PSW #107 and #119, they both indicated that the residents on a specific unit took the devices off the doors. Neither PSW were able to locate a device on this unit and they stated that the hardware that are used to hold the device's were also being removed by the residents.

During an interview with BSO-RPN #120, they said the devices were not being used because the residents would take the devices off the doors and removed the hardware that they used to hold the devices as well. BSO-RPN #120 stated that the devices should be removed from the four identified residents' plans of care as it was not an effective intervention on this unit.

A review of the home's policy titled, "Documentation – Resident Care Plan," last revised May 2, 2013, required the resident's care plan to be assessed and updated as needed so that the resident's preferences, needs, potential needs, abilities and risks were reflective, accurate and current of the actual care provided.

During an interview with the MRC, they verified that applying the devices to residents' doors within a specific unit was not an effective intervention as the residents removed them along with the hardware that used to apply them. [s. 6. (10) (c)]

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the weight monitoring system to measure and record with respect to each resident had height's taken annually.

Ontario Regulation 79/10, s. 68 (2) (e) requires the licensee to ensure that nutrition and hydration programs included a weight monitoring system to measure and record with respect to each resident body mass index and height upon admission and annually thereafter.

Inspector's #642, #609, and #684 reviewed the resident's electronic health care records on Point Click Care (PCC), for the resident's yearly heights for a specific year. Inspectors reviewed residents, #002, #011, #024, #025, #033, #034, #035, #036, #040, #041, #042, #043 and found that all these residents had heights from the previous year. Out of the 40

residents' health records reviewed, 12 or 30% of the population, had no heights recorded for a specific year.

Inspector #642 reviewed the licensee's policy titled, "Resident Heights," last revised, September 27, 2017, which stated, "At a minimum, all residents will have height measured upon admission (within seven days) and on an annual basis and recorded in the resident's record."

Inspector #609 interviewed the MRC, who stated that the Physician Liaisons will take the yearly heights when the residents get their annual medical examinations. This would then be forwarded to the Registered Dietician (RD), for inputting into PCC once the Body Mass Index (BMI) was reviewed.

Inspector #642 interviewed the RD, on a specific date, who stated that the yearly heights were completed with the resident's annual medical physicals, therefore if the yearly physicals were not completed then they would not have the updated heights. The RD stated that the resident's annual physicals should be documented in the residents paper medical files, from this they would then enter the new heights in PCC.

Inspectors #642, #609 and #684, reviewed the resident's paper medical files for the specific year and the yearly heights for the 12 residents identified and found only a certain year was completed for the annual physician physicals. These 12 residents had not had yearly heights completed for a certain year.

Inspector #642 interviewed the Physician Liaison #159, who stated they completed yearly heights for all the resident's with the annual medical physicals in the home, and they confirmed that the 12 residents that the Inspectors reviewed, had not had their specific updated yearly heights completed.

Inspector #642 interviewed the Administrator, who stated that per the Heights Policy, they were required to complete the yearly heights for the 12 residents identified for the specific year. [s. 8. (1) (b)]

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

On a specific date, Inspector #609 observed that the second floor clean utility room in a specific Lodge, was unlocked, open and unattended. Inside the utility room was noted to have a hot water hydrocollator.

During an interview with HCA #101 they verified that the second floor clean utility room in the Lodge should have been locked when not attended by staff and proceeded to lock the clean utility door.

A review of the home's policy titled, "Door Locking" last revised June 28, 2017, indicated that all service room doors, which included utility and linen rooms were to be kept locked at all times. [s. 9. (1) 2.]

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**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 has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A CI report was submitted by the home to the Director, on a specific date. The home had received an email on a specific date, from the Substitute Decision-Maker (SDM) for resident #017, indicating alleged staff to resident emotional abuse.

The home's policy titled, "Abuse: Resident Abuse/Neglect," last revised November 10, 2017, indicated that, "Emotional Abuse was any threatening, insulting, intimidating or humiliating, gestures, actions, behaviour or remarks towards a resident which caused alarm or fear, performed by anyone other than a resident."

Inspector #642 reviewed the home's internal investigation documents, email and interview notes from the SDM, which stated that the incident happened on a specific date. The email stated that resident #017 required assistance prior to attending to an activity, the SDM stated the resident called them and informed them that HCA #132 had said that they could go to the event but they had not been able to provide the required assistance. The SDM called the home, asking for the resident to receive assistance. The resident received assistance after the HCA had been informed by the RN. The SDM stated, that the resident reported to them that the HCA confronted the resident and this upset the resident.

Inspector #642 interviewed HCA #132, who stated that they had made a verbal remark to resident #017 on a specific date, that was intimidating to the resident and had upset them. The HCA stated that they had received disciplinary action.

Inspector #642 interviewed the MRC, and PC #155, who both confirmed that it was the expectation of the home that all staff were to follow the Zero Tolerance of Abuse Policy and HCA #132 had received disciplinary action for this incident.

A Director Order was issued to the licensee on September 14, 2017, to address failure to comply with s. 20. (1) of the LTCHA, 2007. The compliance due date of this Director Order was January 1, 2018. [s. 20. (1)]

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Inspector #609 observed on:
-A specific date, a medication administration with RPN #128, who administered resident #046's injectable medication with a specific device,
-Another specific date, RPN-Student #156 was observed administering resident #046's injectable via a specifc device.
-Another specific date, RPN #158 was observed administering resident #044's injectable via a specific device.

In all three injectable administrations, the registered staff primed the devices with the caps still on in the horizontal position.

A review of the home's policy titled, "Medication Administration Injectables Utilizing Safety Devices," last revised October 20, 2016, required staff to ensure that during the medication injection they followed the specific manufacturer's instructions.

Inspector #609 reviewed, a document with instructions for the injectable device, last revised 2017, which indicated, "The injectable was to be primed two units, top of the needle pointing up to collect air bubbles and continuing to hold the needle up push the dose knob in until it stopped. The medication should then be seen at the tip of the needle."

During an interview with the RPN #163, they outlined how the specific injectable required priming with two units. This was done in the vertical position (top of needle pointing up), with the cap off the needle to visually ensure that the needle was properly primed.

Inspector #609 interviewed the MRC, who verified that staff were to follow the manufacturer's instructions when administering this injectable medication. [s. 23.]

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the responsive behavior plan of care based on an interdisciplinary assessment of the resident includes, any mood and behavior patterns, including wandering, any identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day.

Inspector #642 interviewed resident #008 on a specific date, where they reported an incident of alleged verbal abuse by a staff member. Resident #008 stated that, one staff member had made belittling comments to them. The resident said they were in pain at the time and had refused to take part in a certain activity. Resident #008 stated that it happened a few weeks ago, and that they were provided the care the next day. The resident provided the Inspector with the specific staff member's names, to whom they had reported the incident.

Inspector #642 provided this information to the MRC, on a specific date. The MRC immediately proceeded with an investigation.

Inspector #642, and #609 interviewed the MRC on a specific date, who stated, that they had completed an investigation of the alleged abuse incident. Resident #008 was known to have responsive behaviours and that the incident was not collaborated.

The MRC stated, from the beginning of this investigation, this allegation was due to the resident #008's responsive behaviors, which the home was aware of since the resident had been admitted. The MRC stated that the responsive behaviours where identified on the Community Care Access Centre (CCAC) assessments when the resident was admitted, as well through their own, completed BSO assessments.

During the interview with Inspector #642 and #609, Inspector #609 asked the MRC to show where in the care plan, these responsive behaviours were identified.The MRC

responded after reviewing the full care plan that for resident #008, the responsive behaviour's were not clearly identified.

Inspector #642 reviewed the documentation from CCAC, the hospital, the psychiatrist assessment, the BSO referral and assessment forms. There was extensive documentation, on resident #008's responsive behaviours.

Inspector #642 interviewed BSO-RPN #138, who stated, "That resident #008's responsive behaviours could be written clearer then they were in the care plan." Inspector reviewed the care plan again on a specific date, and it had been updated to include resident #008's mood and behavior patterns, and identified responsive behaviours for different times of the day. [s. 26. (3) 5.]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)**

**Specifically failed to comply with the following:**

**s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,**
**(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination; O. Reg. 79/10, s. 82 (1).**
**(b) attends regularly at the home to provide services, including assessments; and O. Reg. 79/10, s. 82 (1).**
**(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the physician conducted a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produce a written report of the findings of the examination.

Inspector #684, #609 and #642 reviewed the following resident electronic health care records, in PCC, for residents #002, #011, #024, #025, #033, #034, #035, #036, #040, #041, #042, and #043, and found that there were no annual heights taken for a specific year.

Inspector #609 interviewed the MRC, who stated that the heights (HT) come from the yearly physicals that the Physician conducts and then the Physician Liaison enters them into PCC. The MRC stated that if the HT's were not in PCC then they should be documented in the medical file with the yearly medical physicals.

Inspector #684 interviewed Physician Liaison #159, regarding the physicals for the 12 residents electronic health care records reviewed by the Inspectors. The Physician Liaison reviewed their list of medical physicals for the above noted residents and verified that these residents had not had a annual physical conducted.

Inspector #684 interviewed Physician #161, regarding a specific year of resident physicals and they indicated that not all annual physicals were done for that specific year.

Inspector #684 reviewed Policy and Procedure titled, "Documentation Physician Assessments," last revised February 14, 2017. The policy states the following: Each resident will receive a minimum of one comprehensive medical examination upon admission and yearly by the attending physician. The purpose states, to ensure the completion and documentation of an annual medical assessment for each resident of the Home as per legislative requirements.

Inspector #684 interviewed the Administrator, who stated, that physicals must be completed annually. The MRC confirmed, the yearly medical physicals for the 12 identified residents were not all completed for a specific year. [s. 82. (1)]

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

Inspector #684 observed the lunch meal service on a specific date. PSW #101, was observed picking up dirty plates, placing them into a bin, then proceeded to provide a dessert to a resident, without washing their hands in between. After providing dessert to a resident, PSW #101, proceeded to sit down and feed two residents who required assistance, without washing their hands. Inspector #684 then observed PSW #141 on the unit, remove a plate when a resident was finished eating their meal, and without washing their hands, proceeded to bring the resident their dessert.

Inspector #684 reviewed the home's policy titled, "Infection Prevention and Control Program: Hand Hygiene Program," last updated on May 31, 2016. The policy included, "The 4 Moments for Hand Hygiene in Health Care-Just Clean Your Hands," stated which,
-Before initial resident or environment contact,
-Hands of residents, staff, volunteers or family members are to be cleaned before assisting with meals or snacks; and
-If, during assisting with meals or snacks of one or more residents, there is exposure of the hands to saliva or mucous membranes, hands should be cleaned before continuing.

Inspector #684 interviewed PSW #114, regarding proper hand hygiene. The PSW stated, they wash their hands before entering the dining room, before delivering food to a resident, and after picking up dirty dishes.

Inspector #684 interviewed the Infection Control Lead #121, who stated that staff were to use, "The 4 Moments for Hand Hygiene," before and after resident care, and before and after touching residents' objects. Staff were to wash their hands before and after going into the dining room, before serving food, before and after touching any food. The Infection Control Lead said, that the staff had not followed the hand hygiene policy and procedure. [s. 229. (4)]

**Issued on this 15th day of February, 2018**

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

**Original report signed by the inspector.**