1. Every licensee of a long-term care home shall ensure that,

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Approximately 10 night tables in the 300 wing were noted to have very rough surfaces with raised splintered edges along the front perimeter of the top surface. One night table in room #303 had more than a quarter of the top surface worn down to the particle board layer. The Administrator provided documentation that three new night tables had been ordered in January 2013, but were not in the home at the time of the inspection. No information could be provided with respect to when the other seven night tables would be repaired or replaced. [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, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

a) An identified resident had a PASD in use prior to hospitalization in 2013. The resident had a change of condition while in hospital and could no longer undo the device upon return to the home in 2013. Staff identified the use of the device was now a physical restraint and the resident was observed at a specific time 2013, with the device in place however, the restraint consent and physician's order was not obtained until a later date.

b) An identified resident had an order for a restraint device in 2013. A review of the clinical record was unsuccessful in locating a completed Restraint Assessment Tool. Interview with the ADOC confirmed that a Restraint Assessment Tool should have been completed before the initiation of the physical device used to restrain the resident. [s. 30. (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 no resident is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee did not ensure that residents received individualized personal care, including hygiene care and grooming on a daily basis.

a) According to the plan of care, an identified resident required a specific level of assistance every day, for an identified care need related to hygiene and grooming. At approximately 13:00 hours on an observed day in 2013, it was observed that the resident had not received assistance with the identified care need and there was no documentation to indicate the resident had refused care.

b) Another identified resident was observed following the noon meal on an identified date in 2013, at which time it was noted that the resident had not received assistance with an identified care need, related to hygiene and grooming. The resident's plan of care identified that the residents required extensive to total assistance with personal hygiene.

c) According to the plan of care, another identified resident required extensive assistance to complete personal hygiene. On an identified date in 2013, at approximately 13:00 hours, it was observed that the resident had not received assistance with a specific care need related to hygiene and grooming.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents received individualized personal care, including hygiene care and grooming on a daily basis, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee did not ensure that when a resident had fallen, the resident was assessed and when required, a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

a) An identified resident sustained falls with and without injury on five identified dates from 2012 to 2013. The home did not complete post fall assessments for any of the identified falls. The ED confirmed that internal auditing had recently revealed that the home was not completing post fall assessments using a clinically appropriate assessment instrument specifically designed for falls.

b) According the clinical record an identified resident, had sustained in excess of 15 falls in 2012. The ED confirmed the home did not complete post falls assessments when clinically indicated, using a clinically appropriate assessment instrument specifically designed for falls.

c) An identified resident sustained a fall on an identified date in 2013 and was diagnosed with an injury resulting in hospitalization. The resident was not assessed using a clinically appropriate post fall assessment instrument, which is designed for falls. The ED confirmed that internal auditing had recently revealed that the home was not conducting post fall assessments using a clinically appropriate tool. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and when required, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #8: 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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, did not receive 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.

a) An identified resident was identified on a specific date in 2013 to have an area of altered skin integrity. The physician ordered a dressing to the area on a specific date in 2013. The area was present during the course of the inspection, however almost healed. The altered skin integrity was not assessed using a clinically appropriate assessment instrument until a number of days later, in a Head to Toe Assessment. It was confirmed by the staff that the resident did not have an Initial Wound Assessment -Treatment Observation Record initiated.

2. The resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had not been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) An identified resident was identified to have a specific skin problem on an identified area, during the inspection; at times the area was covered by a dressing and other times it was left open to the air. The progress notes and staff interview confirmed that the area had been present for a few months. There was no documentation available to indicate that the area had been assessed by a member of the registered staff over a two month period in 2013, this was confirmed by the wound care champion . Progress notes and Treatment Administration Records (TAR) identified that staff provided treatment to the area as required.

b) An identified resident was identified during the inspection to have an affected area of the skin on an identified area. The progress notes indicated that the resident worsened the area on an identified date in 2013. The area was assessed by the physician and orders for a dressing was received. The clinical record did not include a weekly assessment of the area for at least a one month period in 2013, when the record was reviewed. An interview with the staff confirmed that the area was not assessed weekly by a member of the registered nursing staff. [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 any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

a) In 2013, an identified resident was observed from 10:30 hours until approximately 16:00 hours on a specific date. The plan of care indicated the resident required a brief and was incontinent and required assistance with toileting. Staff confirmed the resident was incontinent and required assistance with toileting. On an identified date in 2013, the resident reported ringing the bell several times, however, assistance was not provided to the bathroom. Staff interviewed, confirmed that the resident had rang the bell several times, and that assistance to the bathroom had not been provided. At 16:00 hours on this date, it was confirmed the resident's brief was wet. [s. 51. (2) (c)]

2. The licensee did not ensure that the resident who required continence care products received sufficient changes to remain clean, dry and comfortable.

a) On an identified date in 2013, an identified resident was observed from 10:30 hours until approximately 16:00 hours. The plan of care indicated the resident required a brief and was incontinent. Staff confirmed the resident was incontinent and required assistance with toileting. On the observed date the resident reported ringing the bell several times, however, assistance was not provided to the bathroom. Staff interviewed, confirmed that the resident had rang the bell several times, and that assistance to the bathroom had not been provided. At 16:00 hours, it was confirmed the resident's brief was wet. [s. 51. (2) (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who are unable to toilet independently some or all of the time, receive assistance from staff to manage and maintain continence; and residents who require continence care products receive sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee did not ensure that all residents were offered a minimum of a snack in the afternoon and evening.

a) An identified resident was monitored during the afternoon on an identified date in 2013. It was identified that the resident was not offered or provided an afternoon snack. The resident was provided a beverage only during the nourishment pass.

b) An identified resident was in their room with the door closed however, staff did not stop at the room to offer a between meal snack in the afternoon on an identified date in 2013. The resident confirmed that staff did not offer a between meal snack. Four identified residents were offered between meal beverages in the afternoon however; staff did not offer between meal snacks in the afternoon. [s. 71. (3)]

2. The licensee did not ensure that each resident was offered a minimum of a between meal beverage in the morning and afternoon and a beverage in the evening after dinner.

a) An identified resident was in their room with the door closed however, staff did not stop at the resident's room to offer a between meal beverage in the afternoon on an identified date in 2013. The resident confirmed that staff did not offer a between meal beverage. [s. 71. (3) (b)]

3. The licensee did not ensure that the planned menu items were offered and available at each meal and snack.

a) The planned menu items for the nourishment menu on an identified date in 2013, indicated puree bran crunch cookie however; staff confirmed that puree bran crunch cookie was not available during the afternoon nourishment pass. The planned menu dessert choice on an identified date was not offered and available for all residents requiring puree texture. The home ran short of puree fruit and it was not offered for at least three residents. [s. 71. (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 all residents are offered a minimum of a snack in the afternoon and evening; that each resident is offered a minimum of a between meal beverage in the morning and afternoon and a beverage in the evening after dinner; and that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The infection prevention and control program does not include measures to prevent the transmission of infections.

The infection prevention and control program included various practices to control the transmission of infections, one of which was cleaning and disinfection of communal equipment and personal care articles. The home had established procedures (ICM-B-60)for cleaning and disinfecting communal and personal care equipment, however staff were not following the procedures and management staff were not monitoring the practices of staff. Staff were required to use the hopper in the soiled utility rooms and to submerge and soak the articles with disinfectant. Secondly, measures to prevent the transmission of infections such as surveillance, screening and following precautions had not been implemented for residents who had been identified via laboratory reports to have an antibiotic resistant organism (ARO).

1. A tour of the home's two soiled utility rooms was conducted on identified dates in 2013. The utility rooms were the designated places to clean and disinfect personal care articles. During the inspection, it was observed that the rooms had not been used and were not being used for any cleaning or disinfection purposes. Cleaning supplies (brushes) or cleaning/disinfection solutions were not observed in either of the rooms on either date. One personal support worker reported using a disinfectant spray that they said they acquired from the soiled utility room (which could not be located when searched for) and another reported just using soap and water and returning the article back under the vanity. One worker reported using the housekeeper's disinfectant when a disinfectant could not be found in the soiled utility room.

Soiled bed pans, wash basins, urinals and kidney basins were noted in random resident rooms on the 300 wing on an identified date in 2013. When the same items were checked on a second date, the same fecal stains, urine stains, water scale marks and other unidentified stains were visible. Failure to clean and disinfect personal care articles between use may lead to wound & eye infections, skin irritations and the transmission of organisms such as Methecillin-resistant Staphylococcus Aureus (MRSA) between residents.

2. The home had not ensured that resident's personal care supplies were stored properly to prevent cross contamination, cleaned adequately and labeled when the supplies were kept in a communal setting. Such practices may lead to the transmission of infections to residents from unsanitary surfaces and sharing of

products. Two unlabeled hair brushes, two combs and a deodorant stick were noted in several white cabinets in the tub room located in the 400 wing on an identified date in 2013. The same items were identified in the cabinets on a second identified date and two unlabeled deodorants and a hairbrush noted in a basket on a vanity in a shared resident washroom. In another identified resident washroom, two unlabeled deodorants were noted in a basket on the vanity. Neither of the baskets contained any kind of identifier to determine which resident the supplies belonged to. Multiple unlabeled toothbrushes were noted to be stored together with hairbrushes in another identified resident washroom. One toothbrush in particular was observed to be coated in a black substance that resembled mould. A kidney basin with a toothbrush in it in a resident washroom was dirty, with particles in it on two identified dates.

3. Communal equipment was not being cleaned and disinfected between use. Staff who gave baths to residents during the inspection period did not clean and disinfect the tubs according to both the disinfectant directions and the tub manufacturer's directions. The manufacturer required that the tub surface be cleaned and then disinfected between use. The home had a policy ICM-B-60 requiring staff to clean the tub with soap and water using a scrub brush, to rinse the tub and to liberally apply the disinfectant and allow to sit according to manufacturer's instructions. Staff reported not using the disinfectant between resident baths and would only use the brush and disinfectant on the tub at the end of their shift. Tub room in the 300 wing did not have a brush on several identified dated in 2013 and the tub in the 400 wing had a brush, but it was dry on several identified dates in 2013 and was checked directly after a bath was given and the worker was finished using the room.

The underside surface of the tub lift seat in the 300 wing tub room was observed on two separate dates in 2013 and noted to be heavily coated in a yellowish film of matter. A soiled bed pan was left on a shower chair in the shower/tub room in the 300 wing after staff had completed the baths or showers for the day.

4. During the inspection, five resident room doors were observed to have a sign posted indicating that staff were to wear a gown. The home's policy and procedure for the management of MRSA (ICM-AA-60) required staff to wear a gown for direct care (bathing, washing, changing incontinent products, toileting, care of open wounds). However, gowns were not worn by any staff member caring for the five residents and gowns were not available in a convenient location (clean linen carts, as per management).

5. Surveillance and screening practices of residents with an ARO in the home did not follow best practices titled "Annex A: Screening, Testing and Surveillance for Antibiotic -Resistant Organisms (AROs)In All Health Care Settings - 4th Revision". The home's policy ICM-AA-60 for AROs was dated 2009 and was currently being used as a guide for staff.

Four out of the six residents who were positive for an ARO last received a screening culture in 2012. The residents had not been monitored since the cultures were taken which were all positive for MRSA. One culture was taken in 2012, but was rejected and the lab was not able to process it. A repeat culture was not taken. Another resident was identified to have a positive MRSA culture in 2013 and no signage was posted on their door. Best practices for screening protocols required that once antibiotic treatment had been discontinued, residents were to be re-screened monthly for six months.

Policy #ICM-AA-60 did not describe how screening and surveillance would be completed on residents. When registered staff were interviewed regarding screening and surveillance protocols, a consistent tool was not used for any resident. Screening tools were used to determine when to screen, when to discontinue precautions, when to initiate precautions, resident risk factors, contacts, resident medical history etc. No consistent approach had been used by staff of the home. [s. 86. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the infection prevention and control program includes measures to prevent the transmission of infections, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were developed and implemented to ensure that, (b) all equipment, devices, assistive aids and positioning aids in the home were kept in good repair. According to the plan of care an identified resident was identified as a risk for falls and required a safety monitoring device in place when in bed. The resident sustained falls on two identified dates from 2012 to 2013; according to the clinical record, the safety device in place was not working properly and therefore did not effectively manage the resident's fall risk, as it was intended if fully operational. [s. 90. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

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

Findings/Faits saillants :

1. The licensee did not ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: that the resident was released from the physical device and repositioned at least once every two hours.

a) An identified resident was observed in a wheelchair with a physical device in place on an identified date in 2013, for a number of hours without being released from the physical device and repositioned. Staff confirmed that the device was a restraint and that they did not check and reposition the resident since providing care for a number of hours. [s. 110. (2) 4.]

2. The licensee did not ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act is documented: including, effectiveness, resident's response, repositioning, and the release of the device.

a) An identified resident was ordered a physical device in 2013, which was applied on the same day. A review of the Restraint Observation Form conducted on an identified date in 2013, identified that the form was incomplete for the period of time the device was ordered.

b) There was incomplete documentation of the resident being reassessed and the effectiveness of the restraining evaluated at least every eight hours by registered staff. The portion of the form which required registered staff to record the residents response was blank for a total of 12 of the 15 shifts after the device was ordered.

b) There was incomplete documentation of the hourly interventions for the restrained resident including application and removal of the device, the resident's response to the device and every 2 hours repositioning. The portion of the form which required PSW staff to record this information was blank for 10 of the 15 shifts after the device was ordered. Interview with the ADOC confirmed that staff are to complete the observation form at all times, even when the restraint was not in use, for example the residents was sleeping. [s. 110. (7) 6.]