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**

**Division de la responsabilisation et de la performance du système de santé**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 6, 2015 | 2014_198117_0031 | O-001137-14 | Resident Quality Inspection |

### Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET OTTAWA ON K1N 5C8

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

RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA OTTAWA ON K1C 2Z6

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

LYNE DUCHESNE (117), ANGELE ALBERT-RITCHIE (545), JOANNE HENRIE (550), MELANIE SARRAZIN (592), PAULA MACDONALD (138)

### 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): November 24, 25, 26, 27, 28 and December 1, 2, 3 and 4, 2014**

**It is noted that one Critical Incident Inspection Log #O-001169-14 and three Complaint Inspections Logs #O-001252-14, #O-000914-14 and #O-000413-14 were conducted during and included in this Resident Quality Inspection.**

**During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer of Bruyère Continuing Care, Administrator, Director of Care, Clinical Care Coordinator, Nurse Practitioner, RAI Coordinator, Registered Dietitian, Facility Manager, Manager of Security and Parking, Food Services Supervisor, Therapeutic Recreation Coordinator, to several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), the home's Behavioural Support Ontario (BSO) champion, several Food Service Workers, several housekeeping staff members, a recreation aide, a physiotherapy aide, an Occupational Therapist, the Director of Mission, Ethics, Compliance and Client Relations, to two administrative assistants, several residents, several resident family members, a sitter, the President of the Resident Council and the Secretary of the former Family Council.**

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

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

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

| 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 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).**

**s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).**

**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 comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (1) in that the licensee did not ensure that the 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; (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 #012 was observed over the course of the inspection sitting in a reclining wheelchair with a padded table top in place. During meals, Resident #012 was observed in a wheelchair set in front of a table in the dining room with food, drinks and utensils placed on the table top. On December 2, 2014 at 10:27 Resident #012 was observed in his/her room, asleep in a wheelchair reclined 30°, with a box of tissue and several cleaned facecloths placed on the padded table top. On December 3, 2014 at 14:00, Resident #012 was observed in a wheelchair, watching television in his/her room. Each

time Resident #012 was observed, the resident was leaning slightly to the right, and both arms were resting on the table top.

On December 2, 2014, interviewed staff members PSW S#124 and RPN S#101 indicated to Inspector #545 that Resident #12's table top was used for activities of daily living such providing assistance during meals, for example to set his/her food, and to set a box of Kleenex and remote control when he/ she watched TV in his/her room. RPN S#101 added that the recliner wheelchair didn't fit under the dining room table; therefore the table top was required. The RPN indicated that the table top could be removed after meals as Resident #012 did not require it for other activities but staff kept the table top in place.

During an interview with Resident #12's family member, the family member indicated that the doctor had requested a seating assessment approximately 18 months ago as Resident #12 leaned to one side when up in his/her wheelchair; added that a therapist prescribed a recliner wheelchair with a table top and that it had been in use for positioning since then.

A review of Resident #12 health care record was conducted by Inspector #545. Resident #12's current written plan of care did not identify the use of a table top as a positioning device to assist with the resident's seating and positioning when in the wheelchair. It also did not identify that the table top was being used for meals and for activities of daily living. The plan did not give clear directions to staff regarding the use of the wheelchair table top. The plan was reviewed with RPN S#101 who indicated that she was responsible for updating Resident #012's plan of care, and confirmed that the above information was not written in the resident's plan of care,

During a discussion with Director of Resident Care (DOC), indicated that it is the home's expectation that a table top used as a Personal Assistive Service Device (PASD) be included in the plan of care.[s. 6. (1)]

2. The Licensee failed to comply with section 6 (1)(a)(b)(c) of the Act in that the licensee failed to ensure that that there is a written plan of care for each resident that sets out the planned care for the resident, the goals the care is intended to achieve, and clear direction to staff and others who provide direct care to the resident.

In accordance with section 26 (3) of the Regulations, the plan of care for residents must

be based on multiple items including article 16: Activity patterns and pursuits. LTCH Inspector #138 reviewed the current plans of care (as defined by the home) for Residents #010, #011, #012, and #028 with respect to activity patterns and pursuits. The inspector noted that there was no planned care, goals, or direction to staff in the plan of care for activity patterns and pursuits for Resident #028 who was coded in the last Minimum Data Set (MDS) dated September 19, 2014 as reduced social interaction and as being tearful. Further, the Psycho-Geriatric Assessment Outreach Program recommendations for April 3, 2014 for Resident #028 suggested providing the resident with music therapy and pet therapy to assist with responsive behaviours.

The plan of care with respect to activity patterns and pursuits for Resident #010 also did not contain any goals or any interventions specific enough to guide staff. This resident was documented to have extensive responsive behaviours and coded in the current MDS dated September 4, 2014 as withdrawn from activities, reduced social interaction, and deterioration in behaviours.

The plans of care with respect to activity patterns and pursuits for Resident #011 did not have any goals in place and, further, any information on the plan of care related to activity patterns and pursuits has not been updated since September 2011. Resident # 011 was coded on the current MDS dated September 18, 2014 as being tearful, withdrawn from activities, reduced social interaction, and demonstrated indicators for depression.

The plan of care with respect to activity patterns and pursuits for Resident #012, who has been confirmed by the Therapeutic Recreation Coordinator and the Recreation Technician to participate in activities, did not have any goals in place. Further, any information on plan of care related to activity patterns and pursuits has not been updated since October 2011.

LTCH Inspector #138 spoke with the Recreation Technician on December 2, 2014 regarding the plan of care for activity pattern and pursuits for residents and she stated that she completes a quarterly review on residents with respect to activity patterns and pursuits but that she was not able to complete the plans of care. The inspector also spoke with the Therapeutic Recreation Coordinator on December 3, 2014 and she stated that she is not aware of the process in which the plan of care with respect to activity patterns and pursuits captures the planned care, goals, and directions to staff. She further stated that this will be an area for improvement with the planned implementation of a computerized health care record system.In accordance with section 26 (3) of the

Regulations, the plan of care for residents must be based on multiple items including article 16: Activity patterns and pursuits. LTCH Inspector #138 reviewed the current plans of care (as defined by the home) for Residents #010, #011, #012, and #028 with respect to activity patterns and pursuits. The inspector noted that there was no planned care, goals, or direction to staff in the plan of care for activity patterns and pursuits for Resident #028 who was coded in the last Minimum Data Set (MDS) dated September 2014 as reduced social interaction and as being tearful. Further, the Psycho-Geriatric Assessment Outreach Program recommendations for April 2014 for Resident #028 suggested providing the resident with music therapy and pet therapy to assist with responsive behaviours.

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The plan of care with respect to activity patterns and pursuits for Resident #012, who has been confirmed by the Therapeutic Recreation Coordinator and the Recreation Technician to participate in activities, did not have any goals in place. Further, any information on plan of care related to activity patterns and pursuits has not been updated since October 2011.

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3. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (7) in that the licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On November 24, 2014, Resident #10 was observed in his/her wheelchair in the hallway between the large and smaller dining room. The resident was yelling that he/she was not going to eat in the dining room with "les malades". A registered staff indicated that Resident #10 had a place setting at his/her own table in the smaller dining room as he/she was disruptive to other Residents. No food was observed at his/her place setting. While staff were delivering food to residents in both dining rooms - close in proximity, and assisting with feeding, staff did not assist Resident #10, 25 minutes later the resident wheeled himself/herself in his/her room, indicating to the Inspector that someone would be bringing food in his/her room. Thirteen (13) minutes later, a registered staff brought Resident #10 a tray with food, into his/her room. On November 25, 2014, the same event occurred again, Resident #10 yelling out, staff not providing assistance but serving other residents meals to finish with Resident #10 eating once more in his/her room.

On December 3, 2014, a review of Resident #10's health care record was conducted by Inspector #545. The plan of care indicated that the resident exhibited daily disruptive behaviours which were not easily altered. Interventions included, but were not limited to: provision of supervision when eating, to be served meals before other residents, to be provided with a peaceful and unhurried atmosphere during meals, to explain to the resident how his/her behaviours affects others and to reassure Resident#10 about the things he/she can have.

On December 3, 2014, 35 minutes before diner time, observed Resident #10 in bed in his/ her room, indicating to Inspector #545 that he/she was waiting for dinner to be served in his/her room. Other residents were waiting to be served dinner in the small and larger dining rooms. RPN S#101 indicated that this strategy was helpful in managing the resident's disruptive behaviour, added that someone always stayed with the resident in his/her room while the resident ate his/her dinner. PSW/BSO S#146 indicated that he had documented a list of strategies to help staff manage Resident#10's behaviours, but was unsure where the document was located. RPN S#101 indicated that the document had been placed with the Medication Administration Record (MAR) for registered staff use, and added that she would have the document typed and placed in the charting room for all direct care staff to access.

On December 4, 2014, during the lunctime meal service, Resident #10 was observed in his/her wheelchair, in hallway between both dining rooms with a blue bib on. Resident #10 indicated to the Inspector that he/she would not eat in the dining room. PSW S#100 was serving bowls of cream soup to Residents in the small dining room. When asked if Resident #10 had been served before other Residents, the staff member indicated that she would serve Resident #10 after the soups would be served. Five minutes later, a PSW delivered a food tray for Resident #10. With encouragement by PSW S#100, Resident #10 wheeled himself/ herself to his/her table in the small dining room, and ate part of his/her lunch.

Upon review of the BSO strategy list, it was documented under Tips for Eating: that Resident #10 needed to be served first, before other residents; that the Resident liked egg and ham sandwiches (eats crusts only), yogurt and thickened apple juice for dinner, breakfast and lunch food preference was left blank.

As such, Resident #10 was not served his/her meals before other Residents as per specified in the plan of care. [s. 6. (7)]

4. The licensee has failed to ensure that staff and others who provide direct care to a resident, kept aware of the contents of the plan of care and have convenient and immediate access to it.

Resident #038 was admitted to the home on December 03, 2009 and she was recently transferred to the 3rd floor on October 20th, 2014. Resident #38 has a foley catheter, mobilizes with a wheelchair and requires some assistance with her personal care. A review of the resident's health care record was conducted by Inspector #550. No written care plan of care, which is the document used by nursing staff indicating the care to be provided to the resident, was found in Resident #38's records.

On November 25, 2014, staff RN #S105 indicated to Inspector #550 that she could not find the written care plan for Resident #38 in either the care plan binder or the resident's chart. The RN indicated to Inspector #550 that Resident #38 had recently been transferred to the 3rd floor from the 4th floor and that maybe the written care plan was still on that floor. As per unit RN #105, the resident is able to communicate with staff as to her care needs and requirements however, each resident is supposed to have a written care plan to guide the staff in the provision of care.

On November 26, 2014, the Director of Care indicated to Inspector #550 it is the home's expectation that all residents have a written plan of care that is accessible to staff to guide them in the provision of care of residents at all times. [s. 6. (8)]

5. The licensee has failed to ensure that Resident #28s plan of care was reviewed and revised when the resident's care needs change.

Resident #28 was observed on November 25 and 26, 2014 to be in a wheelchair with a lap belt and to have a pressure relief boot to a foot, and a pressure relief mattress in place on the bed. It was also observed that the resident was verbally aggressive with staff during the lunch meal service of November 24 2014.

A review of the resident's health care record was conducted by Inspector #117 on December 2 and 3, 2014. The following was noted.

Resident #28 sustained a fracture in December 2013. The resident returned to the home in late December 2013. Upon his/her return, the resident was non-weight bearing, had a narcotic medication, on an as needed basis, prescribed for pain management and had developed at pressure ulcer. The resident was reassessed by the home's occupational therapist (OT) and physiotherapist (PT) regarding the use of a mechanical lift for transfers and a wheelchair with lap belt for mobility as Resident #28 had been independently mobile prior to his/her injury. Progress notes document that the resident's pressure ulcer continued to worsen. In February 2014 a therapeutic air mattress was placed on the resident's bed.
- In April 2014, the resident was assessed by the psychogeriatric outreach team in regards to escalated verbal and physical aggression. A recommendation was made to administer a narcotic pain medication prior to the dressing change to help manage the resident's behaviours.
- In July 2014, the resident was assessed by the ETRN as Resident #28's pressure ulcer wound was infected and the resident had developed 3 other pressure ulcers to both feet. Wound treatment and dressing interventions were adjusted as per recommendations. The ETRN also recommended that the resident's wheelchair seating be reassessed by occupational therapy services.
- On a specific day in September 2014 the resident's pressure ulcer wound was assessed to be a stage 4 but the pressure ulcers to the feet were noted to be healing with the aid of dressings and pressure relief boot to a specific foot. On a specific day in

October 2014, the resident was assessed by the home's nurse practitioner. Documentation notes that the pressure ulcer wound was slowly healing and was now a stage 3 wound. One pressure ulcer to one foot was healed and the 2 wounds on the other foot were almost healed. Recommendation to change some wound treatment and dressing interventions were noted.
- On December 2, 2014, the resident's pressure ulcer wound was still at a stage 3 but all ulcers to both feet were healed.

The resident's current plan of care, dated on a specific day in September 2014, did not have any information related to the resident being primarily bedfast. It did not contain any information related to the resident's pressure ulcers, dressing treatments, therapeutic air mattress, use of narcotics for pain management and responsive behaviours. The plan of care also did not identify that the resident used a wheelchair for mobility and that a lap belt was being applied when the resident was up in the wheelchair.

Interviewed staff members RPN S#121 and PSW S#114, stated to Inspector #117 that since February 2014, the resident has been primarily on bed rest, except for meals, with repositioning every 2 hours due to the resident's wounds and behaviours. They stated that the resident is to be raised and transferred via a mechanical lift to his/her wheelchair only at meal times. They also stated that the resident has not been ambulating since his/her injury in December 2013. The staff members also stated that the resident is not able to self-propel his/her wheelchair. When they reviewed Resident #28's plan of care with Inspector #117, they confirmed that the resident's current rest, mobility and transfer needs are not identified in the plan of care.

In regards to the resident's wound, RPN S#121 stated that resident's pressure ulcer wound dressing is being changed every 2-3 days as per medical orders. The RPN also stated that as per recommendation of the psychogeriatric outreach team, narcotic medication is being given 30 to 60 min prior to dressing changes to help minimise the resident's pain and responsive behaviours. A review of the Medication Administration Records (MAR) for October, November and December 2014, documents that administration of the narcotic medication but there is no directive documented to indicate that the narcotic is to be given prior to the wound dressing change. When the RPN reviewed Resident #28's plan of care with Inspector #117, she confirmed that the resident's current wound, wound care interventions, including use of a pressure relief foot boot and therapeutic air mattress, as well as pain management interventions were not identified in the plan of care. The RPN S#121 stated that all of the resident's wounds and pain issues were reassessed on a quarterly basis but could not identify why the

resident's changing care needs were not identified in the plan of care.

On December 3, 2014, the resident's health care record, quarterly re-assessments of the resident's care needs and plan of care were reviewed with the home's DOC. The DOC confirmed that the changes in the resident's health care needs were not consistently re-assessed during quarterly care reviews. She confirmed that Resident #28's plan of care was not reviewed and revised when the resident's care needs changed after the fracture of December 2013 and that Resident #28's plan of care does not identify the resident's changing care needs as it relates to wounds, wound interventions, pain management interventions, changes in mobility, transfers and bed rest. [s. 6. (10) (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: 1) residents written plans of care set out residents planned care, the goals the care is planned to achieve and gives clear direction to staff as it relates to resident activities for Residents #10, #11, #12 and #28 and use of PASDs for Resident #12; 2) the care set out in the plan of care is given to the residents as it relates to responsive behaviours of Resident #12; 3) that staff have access to the resident's plan of care as it relates to Resident #38 ; and 4) that Resident #28's plan of care is reviewed and revised when there is a change in the resident's care needs, 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. 15. Accommodation services**

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

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

**Findings/Faits saillants :**

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

On November 24, 25 and 26, 2014, Inspectors #545 and #592 observed the following:
- Several areas where the wallpaper was ripped, below and above railings, in all resident unit hallways
- Black scuffed marks mostly at bottom of walls and doors and metal frames of bottom of bedroom doors and dining rooms observed with paint removed exposing metal.
- Bottom of door and walls near doors 305-2 and 305-3 observed with paint chipped exposing drywall and wood rippling near the nursing station on resident unit 3A-B.
- Columns in front entrance, immediately in front of A-B elevator was observed with paint removed, exposing metal & black marks.
- Wall in front of room C-116 observed with a grey duct tape covering a piece of the bottom of the corner which is in disrepair and exposing metal braces.
- Bottom wall beside room C-132 observed in disrepair with a hole of 2 inches wide by 10 inches long and 1 inches deep exposing cement particles.
- Bottom wall of the dining room on the first floor of the C Unit observed in disrepair with a hole of 1 inch wide by 6 inches long and 1 inches deep exposing broken cement particles located under the posting menu board.
- Spa located on first floor of the C unit observed with ceramic tiles broken at the bottom of the wall with black duct tape in place covering half of ceramic tiles. Wood side table in spa observed with wood rippling on both side and underneath exposing sharp edges.
- Spa located on second floor of the C unit observed with ceramic tiles cracked exposing cement. Bottom of walls of the main therapeutic bath room observed in disrepair exposing white metal brace.

During an interview on November 27th, 2014, the Maintenance Coordinator indicated to Inspector #592 that there is no preventative maintenance for home's furnishings and equipment that are in disrepair. The Maintenance Coordinator indicated that he is the one responsible for identifying any repair issues. The procedure in place is that each week there is a walkthrough of a specific floor/resident care unit. During the walkthrough of hallways, resident's room and resident care areas, notes are taken related to the areas and home furniture that are in disrepair.

The Maintenance Coordinator indicated to Inspector #592 that staff members on the different floors are expected to contact the on-call line for any disrepair/repair issues. The

coordinator was unaware of the disrepair identified by the Inspectors and stated that these had not been reported. The Maintenance Coordinator indicated to Inspector #592 that there was no preventative maintenance routine/schedule in place for painting and for walls in disrepair. He indicated that resident rooms are being repainted only when there is a new admission, depending of the need and the damages to the room. He also indicated that he was aware of the ripped wallpaper throughout the home, and that there is no immediate plan to address this issue as the condition of walls/ and wallpaper are part of a 10 year program plan to upgrade the building. [s. 15. (2) (c)]

2. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c) in that the licensee has failed to ensure that the resident-staff communication and response system (the system)is maintained in a good state of repair.

On November 25th and 26th, 2014, Inspectors #545, #592 and #138 observed that the system was not in good repair. The system did not activate when the button at the end of activation cords was pressed, several times, in identified resident's rooms. As well, in other identified resident rooms, the audible component of the system and the screen which displays active calls was not functioning.

1) Observation of room #230-C and #214-C on November 25th, 2014, by Inspector #592: the system did not activate when the button at the end of the activation cord was pressed. The system dome light outside of the bedroom did not illuminate and a call was not placed.

On November 25th, 2014, PSW #117 stated to Inspector #592 that she was not aware of the non-functioning system in resident room #230-C and #214-C. PSW#117 indicated that both residents who are in these rooms have responsive behaviours and that the residents will often pull the system activation cord from the wall unit which can cause the sensor to be altered.

2) Observation of resident room #322-A, on November 26th, 2014, by Inspector #545: the system did not function when the button at the end of activation cords was pressed several times by resident. The system dome light outside of the bedroom did not illuminate and a call was not placed.

On November 25th, 2014, RPN #118 indicated to Inspector #545 that she was not aware of the non-functioning system in resident room #322 as the resident does not

usually call for assistance.

3) On November 28th, 2014, Inspectors #550 and #592 observed that the system dome light outside of resident bedroom #409-B illuminated when the system was activated by pressing the button on the activation cord. There was however no audible sound.

During an interview with housekeeping staff member #S120, who was present during the observation with both inspectors, the staff member indicated that usually a call made from any resident bedroom is audible throughout the unit hallway.

4) On November 28th, 2014, inspector #550 observed in resident rooms #408-B and # 411-B that the system dome light outside of the bedrooms illuminated when the system was activated by pressing the button on the activation cord. There was however no audible sound for either bedroom.

During an interview with PSW #S119, the staff member indicated to Inspector #550 that usually the system is audible in the resident room and throughout unit hallways. The staff member indicated that the system notification screen, located at the end of the unit hallway, should display the room number when a resident has made a call for assistance. The display screen was observed by Inspector #550 and PSW #S119 and no notification of an active call appeared for any of the identified resident rooms.

During an interview with the Maintenance Coordinator and the Manager of Dietary/ Housekeeping/Laundry on November 27th, 2014, with Inspector #592, the managers both indicated that the system activation cord is checked upon a resident's admission and then the system is only checked again if there is a reported problem. They indicated that there is no regular auditing routine in place, other than during the admission process. Both indicated that they were not aware of any non-functioning system in the identified resident bedrooms. [s. 15. (2) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's furnishings and that all equipment are maintained in a good state of repair, specifically related to the resident-staff communication and response system equipment, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**

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

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that where bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

On November 26, 2014, Inspector #592 observed the resident bed in room # 230-C The resident bed was observed to have a half side rail in the up position on the right side of the bed and two half rails in the up position on the left side of the bed.

The following was noted:

Zone 1 internal dimension of each half rail, gap observed to be at 29 inches to upper

area and 31 inches to lower area.

Zone 5 Between Split Bed Rails located on the left side of the bed when both half rails are elevated have a gap of 4 inches long between each other.

Zone 6 Between the End of the Rail and the Side Edge of the Head or Foot Board observe to have a gap of 12 inches to half rail on the up position on the right side of the bed and both half rails located on the right side of the bed.

Zone 7 Between the Head or Foot Board and the End of the Mattress, the space between the inside surface of the head and the foot board and the end of the mattress observed to be at 5.5 inches for the three half side rails.

During an interview with the Director of Resident Care (DOC), the DOC indicated to Inspector #592 that the home's practice for the use of side rails is to have the Occupational Therapist (OT) evaluate the need of side rails for the resident at admission and when there is a change in the resident's condition. The DOC and the Maintenance Coordinator meet together to revise the OT's recommendations. The DOC indicated to Inspector #592 that she was not aware of any assessment tool/form being used in the home to assess bed rails and bed systems to minimize risks to the resident.

Upon showing the bed in room #230 to the DOC, the DOC indicated to Inspector #592 the zone 1, 5, 6 and 7 to be at high risk of entrapment for the resident and added that the bed should not be in use in the home, that she was not aware that this bed was in the home and that the bed be removed from the resident's room. It is noted that on November 26, 2014, after the discussion with the home's DOC, the bed with identified entrapment issues in room 230-C was removed by the home's Maintenance Coordinator and exchanged for a newer bed. [s. 15. (1) (a)]

2. On November 26, 2014 at 9:44 am, Inspector #545 observed Resident #12 in his/her bed watching television with both full bed rails in up position.

Upon review of Resident #12's the most recent plan of care, the plan documented that staff are to encourage the resident to grab onto the bed rails when staff assists her/him with turning, that the two side rails are up when the resident is in bed, that staff need to check the resident for safety and that both side rails are up per policy. However, the plan of care did not specify the type of bed rails use nor the reason for their use. No

information related to a bed assessment of Resident #012's bed system was not found in the resident's health care record.

During an interview with PSW S#124 on December 1, 2014, the staff member indicated that Resident #12 has always had the full bed rails in up position when in bed. The PSW indicated that the resident did not grab on to the rails when turned, as the resident required two person assistance for repositioning and that the bed rails were lowered during this procedure. S#114 indicated that the resident was very nervous and liked to have the bed rails in up position.

During an interview with RN #S105, the RN indicated that she was aware that Resident #12's two full bed rails are used when the resident is in bed. The RN indicated that Resident #12 requires total assistance of two staff for turning in bed and for mechanical lift transfers. RN #S105 indicated that she was unsure why full bed rails were used for this resident. The RN added that the home did not have enough half bed rails and thought that this might be the reason why the resident has two full side rails. RN #105 indicated that Resident #12's plan of care should clearly state that full bed rails are in use and reason for their use.

On December 2, 2014, during an interview with the Director of Resident Care (DOC), the DOC indicated that she had reviewed Resident #12's archived chart and was unable to locate documentation related to the reason for the use of full bed rails for the resident. The DOC confirmed that Resident #12 was provided with a bed with full bed rails upon admission that the bed system was never evaluated to determine if this the bed rails in place were appropriate for the resident's needs  The bed system was never evaluated in accordance with evidence-based practices, or in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

3. Resident #007 has a bed with 2 full side rails. A review of Resident #007's plan of care and health care record was conducted. No information was found related to any assessment and use of the full side rails.

On December 4, 2014, the resident's family member stated to Inspector #117 that  the bed and side rails that are currently in place are the original bed and side rails from the time of the resident's admission. The family member is unaware if there has ever been an assessment regarding the resident's use and need for side rails. The resident and the resident's family member both stated to Inspector #117 that they want to have the full

side rails as resident uses the rails to aid with his/her re-positioning in while in bed and that the resident feels more secure with the full side rails.

On December 3, 2014, during an interview with Inspectors #545 and #117, the DOC confirmed that Resident #007 was provided with a bed with full bed rails upon admission and that the bed system was never evaluated to determine if this the bed rails in place were appropriate for the resident's needs. The bed rails were never evaluated in accordance with evidence-based practices, or in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

4. Resident #28 has a bed with 2 full side rails and a therapeutic air mattress. A review of Resident #28's plan of care and health care record was conducted. No information was found related to any assessment and use of the full side rails.

On December 3, 2014, RPN S#121 and PSW S#114 stated to Inspector #117 that the bed and side rails that are currently in place are the original bed and side rails from the time of the resident's admission. They state that they are not aware of the resident's use of side rails was reassessed when a therapeutic air mattress was applied in February 2014 by the home's OT. They also state that the resident is currently unable to use the side rails to assist with his/her repositioning or provision of care. A review of the resident's health care record was conducted with the home's DOC. No information was found in the chart related to any other assessment related to the appropriateness, type and use of side rails for the resident, especially with the current use of a therapeutic air mattress. The home's DOC stated that to her knowledge, Resident #28's need and use of side rails have not been assessed. [s. 15. (1) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.***

**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices**

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

**s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 31 (1) in that the licensee did not ensure that a restraint by a physical device was included in the plan of care.

Resident #12 was admitted to the home in April 2010 with several medical conditions including, stroke with hemiplegia and aphasia. In a review of the most recent RAI-MDS assessment, it was indicated that Resident #12's cognitive function was severely impaired and that a trunk restraint was not in use.

On November 25, 2014, as well as on December 1 and 2, 2014, Inspector #545 observed Resident #12 seated in a reclining wheelchair with a locked front closure seatbelt and a table top. When asked if he/she could release the seatbelt, Resident #12 was unable to physically unlock the wheelchair seatbelt.

During an interview with PSW S#124 on December 1, 2014, the staff member indicated to Inspector #545 that she applies the front closure seatbelt to Resident #12 each time she transfers the resident to his/her wheelchair. The PSW added that the seat belt had been in place since the resident's admission to prevent the resident from sliding out of the wheelchair. The PSW #S#114 indicated that she was not aware that Resident#12 was not able to release the seat belt and therefore did not monitor the resident's response to the use of the seat belt.

During an interview with RPN S#101 on December 2, 2014, the staff member indicated that she was responsible for updating Resident#12's plan of care. When asked if Resident #12 had a physical restraint when up in his/her wheelchair, RPN S#101 indicated that she was not aware that Resident #12 had a front closure seat belt when up in his/her wheelchair, nor was she aware that Resident #12 was unable to release it.

Upon review of Resident #12's health record, there was no documentation found regarding of the use of the physical restraint in the plan of care. No order by a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved for the restraining of the resident. No consent for the use and application of a restraint by the resident, or if the resident was incapable, a substitute decision-maker of the resident with authority to give consent. Finally there was no information related to the application, repositioning, monitoring of the resident's response to the use of a restraint and reassessment of the physical restraint.

In an interview with the Director of Resident Care on December 2, 2014, the DOC indicated that the daily use of restraint by a physical device for Resident #12 should have been included in the resident's plan of care. [s. 31. (1)]

2. Resident #28 sustained a fracture in December 2013. The resident returned to the home in late December 2013. At his/her return, the resident was non-weight bearing, had a narcotic medication prescribed for pain management and had developed at pressure ulcer to the coccyx. The resident was reassessed upon his/her return by the home's Occupational Therapist (OT) and Physiotherapist (PT) regarding the use of a mechanical lift for transfers and a wheelchair with lap belt for mobility as Resident #28 had been independently mobile prior to his/her injury.

On a specific day in December 2013, progress notes from the OT document that the resident lap belt is in place and the resident does not undo the lap belt. No information was found in the resident's chart related to any other assessment, be it by nursing or therapy services in regards to the resident's use or application of the wheelchair lap belt. No assessment was found to determine if the lap belt is restraint or PASD.

Inspector #117 observed that on December 1, 2 and 3, 2014, that Resident #28's wheelchair lap belt was applied when the resident was seated up in his/her wheelchair. The resident was asked on several occasions throughout these days if he/she could undo the lap belt. Resident #28 was unable to undo the lap belt. Interviewed staff members RPN S#121 and PSW S#114 stated that resident's lap belt is always applied when the resident is up in his/her wheelchair. They also stated that the resident was seen on one occasion, several months ago, to undo the lap belt. The RPN S#121 stated that to her knowledge the use of the lap belt has not been reassessed since its initial application in December 2013. It is noted that in July 2014, the ETRN recommended that

the resident's wheelchair seating be reassessed. No information was found in the chart related to any reassessment of the resident's wheelchair seating. A review of the daily care flow sheet shows that the use and application of the lap belt is rarely documented. There is no order or consent for the use of the wheelchair lap belt in the resident's chart.

On December 2, 2014, RPN S#121 and PSW S#114 stated to Inspector #117 that the lap belt is applied to the resident every time that Resident #28 is up in the wheelchair. They stated that the lap belt is a PASD as resident did undo it once, however they could not say when this occurred and when was the last time that the resident was able to undo the lap belt. On December 2 and 3 2014, on three separate occasions, Inspector #117 asked the resident to undo the lap belt. At each instance, Resident #28 had difficulty finding the applied lap belt and was not able to do undo the lap belt.

On December 3, 2014, Inspector #117 reviewed Resident #28's wheelchair lap belt with the home's DOC. The resident was unable to undo the lap belt in front of the DOC. The resident's health care record was reviewed with the DOC. The DOC confirmed that the resident's lap belt is most likely a restraint, that it has not been reassessed, that the resident's wheelchair seating was not reassessed by the OT in July 2014, that there is no order and no consent for the use of the lap belt and that there has been no monitoring of the use, application and monitoring of the resident's response to the use of the lap belt. [s. 31. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any resident who is restrained by a physical device, is included in the resident's plan of care, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement**

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

**s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:**
**1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**3. The use of the PASD has been approved by,**
**i. a physician,**
**ii. a registered nurse,**
**iii. a registered practical nurse,**
**iv. a member of the College of Occupational Therapists of Ontario,**
**v. a member of the College of Physiotherapists of Ontario, or**
**vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).**
**4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).**
**5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the use of a PASD is included in the resident's plan of care only when 1) alternatives to the use of PASD have been considered and tried as appropriate, 2)the use of the PASD is reasonable in light of the resident's physical and mental condition, 3) the use of the PASD has been approved by a physician, a registered nurse, a registered practical nurse or any other person provided for in the regulations, 4) the use of the PASD has been consented to by the resident or a substitute decision maker, and 5) the plan of care provides for everything required under subsection (5).

Resident #007 was observed on November 25, 2014 to have a tilt wheelchair with a lap tray. A review of the resident's health care record and plan of care was conducted. Information was found related to the resident's use of a wheelchair with 1 person

assistance for mobility. No information was found related to the wheelchair having a tilt mechanism and no information was found related to the use of a lap tray. No approval by a physician or other authorized health care professionals for the use of the tilt wheelchair and lap tray was found in the resident' records. Nor was there any information related the resident and/or SDM consenting to the use of the tilt wheelchair and lap tray found in the resident's records.

On December 4, 2014, the resident's family member stated to Inspector #117 that the tilt mechanism is used when Resident #007 is seated for long periods of time and that this helps with skin pressure relief as the resident is at risk for skin breakdown. The family member also stated that the lap tray is used to help with the resident's meal service and is used also to help position the resident in his/her wheelchair. The family member states that she and the resident have given their consent to the use of these positioning aids to assist the resident with activities of daily living. The family member stated that she was not sure that Resident #007 would be able to push and remove by himself/herself the lap tray from the wheelchair due to the resident's poor health status. The family member stated that these interventions have been in place since 2012 but does not recall any reassessment of the resident's use of the lap tray as a positioning aid/safety device (PASD) being done in the past year.

Unit RPN S#136 confirmed the above information related to the use of the tilt wheelchair and lap tray as positioning aids (PASD) but was unsure if the resident could remove the lap tray when applied, and did not know when the use of the tilt wheelchair and lap tray were approved, implemented and if they were reassessed. On December 4, 2014, the home's DOC confirmed that any use of a tilt wheelchair and lap tray need to be identified in the resident's plan of care and that they need to be identified if they are PASDs. [s. 33. (4)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the use of a PASD is included in the resident's plan of care only when 1) alternatives to the use of PASD have been considered and tried as appropriate, 2)the use of the PASD is reasonable in light of the resident's physical and mental condition, 3) the use of the PASD has been approved by a physician, a registered nurse, a registered practical nurse or any other person provided for in the regulations, 4) the use of the PASD has been consented to by the resident or a substitute decision maker, and 5) the plan of care provides for everything required under subsection (5), to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin

assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #28 currently has a stage 3 pressure ulcer wound. The wound has been present since December 2013. In July 2014 the wound became infected, it was assessed by an ETRN, and changes were made to the wound treatment interventions and type of dressing. In August 2014, chart documentation indicates that the wound had continued to deteriorate to a stage 4 and then started to improve in September 2014. It is also noted that at the same time, the resident developed in July 2014, one pressure ulcer to a foot and 2 pressure ulcers to the other foot. These pressure ulcers were also assessed by the ETRN. The resident's Medication Administration Records (MAR) and progress notes document that the pressure ulcer wound is being changed every 2-3 days and that the wounds to both feet are currently healed but need to be closely monitored.

A wound treatment and evaluation record was found in the chart for the resident's pressure ulcer wound. Documentation shows that the resident's wound was assessed as follows: 3 times in May 2014, 3 times in June 2014, 3 times in July 2014, once in August 2014, twice in September 2014 and once in October 2014. The pressure ulcer wound's last documented assessment was done by the home's nurse practitioner on a specific day in October 2014. In regards to the resident's pressure ulcers to both feet, the only wound treatment and evaluation record found on that same day in October 2014, also completed by the home's nurse practitioner.

On December 2, 2014, unit RPN S#121 stated to Inspector #117 that nursing staff do not regularly use the wound treatment and evaluation record form to assess resident wound status. She stated that any change to a wound is to be documented in resident specific progress notes. On December 2, 2014, a review of Resident #28's health care record was conducted with the home's DOC, RN S#105 and nurse practitioner. All three stated that anytime a resident has a wound, the wound needs to be assessed on a weekly basis by registered nursing staff. The home uses the wound treatment and evaluation form, the home's clinically appropriate assessment instrument for wounds, to document the wound's assessment and track the wound's status.

Since May 2014, Resident #28's pressure ulcer wound has not been assessed on a weekly basis by a member of the home's registered nursing staff, with a clinically appropriate assessment instrument specifically designed for skin and wound assessments.

Since July 2014, Resident #28's pressure ulcers to both feet were not assessed on weekly basis by a member of the home's registered nursing staff, with a clinically appropriate assessment instrument specifically designed for skin and wound assessments. [s. 50. (2) (b) (i)]

***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 #28's skin and 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, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

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

**s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:**
**1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).**
**2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).**
**3. Behaviour management. 2007, c. 8, s. 76. (7).**
**4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).**
**5. Palliative care. 2007, c. 8, s. 76. (7).**
**6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 76 (7) 4 in that the licensee did not ensure that all staff who provide direct care to residents receive, as a

condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.

In accordance with the regulation section 219 (1), the retraining intervals for the purposes of subsection 76 (7) of the Act are annual intervals.

During resident interviews as part of the Resident Quality Inspection, inspectors observed two residents with restraints whereby when asked, they were unable to release. Upon review of resident's health records, assessment, order by a physician or nurse in the extended class, consent by the resident or substitute decision maker, monitoring and documentation of monitoring and reassessment were not found. As a result of these observations, LTCH Inspector #545 interviewed staff about the training they received, specifically related to the home's policy to minimize the restraining of residents as well as reviewed the home's mandatory training program with respect to the Act.

During interviews with PSW #S100 and RPN #S144, they indicated they could not remember when they received their training regarding minimizing of restraints. RPN #S125 indicated that had not received training in 2014, was away in 2013 on leave, therefore the last time she received training was 2012.

LTCH Inspector #545 reviewed the home's Passport to Learning for Long-Term Care Staff (October 2013—January 2014), comprised of seven Modules, including the long-term care home's policy to minimize the restraining of residents as well as other mandatory training as per legislation. It is described as follows:
• Module 1: Home Mission Statement, Residents' Bill of Rights, whistleblowing Protection
• Module 2: Pleasurable Dining
• Module 3: Abuse and Neglect
• Module 4: Least Restraint, Last Resort
• Module 5: Protect Residents, Prevent Falls
• Module 6: Continence Care and Bowel Management
• Module 7: Preventing Pressure Ulcers in Long-Term Care

Upon review of the home's Employee's Mandatory E-Learning Report, dated: December 3, 2014 for the Minimizing Restraints training (Module 4: Least Restraint, Last Resort) provided by the Director of Resident Care, #S141, 128 out of 219 staff (PSW and

registered staff), were identified with a small "x" to identify training received. Further, on December 5, 2014, at the request of LTCH Inspector #545, two reports were provided by the Administrator identifying specific dates of when each employee completed the training. Upon review of these reports, it was documented that 51% of the nursing staff (PSW and registered staff) received the training in 2013. In 2014, it was documented that 9 nursing staff members (PSW and registered staff) received the training; therefore 94% did not receive the training on Minimizing Restraints between January 1, 2014 and December 4, 2014.

The inspector held a discussion with the DOC, on December 3, 2014 regarding the training of staff and the DOC indicated that staff were encouraged to participate in monthly training blitz, and that computers were made available to staff to complete the electronic Modules. The DOC indicated that she was aware that not all staff had received the home's mandatory training program, as per the Act, and was hoping that the home's eLearning program would soon be able to generate reports to allow managers to monitor staff training without having to go into each employee profile to verify if training was completed. There was no immediate plan to address staff training on the Module 4: Least Restraint, Last Resort, for the rest of the month of December 2014In accordance with the regulation section 219 (1), the retraining intervals for the purposes of subsection 76 (7) of the Act are annual intervals.

During resident interviews as part of the Resident Quality Inspection, inspectors observed two residents with restraints whereby when asked, they were unable to release. Upon review of resident's health records, assessment, order by a physician or nurse in the extended class, consent by the resident or substitute decision maker, monitoring and documentation of monitoring and reassessment were not found. As a result of these observations, LTCH Inspector #545 interviewed staff about the training they received, specifically related to the home's policy to minimize the restraining of residents as well as reviewed the home's mandatory training program with respect to the Act.

During interviews with PSW #S100 and RPN #S144, they indicated they could not remember when they received their training regarding minimizing of restraints. RPN #S125 indicated that had not received training in 2014, was away in 2013 on leave, therefore the last time she received training was 2012.

LTCH Inspector #545 reviewed the home's Passport to Learning for Long-Term Care Staff (October 2013—January 2014), comprised of seven Modules, including the long-

term care home's policy to minimize the restraining of residents as well as other mandatory training as per legislation. It is described as follows:
• Module 1: Home Mission Statement, Residents' Bill of Rights, whistleblowing Protection
• Module 2: Pleasurable Dining
• Module 3: Abuse and Neglect
• Module 4: Least Restraint, Last Resort
• Module 5: Protect Residents, Prevent Falls
• Module 6: Continence Care and Bowel Management
• Module 7: Preventing Pressure Ulcers in Long-Term Care

Upon review of the home's Employee's Mandatory E-Learning Report, dated: December 3, 2014 for the Minimizing Restraints (Module 4: Least Restraint, Last Resort) training provided by the Director of Resident Care, #S141, 128 out of 219 staff (PSW and registered staff), were identified with a small "x" to identify training received. Further, on December 5, 2014, at the request of LTCH Inspector #545, two reports were provided by the Administrator identify specific dates of when each employee completed the training. Upon review of these reports, it was documented that 51% staff (PSW and registered staff) received the training in 2013. In 2014, it was documented that 9 staff (PSW and registered staff) received the training; therefore 94% did not receive the training on Minimizing Restraints between January 1, 2014 and December 4, 2014.

The inspector held a discussion with the DOC, on December 3, 2014 regarding the training of staff and the DOC indicated that staff were encouraged to participate in monthly training blitz, and that computers were made available to staff to complete the electronic Modules. The DOC indicated that she was aware that not all staff had received the home's mandatory training program, as per the Act, and was hoping that the home's eLearning program would soon be able to generate reports to allow managers to monitor staff training without having to going into each employee profile to verify if training was completed. There was no immediate plan to address staff training on the Module 4: Least Restraint, Last Resort, for the rest of the month of December 2014. [s. 76. (7) 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 ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training on how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 129 (1) (a) (ii) in that the licensee did not ensure that drugs are stored in an area or a medication cart, that is secure and locked.

1) On November 24th, 2014 , a medication cart was observed by Inspector #592 to be left unattended on the resident unit 2AB. The medication cart was noted to be locked. However, the following medication were left on top of the medication cart: Oxeze Turbohaler, Saline Nasal Mist, Spiriva and Omnaris nasal spray for various residents..

No registered staff were noted to be around or close to the medication cart for 3 minutes. Unit RPN S#110 then arrived at the medication cart. RPN S#110 indicated to Inspector #592 that it was poor practice to have left the medication on top of the cart and that the cart had been close to her but it had been moved away from her without her knowledge

2) On November 24, 2014, during a tour of the home, Inspector #545 observed an unattended/unlocked medication cart on 3-C, located at end of hallway near an office and a dining room. Other than the RAI Coordinator #S126, who was on the phone in the office, no one else was observed near the area. Inspector remained near the cart and 8 minutes later, RPN #S127 arrived in the hallway with a blood pressure on wheels, when asked if he was responsible for this Medication Cart, he replied he was and pushed the top drawer of the medication cart to lock it. RPN #S127 indicated that the Medication Cart was set up to lock automatically on its own, and he thought it had been locked when he had left it unattended. The medication was left unlocked and unattended for 8 minutes.

3) On November 25, 2014, in the morning before lunchtime, during an interview with Resident #015, Inspector #545 observed a medication cup on top of his/her TV filled with a variety of different drugs. When asked, Resident #015 indicated he/she thought they might be his/her evening pills.

On November 25, 2014, Inspector #545 reviewed Resident #015's medication administration record and observed that the resident's ten (10) morning medication that were to be given at 09:00 am, had not been signed for.

On November 25, 2014, during an interview with RPN #S118, the staff member indicated that she had offered Resident #015 his/her 09:00 medications sometime between 09:00 and 09:30 and that the resident had refused as he/she often did. RPN #S118 indicated that she placed Resident #015's medication in a small plastic cup on top of his/her TV with the goal to return later to re-offer refused medications. Inspector then observed RPN #S118 print a code of "2" for each medication refused to indicate that Resident #015 had refused his/her 09:00 medications on November 25, 2014.

4) On December 1, 2014, observed the Medication Cart unlocked and unattended at the Nursing Station on the 3rd floor. When RPN S#125 walked by the Nursing Station 13

minutes later, Inspector #545 asked the staff member if she was responsible for the unlocked Medication Cart. The staff member indicated she was and proceeded to lock it by entering a code on the keypad. RPN #S125 indicated that she should have not left the Medication Cart unlocked and unattended at the Nursing Station. The medication was left unlocked and unattended for 18 minutes.

5) On November 28, 2014, in the mid-afternoon Inspector #117 arrived on the 3AB unit. It was noted that both medication carts are at the nursing station, in front of the elevators, behind the nursing desk . When verified, both medication carts were not locked. No staff was around the nursing station. On one medication cart, was a jar of medicated cream Hyderm 1% for Resident #15. Residents #15, #43 and #46 were observed to be sitting in the hallway immediately beside the nursing station.

Four (4) minutes later, one medication cart, with the medication cream on top, was heard to automatically lock with a loud clicking noise, while the other medication cart remained unlocked.

Three minutes later, 7 minutes after the initial observation, Inspector #117 observed 2 staff members come out of a resident room 320-B, one of them was the unit RPN #101. Inspector #117 showed the RPN S#101 the unlocked medication cart. The RPN stated that the medication cart should lock automatically and could not understand why it was not locked. The RPN tried several times put in the locking code and the cart locked after the 5th try. The RPN stated that she was not aware of any locking issues or locking delays with the medication cart. She stated if there were any issues with the locking mechanism, staff would call the pharmacy MEDISYSTEM as they are responsible for any issues with medication carts.

On December 3, 2014, Inspector #117 notified the home's clinical care coordinator of the delay in the locking mechanism of the 3rd floor medication cart. The clinical care coordinator indicated that she was not aware of any issues but would follow up with MEDISYTEM regarding this issue. [s. 129. (1) (a) (ii)]

***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 drugs are stored in an area or a medication cart, that is secure and locked, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care**

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

**s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,**
**(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).**
**(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).**
**(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O.Reg 79/10 s. 34 (1) (a) in that the home did not ensure that the resident receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

During an interview on November 25, 2014 at 10:00, Resident #11 indicated he/she had problem eating and chewing, but was not sure what the problem was. Resident #11 indicated he/ she had two dentures. Inspector #545 observed upper denture, in the resident's mouth, to be covered with food debris and thick saliva.

On November 27, 2014, Resident #11's sitter indicated to Inspector #545 that Resident #11 had complained of mouth pain seven days ago. The sitter indicated that she informed the nurse of the resident's pain. When the sitter returned on November 25, 2014, she assumed staff had addressed the pain issue as Resident#11 no longer

mentioned pain in his/her mouth.

Upon review of Resident #11's most recent plan of care, it was documented that Resident #11 had two dentures and/or removable bridge. Interventions included to encourage Resident to clean his/her own teeth morning and evening, remove and rinse dentures after each meal and soak dentures in cleansing solution for 15 minutes each evening.

On December 1, 2014 at 08:30, Inspector #545 observed Resident #11 eating a piece of toast in the dining room. At 10:00, Resident was back in his/her room, complaining of nausea. The inspector observed Resident #11's upper denture to be covered with food debris and thick saliva. When asked, the Resident could not remember if his/her denture had been cleaned earlier in the day.

Shortly after, during an interview with PSW S#100, the staff member indicated that Resident #11 required full assistance of one staff for dental care as the resident was unable to brush his/her dentures or to rinse them. PSW S#100 indicated that she brushes the resident's dentures every morning and puts them back in the resident's mouth before breakfast. When asked what toothbrush was used this morning, PSW #S100 indicated that she had not brushed the resident's dentures this morning as she could not find the resident's toothbrush. The PSW later found a denture toothbrush in Resident #11's closet, inside a Voltaren box with the Voltaren cream. The bristles of the toothbrush were covered with dust and hairs.

On December 1, 2014, RPN #S101 indicated to Inspector #545, that she was the registered staff responsible to updating Resident #11's plan of care. The RPN indicated that Resident #11 was no longer able to brush his/her own dentures and required twice daily full assistance with oral care.

When RPN #S101 and PSW #S100 attempted to remove Resident #11's dentures to clean them, the resident informed them that his/her mouth was sore. The RPN indicated she was not aware that Resident #11 had pain in his/her mouth. After brushing Resident #11's dentures, PSW #100 indicated that it was very difficult to remove Resident #11's dentures and that she did not remove & rinse them after meals as per the plan of care. [s. 34. (1) (a)]

**WN #10: 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 each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, are labeled within 48 hours of admission and of acquiring, in the case of new item; and is cleaned as required.

On November 24, 25 and 26, 2014, , Inspectors #545, #550, #117 and #592 observed unlabelled and unclean personal care items in resident shared bathrooms and tub and shower rooms throughout the home.

Personal items in the following shared bathrooms were not identified:

• Room 214A: a soap dish containing 4 used bars of soap.
• Room 234A: 3 used toothbrushes in an unclean ceramic cup.
• Room 214B: 2 metal wash basin on the floor under the sink.
• Room 314A: a used bar of soap
• Room 322A: a used denture toothbrush, a used regular toothbrush, a green mouth guard all in an unclean kidney basin, 2 used bars of soap in an unclean plastic green dish, a used hairbrush, a grey comb, a opened and used jar of VitaRub jar and 2 urinals.
• Room 338A: 2 used soap bar, 2 used toothbrush, a plastic bedpan and 2 white urine collector container.
• Room 356B: 1 used roll-on deodorant stick, an electric toothbrush, 2 regular toothbrush, 3 used blue razors, 1 purple razor in an unclean kidney basin and 1 urinal.
• Room 428A: 2 white urine collector container
• Room 426A: 3 toothbrushes (one identified, 2 not identified) full of dust and 2 white

urine collector container.
• 404B: a toothbrush in a denture cup, 2 white urine collector containers stored on the grab bar and a metal bedpan stored on a grab bar behind the toilet.

Personal items in the following communal tub and shower rooms were not labelled:

• Room 205B: in a drawer in beside the tub, there was a used Ladyspeed stick deodorant, 2 used Freshscent deodorant stick and a black hairbrush with hair in it.
• Room 305B: in a drawer, there were 4 used deodorant sticks and on a metal bookshelf 1 used deodorant stick.

During an interview staff S#119 indicated to Inspector #550 each resident personal care items such as toothbrush, urinals, and bedpans are to be identified with the resident's name if the resident is sharing a washroom. He indicated the PSW's use soap bars to wash the residents, and soap bars are supposed to be stored in a dish labelled with the resident's name.

During an interview RN staff S#123 indicated to Inspector #550 resident's personal care items such as toothbrushes are to be labelled. Each resident should have a labelled basket at beside with all their care equipment inside. When PSW give baths, they are to bring the basket with them.

During an interviewed RPN staff S#122 indicated to inspector #550 all resident personal care equipment such as toothbrush, hair brush, razor, and soap bar have to be identified with each resident's name. She indicated this was not always being done by PSW's.

The Director of Care indicated to Inspector #550 it is the home's expectation that all resident's personal care equipment items including but not limited to toothbrush, deodorant stick or roll-on, denture cup, urinal, bed pan, razors, soap bar, are to be identified with each resident's name and are kept clean. She indicated to inspector she is aware that this is an issue throughout the home. [s. 37. (1)]

2. The licensee has failed to ensure that residents personal equipment are cleaned as required.

On November 25 and 26, 2014, the Inspectors #545 and #592 observed several soiled resident mobility equipment. As a result, Inspector #592 further inspected the ambulation

equipment for three Residents on November 27th, 2014:
• Resident #13's wheelchair frame was observed to be dusty and covered with dry debris on the left arm rest, wheelchair padding on the back of the legs, seatbelt, seat and back rest.
• Resident #28's wheelchair was observed to have white dusty residue on the wheels and base of the wheelchair. Dry beige debris was observed to be crushed on wheels and wheel base.
• Resident #43's wheelchair was observed to have white matter to back and seat rest of the wheelchair as well as white matter on the padded cushions that are holding resident arm rests.

Upon review of the Resident Council minutes dated on October 29th 2014, it was indicated that "the cleaning of residents' personal equipment will be done in the coming week and then each 3 to 4 months". The minutes further indicated that "a resident has inquired during the Resident Council minute if all the residents' equipment would be cleaned at that time and the home indicated that it will be done."

On November 27th, 2014, PSW S#100 indicated to Inspector #592 that it was the responsibility of the housekeeping staff to wipe down residents ambulation equipment with a disinfecting product. The staff member indicated to Inspector #592 that if the PSW observed a resident's equipment to be dirty, they would clean it but they have to report this to the registered staff who then report it to housekeeping, however she could not confirm the process and redirected the Inspector to speak with registered staff.

On November 27th, 2014, interviewed RPN S #101, indicated to Inspector #592 that when PSW or registered staff are made aware of unclean resident mobility equipment, staff need to call the "# 4444 number" which is the on-call line for St-Vincent Complex Continuing Care Hospital to ask for a requisition to have housekeeping come and clean the residents' equipment at Résidence St-Louis.

On November 27, 2014, the interviewed Manager of Dietary/ Housekeeping/Laundry Services and the Maintenance Coordinator of Résidence St-Louis, stated to Inspector #592 that the residents mobility equipment is only being cleaned upon request. The Manager of Dietary/ Housekeeping/Laundry Services indicated that she receives a requisition from the on-line service, from St-Vincent Complex Continuing Care Hospital to have resident specific equipment washed and cleaned. The managers indicated that in the past, it was Shoppers Home Health Care who was the external contractor for all the washing and disinfection of the resident mobility equipment however; the contract was

not renewed in January 2014. Since then, residents' mobility equipment is cleaned by the home only upon request.

Both managers indicated that all resident wheelchairs were cleaned in October 2014 and that the home had just started a new schedule to have residents equipment cleaned every three months. However, since October 2014, they have not received any request for the cleaning of residents' mobility equipment. The Manager of Dietary/Housekeeping/Laundry Services indicated that she was unaware of the Residents #13, #28 and #43 mobility equipment being soiled. [s. 37. (1) (b)]

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**WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council**

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

**s. 56. (2) Only residents of the long-term care home may be a member of the Residents' Council. 2007, c. 8, s. 56 (2)**

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 56 (2) in that the licensee did not ensure that all members of the Residents' Council residents of the long-term care home.

Upon a review of the minutes of the Resident Council meetings in 2014, it was documented that family members participated in the meetings. On November 28,2014, the Client Relations Advisor provided Inspector #545 a document titled: Resident & Family Annual Review 2013-2014; this document indicated that "while no official Family Council meetings were held during the September 2013 to June 2014 time period, family members did attend meetings with the Resident's Council".

During an interview with the President of the Resident Council on November 27, 2014, the President indicated that family members attended Resident Council meetings because there was no Family Council in the home at this time.

During an interview with a family member on November 28, 2014, the family member indicated that she attended the Resident Council meetings to represent her parent who could not attend due to dementia. The family member added that this offered her a venue to voice concerns about her mother's care in the home.

During an interview with the Administrator on November 28, 2014, the Administrator indicated that he was aware that family members attended the Resident Council meeting but he was unaware that family members attended the Resident Council meetings to represent a Resident of the home who was not in attendance. The Administrator indicated that he met with family members on November 10, 2014 to re-launch the Family Council. [s. 56. (2)]

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**WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 57 (2) in that the licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Upon review of the Residents' Council minutes for meetings that took place in 2014 (February 26, March 26, May 28, September 17 and October 29), concerns and/or recommendations were documented, such as:
-Residents fear staff retaliating when making complaints
-Residents indicate some staff do not treat them with respect
-Food Quality, for example food too spicy, soup too thick, coffee and tea served cold
-Collation: not always provided to residents in the afternoon
-Laundry: lost items
-Housekeeping: bathrooms needing daily cleaning, bedroom cleaning not done on weekends

During an Initial Tour of the home on November 24, 2014, Inspector #545 observed a memo dated November 10, 2014 posted on the Bulletin Board of the main floor indicating that the "long term care management team would be conducting investigations on lost laundry items".

During an interview with the President of the Residents' Council on November 27, 2014, the President indicated that she doesn't remember receiving a response from the licensee in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. The President indicated that in the last year, she had seen one response in writing regarding one concern that was brought up at the October 29, 2014 Resident Council meeting. She added that follow-up on issues raised have typically been done via Meeting Minutes presented the following meeting and that she usually received the minutes the day before the meeting or the day of the meeting.

On November 28, 2014 during an interview with the assigned assistant to the Resident Council, the assistant indicated that she had only been in her role since September 2014 and that she was recently made aware of the need for the licensee to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. She indicated that the October 29, 2014 minutes, including follow-up on concerns or recommendations, was posted on the Bulletin Board on the main floor on November 14, 2014.

During an interview with the Administrator on November 28, 2014, the Administrator indicated that in the past he responded verbally, not in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. He indicated that he was now aware of the legislation and responded in writing following the October 29, 2014 meeting related to one concern: lost laundry items. [s. 57. (2)]

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**WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council**

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

**s. 59. (7) If there is no Family Council, the licensee shall,**
**(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).**
**(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 59 (7) (b) in that the licensee did not ensure, if there was no Family Council, to convene semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council.

Upon review of the Entrance Conference Binder provided by the home on November 24, 2014, it was indicated that the home did not have a Family Council, however during a discussion with the Administrator on November 27, 2014, he indicated that the home had a Family Council but that they had not met in ten months; and that he would provide Inspector #545 with the coordinates of the secretary and the assigned assistant to the Family Council.

During an interview with the Director of Mission, Ethics, Compliance and Client Relations (the Director) on November 28, 2014, the Director indicated he was assigned as assistant to the Family Council. He indicated that the home had sent invitations to family members in October 2014 to invite them to a general meeting on November 10, 2014 with the goal to re-launch the Family Council. In a document titled: "Resident and Family Council Annual Review Sept. 2013 - June 2014", that the Director provided, it was documented that the home did not have an official Family Council, and that family members attended meetings with the Resident's Council.

During an interview with a family member on November 28, 2014, the family member indicated that she was the secretary of the previous Family Council but that the council had not met since the fall of 2012. The family member indicated that in the spring of 2013, two members, including herself and the assigned assistant to the Family Council met, but the meeting was canceled due to lack of quorum.

During an interview with the Administrator on November 28, 2014, the Administrator confirmed that the home did not presently have a Family Council. He indicated that the home did not convene semi-annual meetings in 2014 to advise residents' families and persons of importance to residents of their right to establish a Family Council, adding that the home convened one meeting in 2014 (November 10). [s. 59. (7) (b)]

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**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

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

**s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,**
**(a) is a minimum of 21 days in duration; O. Reg. 79/10, s. 71 (1).**

**s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).**

**Findings/Faits saillants :**

1. The licensee failed to comply with section 71.(1)(a) of the regulation in that the licensee failed to ensure that the home's menu cycle is a minimum of 21 days in duration.

In accordance with section 71(1)(b) of the regulation, the home's menu cycle is required to include menus for regular, therapeutic and texture modified diets for both meals and snacks. LTCH Inspector #138 was reviewing the snack programs in the home and reviewed the snack menu provided by a food service worker, Staff#108. It was noted by the inspector that the menu for the snack program was on a seven day menu cycle. The inspector spoke with the Food Service Supervisor and the Registered Dietitian who both stated that the menu for the snack program was only on a seven day menu cycle unlike the menu for meals which is on a 21 day menu cycle. The Registered Dietitian stated that the menu cycle for the snack program could be lengthened to 21 days at the implementation of the next menu revision. [s. 71. (1) (a)]

2. The Licensee failed to comply with section 71.(5) in that the Licensee failed to ensure that an individualized menu is developed for each resident whose needs can not be met through the home's menu cycle.

Resident #052 has a diagnosis that impacts nutritional status. This resident has been assessed and followed by the home's Registered Dietitian. The Registered Dietitian entered a specific diet order on the Physician's Order in October 2014. The Registered Dietitian's quarterly review completed later that same month stated that the resident was to receive a diet that was worded differently than that indicated on the Physician's Order. The dietary Kardex was also reviewed by the inspector and noted to be consistent with

the Registered Dietitian's quarterly review completed in October 2014. LTCH Inspector #138 reviewed the home's menus located on the unit dining room where the resident eats and noted that the diet order in the Physician's Orders was not available nor was there an individualized menu for the resident. There was, however, a generic menu that met some of the resident's dietary restrictions. The inspector spoke with a dietary aide, Staff #108, regarding the resident's diet and Staff #108 stated that the resident does not have an individualized menu to be followed but is instead served meals according to the information that was found in the dietary Kardex. The inspector observed the lunch meal service on November 27, 2014 and noted that the resident was offered and choose food items not consistent with the dietary restrictions in place for the resident. The inspector spoke to the Registered Dietitian about the meal observations and she confirmed that the food items offered were not desirable for the resident. The inspector also spoke with the Registered Dietitian regarding another specific dietary restriction and the Registered Dietitian confirmed that there was no individualized menu or specific direction or tracking that ensured that the resident's diet adhered to the dietary restriction. [s. 71. (5)]

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**WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 85 (3) in that the licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with the President of the Residents' Council on November 27, 2014, the President indicated that the licensee did not seek the Residents' Council advice in developing and carrying out the satisfaction survey, and in acting on its results.

On November 28, 2014, the Administrator indicated that in the spring of 2014, the home delivered the same satisfaction survey questions that was used in 2013 and that the home did not seek the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results. [s. 85. (3)]

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**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

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

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**
**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**
**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**
**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**
**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O.Reg 79/10 s. 101 (2) in that the home did not ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time

frames for actions to be taken and any follow-up action required
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant

1) On November 26, 2014 during an interview with Resident #12's daughter, she indicated that the resident's spouse reported to the staff on November 10, 2014 that the resident's DVD player had been stolen and asked staff to contact her to discuss the complaint. By November 24, 2014, as she had not yet heard back from someone at the home, Resident #12's daughter sent an email to a charge nurse at the home to request the name of the person who was responsible to further investigation the theft of the DVD in her mother's room.

Upon review of the home's Complaints Tracking document dated July 11, 2014 to November 25, 2014 provided by Administrative Assistant S#138, documentation of this complaint was not found.

On December 2, 2014 during an interview with the DOC, the DOC indicated that she was aware of the complaint and that a staff member had completed a Security Incident Report and forwarded it to the Manager Security & Parking, whose office was off-site.

On December 2, 2014, during a phone interview with the Manager of Security and Parking, the Manager indicated that an investigation was underway, and that he had contacted Resident #12's daughter on November 27, 2014 to discuss progress of investigation and actions to be taken. On December 3, 2014 in an email to the Inspector, the Manager indicated that Security Guard S#140 had made three attempts to contact Resident #12's daughter between November 13 and November 17, 2014, but did not leave a message. The Manager indicated that he was responsible for three sites and had not yet completed the required documentation in the home's Complaint Record, such as documenting the nature of the verbal/written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required and every date on which any response was provided to the complainant and a description of the response.

2) On November 28, 2014, during an interview with Resident #24's daughter, the daughter indicated that she had sent a letter to the home's previous Director of Care with a copy to the Administrator and the Director of Mission, Ethics, Compliance on September 5, 2013 to express concerns regarding the safety of her family member after witnessing a resident with responsive behaviours be physically abusive towards another resident. A copy of the complaint letter dated September 5, 2013 was provided to Inspector #545. The daughter indicated that the previous Director of Care, the Administrator or a designate, or anyone else never responded to her concern.

Upon request of the home's Complaint Tracking Record for the period of January 2013 to January 2014, to verify if the complaint received by the daughter of Resident #24's had been documented in the home's complaint record, Inspector #545 was informed by Administrative Assistant S#138 that the home did not have a documented record for that period of time. Administrative Assistant S#138 provided Inspector #545 with two documented records for complaints:

- June 14, 2012 to January 2013
- July 11, 2014 to November 25, 2014

During an interview with the current Director of Care and the Administrator on November 28, 2014, they indicated that managers keep in their office, documented records of complaint letters they respond to. The DOC indicated she reviewed the former DOC's files and was unable to locate the complaint letter sent by the daughter of Resident S#024 on September 5, 2013. The Administrator indicated that some documented records in DOC's files were missing.

The home did not ensure to keep a documented records in the home, including: (a) the nature of each verbal or written complaint, (b) the date the complaint was received, (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant for the period, for a period of 17 months (January 2013 and June 2014). [s. 101. (2)]

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**WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes**
**Every licensee of a long-term care home shall ensure that,**
**(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;**
**(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and**
**(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Resident #28 has an order for a narcotic pain medication to be given on an as needed basis. This order has been in place since the resident sustained a fracture in December 2013 and subsequently developed a pressure ulcer. It is also noted that the resident has cognitive impairments and does become verbally and physically aggressive during the provision of personal care.

A review of the resident's health care record was conducted by Inspector #117. It was noted that in April 2014, the psychogeriatric outreach assessment team was consulted related to the resident's behaviours during the provision of personal care and wound care dressing changes. A recommendation from the psychogeriatric team was to administer the narcotic pain medication 30 minutes prior to the change of wound dressings to help minimize the resident's pain and responsive behaviours.

On December 2, 2014, RPN S#121 stated to Inspector #117 that Resident #28's wound dressing is being changed every 2-3 days as per medical orders. She also stated that as per recommendation of the psychogeriatric outreach team, the narcotic pain medication is being given 30 to 60 minutes prior to dressing changes to help minimise the resident's pain and responsive behaviours during the dressing change. The MAR documentation was reviewed and it was noted that the resident is receiving the pain medication every two or three days prior to the documented wound care treatment. Progress notes document that the resident receives the narcotic 1 hour prior to the wound care treatment, however the effectiveness of the medication is not documented in the resident's health care record.

On December 2, 2014, Inspector #117 did observe Resident #28 become verbally and physically aggressive with staff during the provision of wound care dressing change. The unit RPN S#121 indicated that the resident's response to the narcotic medication should be document but that this is not consistently done.

Resident #28's response to the administration of a narcotic pain medication, prior to a wound dressing change, is not being monitored and documented. [s. 134. (a)]

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**WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator**

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

**s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:**
**1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).**
**2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).**
**3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the administrator works on site at least 35 hours per week.

Résidence St- Louis is a home with 198 licensed long-term care beds. The home has a designated administrator, whose main office is located within the home. The home's administrator is also the Administrator for Résidence Elizabeth Bruyère, which has 70 licensed long-term care beds and is located 15 kilometers from Residence St Louis. On November 25 2014, the home's administrator stated to Inspector #117, that he spends 80% of his time at Résidence St Louis and 20 % of his time at Résidence Elizabeth Bruyère.

During the Resident Quality Inspection, it was noted that the administrator travelled on a daily basis between both long-term care homes. On both November 25 and on December 2, 2014, the administrator was not at Résidence St-Louis. He was at Résidence Elizabeth Bruyère. On December 2, 2014, the homes administrative assistant stated that although the administrator was not physically present in the home, he was available via cell phone and email.

On December 11, 2014, the home's Administrator and the Bruyère Continuing Care Chief Executive Officer (CEO) provided information to the Inspector confirming that the Administrator spends 30 hours per week on Administrative duties for both homes. On January 16, 2015, in a meeting with the Inspector, the Ottawa Service Area office Manager and the Senior Manager, the CEO agreed that the home's current Administrator is not meeting the required legislative time elements, of 59 hours per week, required for Administrator hours for both long-term care homes. On January 23, 2015, the Administrator notified the Inspector that a change in the management structure of both long-term care homes was being done by Bruyère Continuing Care. As of January 30, 2015, Résidence St Louis's clinical care coordinator has been appointed as the home's new Administrator and that he will now be the designated Administrator for Résidence Elizabeth Bruyère. The new Administrator for Residence St-Louis meets the required qualifications for an Administrator under the LTCHA. (or reg as applicable)

Therefore, based on the information provided initially by the Administrator and confirmed by the CEO, the home administrator was not present in the home, Résidence St Louis, for the required 35 hours per week as specified under the legislation for a home of more than 97 licensed long term care beds. [s. 212. (1)]

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**WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.**

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

**s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:**
**1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that information regarding a resident's ability to retain a physician is provided to the residents at the time of their admission.

As part of the Resident Quality Inspection, Inspector #117 reviewed the home's Resident and Family Admission Information package. No information was found in the package as it relates to the resident's ability to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1) of O.Reg 79/10. A review of the information package was done with the home's DOC. She confirmed that the Resident Admission Information package, which was prepared corporately, does not contain any information related to residents' ability to retain a physician or registered nurse in the extended class to perform the services required under the Regulations. [s. 224. (1) 1.]

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**Issued on this 6th day of February, 2015**

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

**Original report signed by the inspector.**