Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 26, 2015	2015_198117_0010	O-001790-15	Resident Quality Inspection

Licensee/Titulaire de permis

UNITED COUNTIES OF PRESCOTT AND RUSSELL
59 Court Street Box 304 L'Orignal ON K0B 1K0

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

RESIDENCE PRESCOTT et RUSSELL
1020, Cartier Boulevard HAWKESBURY ON K6A 1W7

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

LYNE DUCHESNE (117), JOANNE HENRIE (550), LISA KLUKE (547), SUSAN WENDT (546)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 13, 14, 15, 16, 17, 20, 21, 22, 23 & 24, 2015

It is noted that a Critical Incident Inspection (Log # O-001927-15) and a Complaint Inspection (Log # O-002011-15) were conducted concurrently and findings of non-compliance are incorporated into this inspection report.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Nursing Supervisor, Clinical Coordinators, RAI Coordinator, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), several Dietary Aides, several Housekeeping Aides, the home Environmental Supervisor, a Maintenance staff member, to several residents, to several family members and caregivers, as well as to the President of the Resident Council and the President of the Family Council. During the course of the inspection, inspectors reviewed resident health care records, several of the home's policies and procedures including Zero Tolerance for Abuse Policy and Minimizing Restraint Policy, the home's Continence Care and Bowel Management Program, the home's Responsive Behaviour Program, observed the meal service of April 13 2015, reviewed the minutes of the Residents and Family Councils for 2014-2015, observed several resident rooms, common areas and resident care equipment.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
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.
- **7 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s. 6 (1) (a) in that the written plan of care for each resident did not set out the planned care for the resident.

Resident #017 has advanced cognitive impairments and requires staff assistance with the provision of personal care, dressing and grooming.

On April 16, 2015, Resident #017 was observed to be partially undressed at 11am. The resident had removed his/her top, both shoes and a sock. The resident did have on a camisole. The resident was observed to be rummaging in his/her bedside table. Resident #017 was unable to explain to Inspector #117 why he/she had removed part of his/her clothing. PSW staff member S#102 stated that Resident #17 does regularly remove part of his/her clothing. This behaviour usually occurs in late mornings and late afternoons. The PSW stated that staff have to monitor to ensure the resident is clothed and if he/she does remove his/her clothing that they assist with his/her dressing. On April 23, 2015, at 11:15am, the resident was observed in the unit TV lounge to be fully clothed, when the resident started to take off his/her top. PSW S#106 was observed to intervene and redirect the resident to ensure that he/she does not undress himself/herself.

A review of the resident's health care record and plan of care was conducted by Inspector #117. No information was found in the record and plan of care in regards to the resident's responsive behaviours of undressing. As per interviewed staff members PSWs S#102, S#106 and unit RPN S#107, Resident #017 has been undressing and rummaging in his/her clothing for several months. Staff reports that the behaviours occur several times per week. PSW staff S#102 and S#106 report that on occasion the resident

can be resistive to redressing and staff needs to redirect and re-approach the resident when this occurs. The unit RPN S#107 was not aware that the resident's responsive behaviour related to undressing was not identified in the resident's plan of care and stated that it should be as this occurs on a regular basis.

On April 23 2015, the home's Nursing Supervisor stated that resident's responsive behaviours should be identified in the resident's plan of care and concurred that Resident #017's plan of care did not set out the planned care for the resident in regards to undressing responsive behaviours. [s. 6. (1) (a)]

2. The licensee failed to comply with LTCHA s. 6 (1) a) in that the written plan of care for each resident did not set out the planned care for the resident.

Resident #015 is hemiplegic, aphasic and requires 1-2 person assistance with all aspects of personal care. On April 15 2015, Resident #015 was observed to lying in bed. Bruises to both forearms and a dressing to a forearm were observed by Inspector #117. No date on the dressing was noted to be present.

Resident #015's health care record was reviewed with the unit RPN S#104 on April 22 2015. It was noted that the resident has been on long term anticoagulant therapy for several years. To monitor the effectiveness of the anticoagulant therapy and blood chemistry, blood work is done every 3 weeks. The unit RPN S#104 stated that Resident #015 has very fragile skin that bruises easily and that the resident frequently has bruises to his/her arms after laboratory services have come to the home to complete the requisitioned blood work. Documentation indicates that on a specified day in March 2015, the attending physician discontinued the medical order for anticoagulant therapy. However blood work is still being done monthly to monitor the resident's blood chemistry. The RPN confirmed that Resident #015's fragile skin and risk of bruising due to medication and blood work is not identified in the resident's current written plan of care.

Further discussion was held in regard to the elbow dressing. Unit PSWs S#127 and S#128 stated that Resident #015 has a behaviour in which he/she rubs and hits his/her Broda chair plastic lap tray when he/she is seated in the Broda chair. Both PSWs report that resident's behaviours caused a skin tear on a specified day in April 2015. Unit RPN S#130 confirmed the resident's behaviour and cause of the skin tear. The treatment of the skin tear and dressing was noted in the resident's Treatment Administration Record (TAR). The unit RPN confirmed that there is no information in Resident #015's written

plan of care in regards to the resident's behaviour of rubbing and hitting his/her arm on the Broda lap tray and the resident's risk of bruising and skin tear.

Resident #015's written plan of care does set out the planned care to the resident in regards to the potential risk of skin tears and bruises due to behaviours, anticoagulant therapy and monthly prescribed blood work. [s. 6. (1) (a)]

3. The licensee has failed to ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.

Resident #004, diagnosed with urinary retention, was admitted to the Home in May 2014 with an indwelling catheter.

During an interview with RPN Staff #108 on April 15 2015, the RPN indicated that the resident was admitted to Home with the indwelling catheter. Staff #108 indicated that Resident #004 did not use the toilet for voiding as he/she had a catheter in place and had had frequent urinary infections. Upon observations, the inspector noted that the resident also wore an incontinence brief as he/she also experienced fecal incontinence.

A review of Resident #004's written plan of care was conducted by Inspector #546. It was noted that the resident has a urinary Foley Catheter #14; the catheter is to be changed monthly and the urinary catheter is to be irrigated twice a week. It also notes that the resident would be kept clean, dry and odor-free in all times; staff are to observe and report to the nurse all redness and ensure that skin is clean and dry at all times; and finally that the resident also wears a continence brief.

Further review of the resident's health care record was done. Documentation indicates that the resident had 9 urinary infections, which required antibiotic treatment between May 2014 and March 2015. This was not identified in the resident's written plan of care.

The written plan of care documents that the resident has a size #14 urinary Foley catheter. A review of the Medication Administration Records (MAR) documents that from May 2014 until September 2014, registered nursing staff changed the size #14 foley catheter on a monthly basis. However, in September 2014, the MAR documented that

the foley catheter was a size #16. MAR documentation from September 2014 to April 2015 shows that the resident's foley catheter was a size #16 versus the prescribed size #14 catheter. Inspector #546 observed that the resident currently has a size #16 Foley catheter in place. No medical orders or reason for a change in the size of the urinary Foley catheter was found in the chart. It was also noted that no catheter change was completed in June 2014 and that there are omissions and inconsistencies in catheter irrigations and drainage bag changes.

During interviews with RPN S#100 and RPN S#108 on April 15 and on April 20 2015, staff indicated that Resident #004 had an indwelling catheter, but could not relate the type of care involved other than it being changed or irrigated as ordered. Both registered staff stated that the plan of care should provide clear directions that clearly provided planned direct catheter care for Resident #004.

During an interview with the Inspector on April 20 2015, the Nursing Supervisor and the Director of Nursing both confirmed that a personalized care plan is developed for a resident admitted with a foley catheter. They reviewed Resident #004's written plan of care with the Inspector. Both confirmed that Resident #004's plan does not identify the resident's risk of urinary infections, required monitoring and interventions and the plan does not give clear direction as to which size of urinary catheter is to be used for the resident. [s. 6. (1) (c)]

4. . The licensee has failed to ensure that the care set out in the plan of care is provided to Resident #009 as specified in the plan.

During an interview, Resident #009, who is alert and has no cognitive impairments, indicated to Inspector #547 that staff did not clean his/her teeth twice daily and that staff might brush them once a day. The resident further indicated he/she has to ask staff for help to brush his/her teeth as they would not offer assistance and that he/she would prefer that his/her teeth were brushed twice a day.

Inspector #550 reviewed Resident #009 current written care plan dated March 18, 2015 and observed it was documented that Resident #009 requires his/her teeth and tongue to be brushed by staff every morning and at bedtime with a soft bristle brush.

Inspector #550 reviewed the flow sheets for oral care from January to April 2015 for Resident #009. It was documented Resident #009 had his/her teeth brushed in the

morning and at bedtime as per her plan of care on one specified day in January and on three (3) specified days in April 2015. For all other days, it was documented the resident had his/her teeth brushed once per day on 57/109 days and there was no documentation for 47/109 days. As such, Resident #009 does not receive the care as specified in his/her care plan. [s. 6. (7)]

5. The licensee has failed to ensure that Resident #011 received mouth care as specified in the resident's plan of care.

On April 14, 2015 during a resident interview with Inspector #547, Resident #011 indicated that staff are to brush his/her teeth as he/she is not able to brush them on his/her own. Resident #011 further indicated that he/she had a bad taste in his/her mouth, and staff often forget to brush his/her teeth. Inspector #547 observed this resident's teeth during the interview to be soiled with food matter.

On April 21, 2015 Inspector #547 reviewed this resident's current care plan which indicated that the resident requires one person assist for ADL's and is completely dependent for mouth care by staff." Suite à la paralysie … le/la résident(e) est incapable de faire ses soins buccaux lui-même/ elle-même. Maintenir l'hygiène orale pour le/la résident(e) quotidiennement. A quelques ou toutes ses dents naturelles adéquate. Nettoyage quotidien des dents par le personel."

On April 22, 2015 Inspector #547 interviewed staff S#117, S#118 and S#119 PSW's on the second floor, who indicated that "Quotidiennement" meant that the resident required mouthcare on every shift. Each staff member indicated that technically "Quotidiennement" means daily, however in the resident's MEDECARE "Plan de Soin " (PDS) flowsheets completed by PSW staff on every shift, they have to sign for mouth care provided to this resident.

On April 22, 2015 Inspector #547 received a copy of the resident's PDS flowsheet report for the month of April to this date mouth care from one of the RAI-Coordinators S#121. This flowsheet indicated that mouthcare is identified as "dentiers/dents nettoyés" was required on day and evening shifts. For 21 days of April to this date, the resident's mouthcare was documented to be performed 12 out of 21 times during the day shift, and 4 out of 21 times on the evening shift. Interview with Staff #121 indicated that staff are aware that if the flowsheets from the PDS are not completed, that this means that the activity did not take place. Staff #121 further indicated upon review of this flowsheet

report and indicated that the resident did not receive mouth care twice a day over 21 days of April, as specified in the plan of care.

On April 22, 2015 Staff #123 and #124 indicated to Inspector #547 during an interview that Resident #011 is alert and oriented and can assist in directing his/her care needs. Staff #123 and #124 indicated that the registered staff are required to verify with PSW staff that they have brushed Resident #011's teeth on days and evening shift, and then sign the MAR sheet. Staff #123 and #124 indicated they started doing this after the resident went to the dentist in January 2015, and received orders that indicated the resident requires his/her teeth and tongue to be brushed twice a day, and his/her teeth flossed twice a day. The house physician ordered the same as of a specified day in Feb 2015 requiring teeth and tongue brushed BID. A review of the Resident's MAR sheet indicated registered staff verified every day and evening for these 21 days in April, 2015. However, when the Inspector asked further clarification on their documentation, both staff members indicated that they do not verify with the resident, or look at the resident's teeth to ensure that the mouth care is complete. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident's written plan of care set out the planned care in regards to responsive behaviours for Resident #017, potential skin injuries and wound care for Residents #015 and #017, indwelling catheter care for Resident #004 as well as that residents received their planned care as set out in their plan of care in regards to mouth care for Residents #009 and #011, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including (b) Identifying and implementing interventions. [Log #O-001927-15]

A critical Incident report was submitted to the Director by the home on a specified day in March 2015 reporting an incident of abuse between two residents. It was reported that the previous afternoon, Resident #019 was sitting in the living room and another resident went to sit in the chair beside him/her. Resident #019 pushed the other resident and got up with closed fists and was verbally aggressive. A PSW prevented the other resident from falling. Resident #019 was instructed to sit down in his/her chair and not to hit anybody. Resident #019 sat down with a suspicious look on his/her face. Later that same day after dinner, Resident #019 was observed by a visitor storming out of his/her room, cursing and pushing Resident #020 who was in the hallway. Resident #020 fell backwards, hit his/her head on the handrail and fell to the floor.

Inspector #550 reviewed Resident #019's health records from January 1 to March 29th 2015 and observed it was documented in the progress notes this resident was verbally and/or physically aggressive towards other residents as follows:

February 1: verbally aggressive towards another resident in the dining room and hit the table.
February 17: pushed resident in room 187
March 10: spat on another resident at the nursing station

March 11: hit resident in room 187 on the right cheek and was verbally abusive. Resident #019 motioned to hit another resident with his/her walker.
March 24: Resident #019 does not tolerate other residents during mealtime and becomes verbally aggressive. He/She pushed another resident with his/her walker in an aggressive way.
March 26: threatens resident in room 184 to hit him/her.
March 29: pushed another resident who went to sit in the chair beside him/her in the living room, got up with closed fists and was verbally aggressive. Resident #019 pushed Resident #020 in the hallway, the resident fell backwards, hit his/her head on the handrail and fell to the floor.

During an interview, BSO staff S#131 indicated to Inspector #550 that Resident #019 is often physically aggressive towards residents and staff. He indicated this resident is a very solitary person; he/she does not like to have people around him/her and likes to stay in his/her room with the door closed. Resident #019 will participate in some activities depending on his/her mood. BSO staff S#131 indicated to inspector he does not do any "one on one" activities with Resident #019 as there is a language barrier; Resident #019 only speaks French, sometimes his/her speech is incomprehensible and BSO staff has limited knowledge of French. BSO staff S#131 indicated Resident #019 feels trapped in the locked unit, and gets upset because he/she cannot leave the unit. He further indicated when the resident was last hospitalized for aggressive behaviours, the resident was returned to the home because he/she did not exhibit any aggressive behaviours while in hospital because the resident was not in a locked unit, and he/she could move around freely. Resident #019 is often heard by BSO staff S#131 wanting to leave the unit. The staff member indicated last summer he would take Resident #019 outside for walks and that the resident enjoyed this but he has not done this since last summer.

The two triggers to Resident #019's aggressive behaviours identified by the BSO staff S#131 were not communicated to the interdisciplinary team, so interventions could be identified and implemented to respond to the needs of Resident#019 to minimize the risk of altercations and potentially harmful interactions between Resident #019 and other residents. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between Resident #019 and other residents by identifying factors that could potentially trigger such altercation as well as by identifying and implementing interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to

restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that O.Reg. s. 110. (7) that every use of a physical device to restrain Resident #002, the following are documented: 1. The circumstances precipitating the application of the physical device. 2. What alternatives were considered and why those alternatives were inappropriate. 5. The person who applied the device and the time of application. 6. All assessment, reassessment and monitoring, including the resident's response. 7. Every release of the device and all repositioning. 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Resident #002 was admitted to the Home in April 2014, where he/she was assessed as having very severe cognitive impairment, as being at high risk for falls due to his/her diminished physical capacity to ambulate; the resident no longer ambulates. Since the admission, Resident #002's transfers have been completed by 2 persons using a mechanical lift to a wheelchair which is equipped with a standard blue buckle lap belt. Resident is unable to undo the buckle on his/her lap belt.

Selected as for comfort measures on Form 833 (Ordonnance médicale d'un moyen de

contention) from the time of admission, the lap belt (when up in wheelchair) and the 2 bed siderails (when the resident is in bed) have a signed doctor's order for restraints and there is a consent from the POA, as confirmed by RPN S#122.

Resident #002 was observed up in his/her wheelchair with his/her lap belt secured by the standard buckle on April 14, 15, 16, 20, 21, 22, 2015 every morning. Resident #002 was observed to be in bed with both siderails up, every afternoon.

During an interview with Inspector #546 on April 22 2015, PSW S#120 confirmed that Resident #002 is up in the wheelchair with the standard blue buckle lap belt attached every morning for breakfast and is returned to bed with both siderails up every afternoon. When asked why Resident #002 has a lapbelt, S#120 indicates it is for his/her position to be maintained and to prevent sliding. When asked if the resident is repositioned, S#120 hesitates and says that they check in on the residents and record it in the eRecord (POC - point of care) electronic system.

Resident #002's plan of care indicates the restraints used, but it does not provide clear guidelines for reassessment, monitoring of the restraint, nor does it indicate when the restraint is to be released and the resident repositioned, or the frequency of such release and repositioning. A review of all previous care plans since Resident #002's admission confirms the same.

Upon reviewing the documentation on the restraints' flowsheet (Formulaire de vérification quotidienne des contentions pour le mois d'Avril 2015) used by the PSWs, Inspector 546 observed numerous omissions in the documentation for the month of April 2015 for Resident #002. It was noted that 10 out of 21 day shifts and 15 out of 21 evening shifts had no documentation, regarding the removal of the restraint every 2 hours while awake, nor that the resident was repositioned every 2 hours while awake. It was further noted that the restraint flowsheet does not collect any of the following:
a) the time the restraint was applied,
b) the resident's assessment/reassessment or monitoring completed including the resident's response,
c) every release of the device and repositioning conducted, or
d) the removal time of this restraint [s. 110. (7) 1.]

2. The licensee failed to ensure that O.Reg. s. 110. (7) that every use of a physical device to restrain Resident #011, the following are documented: 5. The person who

applied the device and the time of application. 6. All assessment, reassessment and monitoring, including the resident's response. 7. Every release of the device and all repositioning. 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

On April 14, 2015 Inspector #547 observed Resident #011 to have a restraint seat belt while seated in his/her wheelchair. Resident #011 is diagnosed with a neurological disorder and is no longer able to use his/her arms or hands to release this restraint. This seat belt restraint was observed applied to the resident on every day of the RQI while he/she was seated in his/her wheelchair.

On April 21, 2015 Inspector #547 interviewed Staff #116 and Staff #119 regarding the documentation of who and when the restraint is applied to the resident, and the assessment, reassessment and monitoring conducted, that the device is released and repositioning of the resident and then finally the removal of the device daily located. Staff #116 and #119 indicated that they tick off these areas in the point of care system (PDS) as well as document manually on a flowsheet at the nursing station.

On April 21,2015 Inspector #547 reviewed the "Formulaire de vérification quotidienne des contentions pour le mois de Avril 2015" document for Resident #011 that was incomplete during the 21 days period to date for April 2015. It was noted that 17 out of 21 day shifts and 7 out of 20 evening shifts that no documentation was completed regarding the removal of the restraint every two hours while awake or that the resident was repositioned every 2 hours while awake. It was further noted, that this document does not collect :
a) the time the restraint was applied,
b) the resident's asssessment/reassessment or monitoring completed including the resident's response,
c) every release of the device and repositioning conducted,
d) or the removal time of this restraint utilized for Resident #011.

On April 22, 2015 Inspector #547 interviewed Staff #121 regarding the home's PDS system, and Staff #121 indicated that the home has decided not to use the PDS system to record the restraints monitoring, and staff are required to complete a manual checklist for these restraints on every shift. The current PDS system is equipped to monitor the time of restraint application, including the staff name, the times for repositioning that is required every two hours, which also includes the staff name and time stamp for when

this intervention is completed, and then the time of removal including name of the staff member. Staff #121 indicated that to her knowledge, the home is not using the PDS system to capture of this activity at this time, as they are using the manual checklist format. [s. 110. (7) 5.]

3. The licensee failed to ensure that O.Reg. s. 110. (7) that every use of a physical device to restrain Resident #017, the following are documented: 5. The person who applied the device and the time of application. 6. All assessment, reassessment and monitoring, including the resident's response. 7. Every release of the device and all repositioning. 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Resident #017 was observed on April 15, 21, 22 and 23 2015, to be seated in a wheelchair and to have a 10lb front buckle closure lap belt, covered by a sleeve. The resident was noted to have cognitive impairments and was unable to undo and remove the lap belt. A review of Resident #017's current plan of care identifies that the resident is identified as being at high risk for falls.

On April 21 2015, PSW staff members S#102 and S#132 stated to Inspector #117 that Resident #017's wheelchair lap belt is a restraint. Both stated that the resident is physically and cognitively unable to undo the lap belt. As per unit RPN S#107, the lap belt restraint has been in place since August 2014 as a fall prevention intervention.

A review of the resident's health care record shows that the lap belt was ordered by the attending physician in August 20 2014, consent was given by the resident's Power of Attorney and the lap belt type was assessed by the registered nursing staff and the home's physiotherapist. Monitoring sheets for the use, application, repositioning of the resident, removal of the lap belt restraint as well as the monitoring of the resident's response to the use of the restraint were reviewed by Inspector #117 and PSW staff S#102 and S#132. As per the PSWs, staff are to document on both the home's MEDECARE electronic Point of Care/ Point de Soin (PDS) system and on the paper "Formulaire de vérification quotidienne des contentions pour le mois d'Avril 2015" the application and use of the lap belt restraint.

A review of both documents was done in the presence of the PSW staff members S#102 and S#132 as well as unit RPN S#107. It was noted that staff do not consistently document the use, application, repositioning of the resident, the removal of the lap belt

restraint, nor the resident's response to the use of the restraint. MEDECARE system documentation indicates that the lap belt restraint was applied 9/22 days in April and the paper monitoring sheet indicates that the lap belt restraint was applied 4/22 days in April with no correlation between the documentation on both forms. It was further noted that the restraint paper flowsheet does not collect any of the following:
a) the time the restraint was applied,
b) the resident's assessment/reassessment or monitoring completed including the resident's response,
c) every release of the device and repositioning conducted, or
d) the removal time of this restraint.

As per the interviewed PSWs S#102 and S#132 and RPN S#107, restraint documentation is to be done every shift, on both systems as some information is in the MEDECARE system and other information is on the paper monitoring sheet. The interviewed staff were unable to explain as to why there restraint monitoring records, both electronic and paper, were not completed when the lap belt is being applied daily.

On April 22 2015, Inspectors #117, #546 and 547 spoke with the home's Nursing Supervisor regarding the home's procedures for documenting the use, application, repositioning of the resident, removal of the lap belt restraint as well as the monitoring of the resident's response to the use of the restraint. The Nursing supervisor stated that since July 2014, after the home's 2014 Resident Quality Inspection (RQI), the home changed how the use of restraints is documented. She indicated that the MEDECARE PDS system does not give accurate information as to the use , application and removal of the restraints. A decision was made by the home's management to have PSW staff document the application, repositioning, removal and response to restraints on a paper monitoring sheet. The Nursing Supervisor stated that all PSW and registered nursing staff are aware that they have to document application, repositioning and removal of restraints on the paper monitoring forms. Unit Registered staff are to ensure that they document every shift the use and application of the restraints in the residents Medication Administration Record (MAR).

The Nursing Supervisor stated that staff have had training on the use of the paper form. She states that staff receive regular reminders to use and complete the paper form during team meetings and via electronic reminders on MEDECARE when they log on, to do to their documentation. The Nursing Supervisor reviewed the restraint monitoring documentation for the Residents #002, #011 and #017, confirmed that staff are not documenting the use, application, repositioning of the resident, removal of the lap belt

restraint as well as the monitoring of the resident's response to the use of the restraints. [s. 110. (7) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff document the use, application, repositioning of the resident, the removal of the lap belt restraint, and the residents' response to the use of the restraint, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that doors to non-residential areas remain closed and locked when unattended by staff in the home.

Inspector #547 conducted an initial tour of the home on April 13, 2015. It was noted that the kitchenette doors open on both the second and third floors units. The kitchenettes contain coffee makers, next to the fridges, that have hot water dispensers which pour steaming hot water. These hot water dispensers would pose significant burning risk to residents on these units and were left open and unattended by staff on several occasions on April 13, 14, 15 and 16 2015, during Stage One of the RQI inspection.

During this initial tour, it was also noted that bathroom #1153, on the first floor near the main kitchen, and bathroom #2151, on the second floor, were not locked and accessible to residents on these floors. The identified bathrooms were not equipped with any call system or grab bars for resident safety. An electrical room #231, located outside the second floor nursing station, was open and not locked, leading to the electrical boxes and the main sprinkler control panel, leaving these accessible to anyone in this resident area.

On April 20, 2015 Inspector #547 interviewed the Environmental Supervisor regarding the unlocked doors to non-residential areas in the home. The Environmental Supervisor indicated each of these doors should have been locked. He indicated that the second and third floor kitchenette doors were equipped with a locking mechanism and should remain closed and locked when unattended by staff due to boiling hot water inside these spaces. The Environmental Supervisor indicated that the bathrooms and electrical/Sprinkler rooms were equipped with locking mechanisms, and were not residential areas and should remain closed and locked. [s. 9. (1) 2.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1.
The licensee has failed to ensure that each resident bedroom occupied by more than one resident had sufficient privacy curtains to provide privacy.

On April 13, 14 and 15 2015, during Stage 1 of the Resident Quality Inspection, Inspectors #117, #546 and #547 noted that eleven (11) resident rooms, occupied by more than one resident, to be lacking sufficient privacy curtains.

On April 19,2015 Inspector #547 toured every room identified by the Inspectors, and confirmed that each of these shared resident rooms had gaps in their privacy curtains varying from nineteen inches to four feet in space on the second and third floors. It was further noted on the secured resident care unit on the first floor that residents in bed "B" of every shared resident room did not have a curtain track at all across the front of these resident's beds. One of these resident rooms, room #178, did not have any curtains hung at all in this room.

The Inspector then interviewed the Environmental Supervisor regarding the lack of privacy curtains in shared bedrooms for residents in the home. The Environmental Supervisor indicated that he was aware of this issue, as the sprinkler pipes in several rooms prevented the curtain racks from providing complete privacy to residents. The home purchased and has obtained new curtains and tracks that are not installed at this time due to priorities with maintenance department.

Inspector #547 along with the Environmental Supervisor toured the rooms on the first floor resident care unit, and indicated that he was not aware of the lack of curtain tracks along the front of the beds near the windows in the shared rooms. The Environmental Supervisor also indicated that room #178 should have had curtains hung up to provide each resident privacy and was not acceptable. He indicated that the home has a plan for these curtains in order to provide sufficient privacy to each resident in shared rooms, however there was no date of when the curtains would be installed. [s. 13.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1.
The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

On April 16 2015, the caregiver to Resident # 013 expressed concerns to Inspector #117 regarding the resident's bath care. The caregiver stated that Resident # 013 has scheduled baths every Thursday and Sunday. The caregiver stated that there is no problem with the Thursday baths, but that the resident often did not receive his/her scheduled Sunday bath and that the bath was not rescheduled to another time during the week.

Resident #013 has advanced cognitive impairments and requires 1-person assistance with his/her personal care, hygiene and bathing. The resident's plan of care as well as the unit bath schedule indicates that the resident is to have 2 full baths per week and the baths are scheduled for Thursdays and Sundays. A review of the resident's health care record showed that the resident had received all his/her baths except for an identified Sunday in April 2015. No information was found in the resident's chart or elsewhere as to why the bath was not given. No information was found in the resident's chart in regards to any rescheduling of the missed bath.

Inspector #117 spoke with Resident #022 on April 22 2015, regarding the provision of baths on the unit. Resident #022 is alert, a good communicator with mild cognitive impairments. The resident shares his/her room with his/her spouse, Resident #021, who does have advanced cognitive impairments. As per Resident #022, he/she received 2 baths per week up until a few weeks ago when suddenly, staff started offering and giving him/her only one bath per week. Resident #022 states that he/she does not know why there was a change in his/her bathing schedule. Resident #022 stated that his/her spouse's baths were also changed from 2 baths per week to one bath per week and

he/she is unsure why this also occurred. A review of both Resident #021 and #022's health care records was conducted. The records note that both residents are to have full tub baths every Wednesday and Saturday. A review of the March and April MEDECARE system PDS documentation indicates the following:
- Resident #021 did not receive a bath on two (2) days in March and on four (4) days in April
- Resident #022 did not receive a bath on one (1) day in March and on four (4) days in April

No information was found in the residents' charts or elsewhere as to why the baths were not given. No information was found in the residents charts in regards to any rescheduling of the missed baths.

Inspector #117 verified the bathing schedule for several other residents on the unit and noted the following:
- Resident #020: plan of care indicates that the resident is to have 2 baths per week on Monday and Thursday. Chart documentation indicates that no baths were noted to have been given on three days in April
- Resident #023: plan of care indicates that the resident is to have 2 baths per week on Tuesday and Saturday. Chart documentation indicates that no baths were noted to have been given on a specified day in March and on two (2) specified days in April
- Resident #025: plan of care indicates that the resident is to have 2 baths per week on Wednesday and Sunday. Chart documentation indicates that no baths were noted to have been given on four (4) specified days in March and two (2) specified days in April

No information was found in the residents' charts or elsewhere as to why the baths were not given. No information was found in the residents charts in regards to any rescheduling of the missed baths. It is noted that Residents #020, #023 and #025 have significant cognitive impairments and were unable to give any information as to whether or not they had received their scheduled baths.

As per interviewed staff members S#102 and S#106, residents bathing schedule for the unit does identify that each resident is to have 2 baths per week. When the bath is done it is to be documented on the MEDECARE electronic system. If a resident refuses to have a bath due to responsive behaviours this is to be documented as a "bath refusal" in MEDECARE and the unit RPN is to document the resident's responsive behaviours in the progress notes. The bath is then rescheduled to another day when the resident is more receptive to having a bath. This process is confirmed by the unit RPN S#107. The

interviewed staff members were unable to say if the residents had or had not received their baths. They were unable to explain why the provision of the residents' baths were not documented; if the scheduled baths were not given, why the baths were not rescheduled and why there was no documentation as to why the baths were not given as per the residents' plan of care.

On April 23, 2015, Inspector #117 verified the home's process related to the documentation of baths in MEDECARE and what is home's process for rescheduling residents' baths with home's DOC and Nursing Supervisor. The DOC and Nursing Supervisor confirmed that the information given in regards to residents' baths by the nursing staff is accurate. Both expressed that if a resident refuses to have a bath due to behaviours, or any other reason, this should be documented in progress notes and baths rescheduled. The DOC and Nursing Supervisor reviewed Residents #013, #020, #021, #022, #023 and #025 MEDECARE documentation on provision of baths and confirmed that the residents were not receiving their two baths per week. [s. 33. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #547 conducted the tour of the home on April 13, 2015 and noted the following in the shared tubrooms in the home:
-The third floor tubroom on the Cartier wing had pink plastic container next to the tub containing two nail clippers, a disposable razor, cuticle scissors and an electric razor inside the drawer of the table next to the tub, that had no labels.
- The third floor Tub/Shower room next to elevators had a white plastic basket with four nail clippers with no label. Another blue larger basket contained a used secret antipersperant stick.

- The second floor Tubroom on the Spence wing had a white cupboard that contained blue denture containers labelled with "clippers" with seven unlabelled nail clippers and remnants of nails in the bottom of this container. Another denture container had three nail clippers labelled "Ongles" and another denture container labelled "razors" with wooden cuticle sticks, one nail clipper unlabelled and remnants of nails in the bottom of this container.
- The second floor Tubroom on the Cartier wing had a nail clipper located on table next to tub with no label as well as two nail clippers inside the left drawer of this table and a white ivory bar of soap opened without container sitting on the wood base of the drawer that appears to have been used. The common bathroom next to this tubroom utilized by residents on this wing had a nail clipper located next to the toilet on a table with no label.
- The first floor Tubroom on Cartier wing had a table next to tub with nail brush, four nail clippers and a nail cuticle stick with plastic handle all that had no labels.
- The first floor secure unit Tubroom had a used bar of white soap as very thin and no longer had any name on the bar showing in the tub trolley cart next to the tub.

On April 20 2015, staff PSWS#115 indicated to Inspector #547 during an interview that nail clippers should be in the resident's basket, but staff like to keep one beside the tub just in case. Staff S#115 further indicated that the home does not have a method to label nail clippers at this time that she is aware of.

On this same date, PSW staff S#112 and S#113 indicated that nail clippers are kept in the tubrooms and are cleaned between residents with the tub cleaner or the wall hand sanitizer. Inspector #547 noted that the tub/shower cleaning solution is not a high level disinfectant solution. Both PSWs indicated that residents should have their own nail clippers, soap, and deodorant for sanitary purposes vs sharing these items located in the tub rooms.

On April 20 2015, the Nursing Supervisor and the Director of Care indicated to Inspector #547 that the above nail clippers located in tub rooms that had nail remnants in containers were likely not washed between each resident and indicated this was not acceptable or sanitary. The Nursing Supervisor further indicated that there is no reason for shared items between residents in the home, as the home provides personal care items, such as brushes, soap, deodorant, nail clippers and more. The Director of Care indicated that every personal care item should be labelled with black marker, and soap is only to be unwrapped to be replacing a resident's plastic labelled container that should be kept in each resident's basket that is labelled with their name. The Director of Care further indicated that the home follows recommendations from PIDAC (Provincial

Infectious Diseases Advisory Committee).

On April 22, 2015 Inspector #547 reviewed the policy and procedure provided by the Director of Care for cleaning of equipment for nail care, called. "Nettoyage et désinfection de l’équipement destiné aux soins" revised March 2014 stated the following under procedures:

1. Ceci s'applique à tout équipement destiné aux soins des résidents, notamment les fournitures et équipements pour soins des pieds, des ongles, rasoirs électriques ou autres.
2.Verser la solution HLD5 (accel) dans le cabaret en métal. Les instruments doivent être recouverts au complet par la solution.
3. Laisser tremper pendant 20 minutes.
4. Mettre une paire de gants et frotter chaque instrument avec une petite brosse trempée dans la solution.

Staff #116 and Staff #117 indicated they were not aware of this protocol for cleaning of nail clippers.

Inspector #547 reviewed the Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in all Health Care Settings from Provincial Infectious Diseases Advisory Committee (PIDAC) which Classify fingernail care equipment used on multiple residents as Semi-critical equipment/devices which requires High-Level Disinfection between uses and foot care equipment as critical equipment/devices which requires sterilization.

The Director of Care indicated that measures are currently not in place for the cleaning, disinfection or sterilization of re-usable and/or shared resident equipment which poses a potential cross infection risk to residents and would order nail clippers for every resident in the home and have the resident's room number engraved on every clipper. [s. 229. (4)]

Issued on this 26th day of May, 2015

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

Original report signed by the inspector.