Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 27, 2015;	2015_341583_0006 (A2)	H-002110-15	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

GARDEN CITY MANOR
168 Scott Street St. Catharines ON L2N 1H2

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

Ontario

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KELLY HAYES (583) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date changed to for order number 003 to July 31, 2015.
This date was changed by hand in the faxed licensee orders due to typo error.
It is now corrected electronically.

Issued on this 27 day of July 2015 (A2)

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

Original report signed by the inspector.

KELLY HAYES (583) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): March 24, 25, 26, 27, 30, 31, April 1, 2, 7, 8, 9, and 10, 2015.

This inspection was conducted simultaneously with CI inspection #H-000601-14; H-001986-15; H-001825-15 and follow up inspection #H-001770-14.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED); Director of Care (DOC); Associate Director of Care (ADOC); Office Manager; Environmental Service Manager (ESM); maintenance staff; Food Service Manager (FSM); Activation Manager; Infection Control Nurse; Resident Assessment Instrument (RAI) Coordinator; Physiotherapist; Registered Dietitian (RD); Wound Care Champion; housekeeping staff; Registered staff including Registered Nurses (RN) and Registered Practical Nurses (RPN); Health Care Aides(HCA)/Personal Support Workers(PSW), residents and families. Inspectors also reviewed relevant clinical records; policies and procedures; training records; program evaluations; critical incidents submitted by the home; the home's complaint and maintenance logs and observed the provision of care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

22 WN(s)
15 VPC(s)
5 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 26. (3)	CO #001	2014_214146_0026	583

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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 failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in behaviour management. [76(7) 3]

A staff person identified as coordinating staff education was asked to provide documentation of training provided in 2014 in the area of behaviour management. Documents provided included training related to abuse, sexuality in dementia, person centered care, a sign in sheet which indicated five staff attended training related to sundowining/delirium/dementia as well as sign in sheets indicating that 44 staff attended a training program related to gentle persuasive approach to care. At the time of this inspection documents provided by the home indicated that 128 staff out of 177 staff identified as providing direct care to residents did not receive training in the area of behaviour management in 2014. (129) [s. 76. (7) 3.]

2. The licensee failed to ensure that all staff who provided direct care to residents received, 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:
4. How to minimize the restraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations.

In an interview with the front line nursing staff on a specified date in April 2015, it was

identified that resident #009 was not being monitored hourly or released and repositioned at least every two hours while restrained in their physical device. Staff confirmed they did not know it was a requirement for resident #009's care. On a specified date in April 2015, in an interview with the ADOC it was confirmed that there was no documentation to support that any of the staff members who provided direct care to residents received training on how to minimize the restraining of residents and, where restraining was necessary, how to do so in accordance with this Act and the regulations. (583) [s. 76. (7) 4.]

3. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in accordance with O. Reg. 79/10, s. 221(1)1 in the area of falls prevention and management. [76(7) 6]

The staff person identified as coordinating staff education was asked to provide documentation of training provided in 2014 in the area of falls prevention and management. The home provided a number of meeting minutes, unrelated training information and emails in response to this request. At the time of this inspection the home was unable to provide evidence to confirm that any of the 177 staff identified as providing direct care to residents received training in the area of falls prevention and management.(129) [s. 76. (7) 6.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

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 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: 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, to be implemented voluntarily.

WN #2: 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 failed to ensure that where bed rails were used the resident was assessed in accordance with evidence-based practices to minimize risk to the resident, taking into consideration all potential zones of entrapment. Evidence based practices have been identified by the Ministry of Health and Long Term Care as those developed by Health Canada related to bed safety.

A) According to the home's registered staff and the physiotherapist, residents had not all been assessed for bed rail use by the time of inspection. Five random residents' health care records were reviewed with the physiotherapist, three of which identified that the resident required one or more bed rails but did not provide a reason, one without any bed rail information and one stated that the resident did not require any bed rails. According to records provided, 138 out of 200 residents were using either a quarter, three quarter, rotating assist or full bed rail. For those residents who were

assessed, no template or guidance form was being followed to ensure that all aspects of bed rail safety were evaluated, as per evidence based practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and endorsed by Health Canada). According to the guidance document, residents would need to be evaluated while sleeping in bed over a period of time by an interdisciplinary team to determine if the bed rail was a safe alternative for the resident after trialling other options. The licensee had only developed three questions strictly related to resident mobility to evaluate the resident and no other criteria. The staff tasked to complete the assessments did not implement their corporate Revera policy titled "Side Rails" (LTC-K-10-ON dated October 2013) which required that "all residents using side rails be assessed for the need for side rails and the associated risk with the utilization of side rails using the "Side Rail and Alternate Equipment Decision Tree". Residents were therefore not assessed in accordance with evidence based practices by an interdisciplinary team (PSW, RN, Physiotherapist) to ensure that each resident was reviewed consistently to minimize bed rail use risks. (#120)

B) A review of resident #301's care plan interventions identified resident #301 could use bed rail with one staff to move from side to side while in the bed. In an interview with front line nursing staff on an identified date in April 2015, staff confirmed that the resident used side rails when in bed. In a review of the plan of care and in an interview with the RAI Coordinator on an identified date in April, 2015 it was confirmed that there was no assessment for resident #301 in relation to their bed rails and their bed system was not evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.(583) [s. 15. (1) (a)]

2. The licensee failed to ensure that where bed rails were used that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A) Two residents in identified beds were observed to be sleeping in beds with a therapeutic air mattress on the bed frame on an identified date in March, 2015. Both beds had two bed rails elevated. Neither bed had any accessories added to reduce the entrapment gap between the bed rail and side of the soft and flexible mattress. A review of the residents' health care record (plan of care, care plan etc) did not identify that the resident required specialized accessories when in bed when bed rails were in use as a step to prevent resident entrapment.

B) Resident bed systems were re-assessed for entrapment zone risks in November 2014 by an external contractor using a specialized tool as per Health Canada's Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006". According to the ESM, mattresses were replaced, mattress keepers partially installed and bed rails tightened after bed systems were noted to have failed one or more zones of entrapment. Upon re-assessment in November 2014, all but one bed passed all zones of entrapment. Over the course of the last 3 months however, bed systems were switched (mattresses removed from the originally tested frame). The original bed system assessment did not include a process to ensure that the mattress and bed frame remained together after it was tested and that nursing staff followed a strict protocol to ensure that the bed remained safe after making changes. As the home had approximately five different style of beds, the entrapment status of the beds at the time of inspection was unknown to the home staff and the associated potential risks to residents. The home did not have any immediate method in which to verify entrapment zone status and therefore adequate steps were not taken to reduce or prevent resident entrapment.

C) During the inspection, a tour of all resident rooms was completed and numerous unoccupied beds were observed to have elevated bed rails for no apparent reason. The practice of keeping bed rails elevated was described by some staff as habit. Residents returning to a bed with an elevated bed rail may not be required to have one and thereby be at a risk of entrapment (especially when the bed entrapment status was unknown). Leaving bed rails down unless directed for in the residents' plan of care was another step that was not taken by staff to reduce or prevent resident entrapment.(120) [s. 15. (1) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care Specifically failed to comply with the following:

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

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

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

A) On an identified date in March, 2015, resident #002 was observed to have white mucus covering their tongue. A review of this resident's written plan of care on an identified date in March 2015, indicated under dental care deficit that the resident had no teeth and no dentures and that daily mouth care would be provided that included cleaning the resident's gums and mouth tissues as well as their tongue. A review of the Point of Care (POC) documentation, specifically for, "mouth care completed by", was reviewed from March 1 - March 25, 2015 and indicated that the resident refused mouth care on 13 occasions. An interview with front line nursing staff confirmed that the resident does have a history of refusing mouth care. A review of the resident's written plan did not identify this responsive behaviour of refusing mouth care including any potential behavioural triggers. An interview with the DOC confirmed that the resident's refusal to have mouth care completed was behavioural in nature and that their plan of care was not based on an interdisciplinary assessment of this responsive behaviour of refusal of mouth care or any potential behavioural triggers. (214)

B) Resident #004's clinical record indicated that the resident demonstrated behaviours with respect to the provision of oral care. PSW documented in the Point of Care (POC) computerized record that over an identified period of 30 days in March 2015, the resident refused to have mouth care provided on 18 of those days. Staff and the

clinical record confirmed that an attempt to complete an assessment of the potential triggers for this behaviour was not made, a request/referral for support from Behavioural Support Ontario (BSO) staff available to the home in order to assist in the assessment and management of this behaviour was not made, a request/referral to dental services to assess the condition of the residents oral status was not made and staff in the home did not complete an oral assessment to determine possible causes for the resident refusing to have staff provide mouth/oral care. Staff confirmed that no additional assessments where documented in the clinical record and the plan of care for resident #004 was not based on an interdisciplinary assessment of responsive behaviours this resident demonstrated. Staff and the clinical record confirmed that the plan of care for resident #004 was not based on an interdisciplinary assessment of responsive behaviours this resident demonstrated around the provision of mouth/oral care. (129)

C) Resident #010's clinical record indicated that the resident demonstrated four responsive behaviours that included, wandering, refusal/resistance related to care as well as verbal and physical responsive behaviours towards staff. Documentation made by PSW staff indicated the resident demonstrated verbal and physical responsive behaviours towards staff 10 times over a 14 day period in March 2015, demonstrated refusal/resistance to care on three days over a 28 day period in March, 2015 and demonstrated wandering behaviours six times over a 14 day period in March and April, 2015. Staff and the clinical record confirmed that an attempt to complete an assessment of the potential triggers for these behaviour was not made, a request/referral for support from Behavioural Support Ontario (BSO) staff available to the home in order to assist in the assessment and management of these behaviour was not made, a request/referral to dental services to assess the condition of the residents oral status was not made and staff in the home did not complete an oral assessment to determine possible causes for the resident refusing to have staff provide care. Staff confirmed that no additional assessments were documented in the clinical record and the plan of care for resident #010 was not based on an interdisciplinary assessment of responsive behaviours this resident demonstrated. (129)

D) Resident #401's clinical record indicated that the resident demonstrated responsive behaviours towards cognitively impaired co-residents. Clinical notes written by registered staff indicated that on an identified date in March, 2015 this resident had a physical interaction with co-resident who entered their room, on an identified date in March 2015, this resident was upset with a co-resident resident who was attempting to wander into their room and demonstrated a responsive behavior

that indirectly caused the wandering resident to fall. On an identified date in March 2015 the resident was verbally responsive with a co-resident. Staff and clinical documentation confirmed that an attempt to complete an assessment of the potential triggers for this behaviour was not made and a request/referral for support from Behavioural Support Ontario (BSO) staff available to the home in order to assist in the assessment and management of this behaviour was not made. Behavioural Support Staff in the home at the time of this inspection confirmed that they have not received a request for assistance in the assessment of this responsive behaviour. Staff confirmed that no additional assessments where documented in the clinical record and the plan of care for resident #401 was not based on an interdisciplinary assessment of responsive behaviour this resident demonstrated. (129) [s. 26. (3) 5.]

2. The licensee failed to ensure that every plan of care was based on, at a minimum, interdisciplinary assessment of dental and oral status, including oral hygiene, in relation to the following: [26(3) 12]

Resident #004's plan of care was not based on interdisciplinary assessment of dental and oral status. During an interview on an identified date in March, 2015 resident #004 's family expressed concern about the resident's oral health and the condition of the resident's teeth. The clinical record indicated that family expressed this concern to staff several months previously; however an assessment of the residents oral status including the condition of the resident's teeth was not completed. The resident's plan of care identified oral hygiene and good oral health as a care goal, the resident demonstrated responsive behaviours around oral care, the resident has their own teeth and the resident's teeth are to be brushed using a tooth brush. During an interview with the DOC the home's policy related to oral assessment and care was reviewed. This policy indicated that an oral assessment will be completed upon admission, quarterly, annually and as required. The DOC confirmed that at the time of this inspection the home did not have an assessment tool for staff to use in completing an oral assessment and there is no documentation in the resident's clinical record to indicate that an oral assessment had been completed for this resident.(129) [s. 26. (3) 12.]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 003

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 plan of care is based on, at a minimum, interdisciplinary assessment of dental and oral status, including oral hygiene, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee did not ensure that procedures were implemented and/or developed for cleaning of the home, specifically floors and window tracks.

A) The flooring material in many resident bedrooms and bathing rooms were observed to be sprinkled with paint chips that had fallen away from damaged walls and trim. The paint chips were stuck to the flooring material when tested during the inspection. According to housekeepers, the paint chips could only be removed with a scraper or a good scrubber pad on a floor machine. No routine schedule was in place

for resident rooms to be deep cleaned with a floor machine.

B) The activity room on the 2nd floor was observed to have a build-up of stuck on debris on the floor in front of furniture and fixed cabinets. A floor machine, used occasionally but not routinely as per housekeeping staff, was not able to clean close to these areas and no alternative measures were instituted to address the issue.

C) An accumulation of debris was observed under the kitchen stove, ice machines, dishwasher and under shelving in the dried goods storage room (especially around mouse trap). The stainless steel table and sink legs throughout the kitchen and lower shelves, storage racks were rusty and dusty. According to the Food Services Supervisor, the floors were not scheduled for a routine deep cleaning, especially under tables, sinks and other equipment. The floors were deep cleaned when maintenance staff had time. No specific procedures were developed to address the cleaning of the above noted areas.

D) Numerous resident room window tracks were filled with dirt. The windows were closed for the majority of the winter months and the dirt was therefore determined to be from the warmer months in 2014. According to the housekeeper's routine, window tracks were to be cleaned during a designated deep clean day or approximately once every 2 weeks (2 rooms per day).(120) [s. 87. (2) (a)]

2. As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee did not ensure that procedures were implemented and/or developed for cleaning and disinfecting resident care equipment (non-critical devices such as bed pans, wash basins and urinals and personal care articles such as nail clippers) in accordance with evidence based practices. Evidence based practices related to cleaning such devices and articles are identified in a document titled "Cleaning, Disinfection and Sterilization of Medical Equipment/Devices", 2013 developed by the Provincial Infectious Diseases Advisory Committee.

According to the home's bed pan cleaning and disinfecting procedure PPC-C-10-05, dated May 2013, personal support workers were tasked to clean the devices after each use and disinfect them weekly. No specific instructions were provided. A procedure for cleaning and disinfecting bed pans and wash basins located in each soiled utility room identified that they were to be cleaned and disinfected after each use, by using the hopper, a sink and a liquid disinfectant. However, the soiled utility rooms were not equipped with any liquid disinfectant and were equipped with a dishwasher, according to staff for the purpose of cleaning the devices. No instructions

were developed for the use of the dishwasher and how the devices would be disinfected after they were cleaned. The frequency of deep cleaning the devices was established for the night shift personal support workers as twice per week, coinciding with the resident's bathing days. Confirmation could not be made that any dishwasher was used over a 3 day period. According to evidence-based practices, and in following outbreak control measures, bed pans and wash basins were to be cleaned and disinfected after each use.

According to the observations made on three identified dates in March and Apirl 2015, staff did not implement the procedures that were developed for cleaning and disinfecting the devices and the licensee did not develop procedures to include the use of the dishwashers in the cleaning process.

A) Visibly soiled or dusty bed pans were found unlabeled and stored on top of toilet tanks or hanging on walls in washrooms 111 (unlabelled only), 127, 133 (on floor), 134 (on floor) on an identified date in April 2015 and in washrooms 201, 202, 207, 214, 215, 227, 237, 243, over a 3-day period.

B) Wash basins with water left in them were found in washrooms 101 (soap scum), 102, 107 (soap scum), 108, 111, 153, 201, 207, 227, 237. According to some staff, the basins were filled with soapy water for routine care and then the water was drained into the bathroom sink, rinsed and placed back under the vanity onto a shelf. Staff stated that no disinfectant was applied after use.

C) According to the licensee's "Night Shift Sanitization by HCA/PSW" form, urinals were to be replaced weekly. According to the infection control designate, the urinals were to be labeled, odour free, free of stains and stored properly. Urinals were expected to be labeled with the resident's name and the date they were replaced. During the inspection the following were identified; unlabeled urinal stored on top of a toilet tank in shared identified resident bathroom with a date of February 13, 2015 on it and was odourous, an unlabeled urinal with a brown stained rim with a date of February 28, 2015 stored on toilet tank in an identified shared bathroom, soiled urinal on toilet tank in an identified bathroom and a yellow stained urinal on a night table in an identified bedroom dated February 23, 2015.

D) Nail clippers, those that were being used communally on residents, were being disinfected between use, however the staff were not following the manufacturer's instructions to clean the clippers before disinfecting them. The home's nail clipper cleaning procedure (PPC C-10-05) required staff to clean the clippers after each use

and to disinfect them monthly (for those dedicated to each resident). In all four bathing rooms, a container filled with a liquid disinfectant and nail clippers were observed. The solution had floating material in it and nail clippings on the bottom of all the containers. The containers had no label or safety information on them except for a statement that the nail clippers must only be left immersed for 10 minutes. During the inspection, it was noted that the clippers remained in the solution for many hours.(120) [s. 87. (2) (b)]

3. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee did not ensure that procedures were implemented and developed to address incidents of lingering offensive odours.

The licensee's procedure titled "Urine Odour Audit" ES C-25-15 was limited to managing urine odours and did not identify other types of offensive odours. No procedures were included for staff in various departments as to their role in mitigating odours before contacting the ESM. The procedure consisted of a checklist for the ESM to complete, followed by their conclusion. The policy directed the ESM to forward the completed form to the Executive Director or Director of Care for follow-up action. The procedure identified that the form would only be completed when a concern was raised and the ESM confirmed that the urine odour audit was completed only if a staff member, visitor or resident reported their concerns to the ESM.

During the inspection, lingering offensive odours related to bodily fluids (urine) were noted throughout the day on three identified dates in March and April 2015 in the Short Hills Tub room and an identified resident room.

A) Ineffective urine control measures were implemented in an identified resident room. On all three days of the visit, and throughout various times each day, a urinal was observed hanging off the resident's night table partially full of urine. Due to the resident's condition, the urine odour was stronger than normal and the odour could be detected outside the room. Urinal filters were available in the resident's room to absorb the urine, however they were not employed. Through observation, the urinal was not emptied as frequently as it should have been to control the odours. The ESM installed an air filter machine but it did not completely eliminate the urine odour until the urine was removed and the urinal cleaned.

B) No odour control measures were initiated on two identified dates in March and April 2015, for an identified resident bathroom by personal support workers. Urine odour was strong in the bathroom on both days and on the second day, a towel was

on the floor and it appeared that it was to soak up some urine. The urine was not immediately cleaned up by personal support workers.

C) No urine control measures were implemented in the Short Hills shower/tub room over a 3-day period where commode chairs were used to toilet a number of residents each day as the room was not equipped with a toilet. Urine and feces were collected in commode pots and transferred a short distance to a soiled utility room for disposal. During the inspection, the exhaust system, which was on a timer, was not turned on and it appeared that appropriate waste disposal rules were not followed. Although urine could not be seen in the room, urine odours were emanating from the tub drain and shower drain in the room. (120) [s. 87. (2) (d)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 004

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 implemented and/or developed for cleaning of the home, specifically floors and window tracks and to ensure that procedures are implemented and developed to address incidents of lingering offensive odours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours the behavioural triggers for the resident are identified, in relation to the following: [53(4) (a)]

A) Staff providing direct care to resident #004 and clinical documentation indicated the resident demonstrated four known responsive behaviours. Staff and the Resident Assessment Instrument/Minimum Data Set (RAI-MDS) coordinator confirmed that there had not been an attempt to identify triggers for these behaviours.

B) Staff providing direct care to resident #010 and clinical documentation indicated the resident demonstrated five known responsive behaviours. Staff and the MDS coordinator confirmed that there has not been an attempt to identify triggers for these behaviours.

C) Staff providing direct care to resident #401 and clinical documentation indicated the resident demonstrated three known responsive behaviours. Staff and the MDS coordinator confirmed that there has not been an attempt to identify triggers for these behaviours.(129) [s. 53. (4) (a)]

2. The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours. [53(4)(b)]

Care strategies were not developed for resident #010 when staff identified that the resident's wandering behaviours placed the resident at risk from other residents. Staff documented this responsive behaviour following an incident on an identified date in

March, 2015 when this resident wandered into a co-resident's room. In an attempt to stop resident #010 from entering the room the co-resident demonstrated a responsive behaviour that indirectly caused resident #010 to fall and sustain fractures. Staff also documented in resident #010's plan of care that the resident would often push resident occupied wheelchairs and this behaviour also placed the resident at risk of altercations with co-residents. During the course of this inspection the resident was observed to wander daily throughout the home area, attempt to enter co-resident's rooms and to push resident occupied wheelchairs down the hallway. Staff confirmed that although they are aware of these behaviours there were no care strategies in place in an attempt to manage either of these behaviours resident #010 was demonstrating. (129) [s. 53. (4) (b)]

3. The licensee failed to ensure that for each resident demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A review of a critical incident that was submitted by the home indicated that on a specified date in 2015, resident #200 was observed to have several bruises. The home conducted an investigation and was unable to determine the cause of the resident's injuries. A review of the resident's clinical record indicated that on a specified date in 2015, the resident demonstrated responsive behaviours towards a visitor, causing the visitor to fall to the floor. A review of the resident's progress notes over a specified 30 day period in 2015, indicated that the resident demonstrated multiple known responsive behaviours.

A) According to the resident's progress notes on a specified date in 2015, the resident demonstrated responsive behaviours when staff attempted to redirect the resident from pushing another resident's wheelchair. Registered staff documented that they would continue to monitor the resident; however; no documentation was included regarding what actions were taken to respond to the needs of the resident or the resident's response to any interventions that were implemented.

B) According to the resident's progress notes on a specified date in 2015, the resident demonstrated responsive behaviours to staff. Registered staff documented that the resident was redirected and would continue to be monitored; however; no documentation was included regarding the resident's response to the intervention provided.

C) According to the resident's progress notes on a specified date in 2015, the resident had taken a walker from another co-resident causing that resident to become angry. Registered staff documented that the resident was redirected and the plan was for ongoing monitoring; however; no documentation was included regarding the resident's response to the intervention provided.

D) According to the resident's progress notes on a specified date in 2015, the resident was demonstrating responsive behaviours of dismantling electronics; grabbing on to other residents and responsive behaviours to staff when trying to separate the resident from other residents or documents; however; no documentation was included regarding what actions were taken to respond to the needs of the resident or the resident's response to any interventions that were implemented.

E) According to the resident's progress notes on a specified date in 2015, the resident was witnessed to place them self onto the floor at the end of the hallway. Staff attempted three times to help resident up, however they became physically responsive. Registered staff documented that they would continue to monitor; however; no documentation was included regarding what actions were taken to respond to the needs of the resident or the resident's response to any interventions that were implemented.

F) According to the resident's progress notes on a specified date in 2015, the resident was found sleeping in their roommate's bed. The resident declined to come to breakfast and then became responsive toward staff. No documentation was included regarding what actions were taken to respond to the needs of the resident or the resident's response to any interventions that were implemented.

G) According to the resident's progress notes on a specified date in 2015, registered staff documented that the resident was restless and noisy while in their room and the plan was for ongoing monitoring. No documentation was included regarding what actions were taken to respond to the needs of the resident or the resident's response to any interventions that were implemented.

An interview with the DOC confirmed that the progress notes are the only place that registered staff document incidents of responsive behaviours and that actions were not taken to respond to the needs of the resident or the resident's response to any interventions that were implemented, for the incident's noted above. (#214) [s. 53. (4) (c)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 005

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 for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours and that actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's response to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee did not ensure that the home was a safe environment for its residents.

A) Wall-mounted reading lights with a long fluorescent tube bulb above and below the frame of the fixture were located over the head of each resident bed. Many light fixtures (i.e. 106, 214, 217) were observed to be used as a shelving unit for stuffed toys, pictures and other objects. Objects on top of the tube lights can break the bulb, causing shrapnel injury and small amounts of mercury to be released and stuffed toys can present a fire hazard. Lighting fixtures were also noted to be emanating less illumination when the top bulb was blocked.

B) Bed alarms that were implemented by the licensee for residents at high risk of falls could not be adequately monitored due to excessive noise. Overhead speakers located in corridors were playing music (at the request of residents) throughout the day on an identified date in April 2015. A resident located at the end of the corridor on Short Hills and furthest away from the nurse's station (between 75-100 feet away) who activated their alarm, could not be heard by the inspector when at the nurse's station. Staff were informed at that time that an alarm was sounding. A bed alarm activated in room 200 in the Burgoyne home area on an identified date in April 2015 could not be heard once the inspector walked approximately 50 feet away. A PSW voiced their concern that they could not hear the alarms. According to the ESS, the system volume could be controlled very easily or could be shut off. (120) [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe environment for its residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, 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. (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 failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, in relation to the following: [6(1)(c)]

A) Resident #010's current plan of care provided conflicting directions to staff in relation to oral care to be provided to the resident. Directions for care in the support for Activities of Daily Living (ADL) section of the written plan directed staff to "ensure dentures are in place before each meal – does not wear dentures", "has upper and lower partial dentures", "soak dentures overnight with denture tablets, brush with tooth paste in a.m. and put in mouth in the morning" and "check linens/wastebasket for dentures before discarding". Directions for care in the support required for eating and swallowing section of the plan conflicted with the above noted directions when staff were directed to "ensure dentures are in place for each meal". Direction for care in the oral hygiene section of the plan conflicted with the above noted directions when staff were directed for staff indicate "will sometimes refuse application of partial plate – this does not impede chewing or eating", "requires reapproach when refusing" and "has upper and lower partial plate – family have removed – has some of own teeth". Staff providing direct care to the resident reviewed oral care directions in the written plan of

care and confirmed that this resident's plan of care related to oral care did not provide clear directions.

B) Resident #004's current plan of care provided conflicting directions to staff in relation to oral care to be provided to the resident. Directions for care in the support for ADL section of the written plan directed staff that "refuses to wear upper denture and is kept in the medication room – sent home with family", "prefers not to wear dentures" and "requires reapporach when refusing". Directions for care in the oral hygiene section of the plan directed staff that "requires regular manual tooth brush-requires dental brush". Directions for care identified as a task in the POC computerized plan conflicts with the above directions when staff were directed to document an assigned task to clean the resident's dentures. Staff providing direct care to the resident reviewed oral care directions in the written plan of care and confirmed that this resident's plan of care related to oral care did not provide clear directions. (129) [s. 6. (1) (c)]

2. The licensee did not ensure the care set out in the plan of care was provided to the resident as specified in the plan, in relation to the following: [6(7)]

A) Resident #004 did not have care provided as specified in the resident's plan on a specified date in March, 2015 when it was noted that the resident's fingernails were unclean. The resident was noted at an identified time period to be clothed in street clothes, sitting in the hallway and brown material was noted to be under the resident's fingernails on both hands. The resident's plan of care indicated the resident often would awaken with debris under fingernails and staff were directed to soak the resident's hands and utilize a nail brush for cleaning. Nail care as directed in the plan of care had not been provided to the resident. (129)

B) Resident #400 did not have care provided as specified in the resident's plan of care when it was noted that the resident position in bed had not changed for a period of time in excess of two hours. The resident's plan of care indicated that staff were to follow a turning and positioning clock at the bedside and turn and reposition the resident from side to side every two hours as an intervention to manage impaired skin integrity. At an identified time period on a specified date in April 2015 the resident was noted to be lying on their back with the head of the bed slightly elevated. The resident was monitored over a course of two hours and twenty minutes and the resident's position in bed did not change over this period of time. The wound care champion confirmed staff are to follow the positioning schedule identified at the resident's bedside, the resident is to be turned from side to side every two hours and the

resident is not to be positioned on their back. (129) [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A) A review of resident #002's Minimum Data Set (MDS) coding on a specified date in August 2014, indicated under Communication Problems that the resident was coded as "usually understands". A review of the following quarterly MDS coding on a specified date in November 2014, indicated under Communication Problems that the resident was coded as "sometimes understands" and that no change had occurred as compared to the status of the resident 90 days ago. A review of the resident's written plan of care on a specified date in November, 2014, indicated under "communication alteration" that the resident will maintain current communication skills over the review period, despite the resident demonstrating deterioration in their communication abilities. An interview with the RAI Coordinator confirmed that the resident exhibited a decline in their ability to communicate over the identified quarterly time period and that the resident's plan of care was not revised when their care needs changed.(214)

B) A review of a critical incident that was submitted by the home indicated that on a specified date in 2015, resident #200 was observed to have several bruises. The home conducted an investigation and was unable to determine the cause of this resident's injuries. As per the critical incident, the home implemented immediate actions of having two staff provide care to the resident at all times. A review of the resident's written plan of care indicated that for all activities of daily living (ADL's) the resident required only one staff to provide care. An interview with the DOC confirmed that two staff was to be present for all of the resident's care needs and that the resident's plan of care was not reviewed and revised when their care needs changed. (214)

C) A review of resident #014's Minimum Data Set (MDS) on a specified date in December 2014, indicated under Section I-Disease Diagnoses, that the resident was coded as having a respiratory infection. A review of the resident's clinical record indicated that on a specified date in September 2014, the resident began to demonstrate signs and symptoms of a infection and orders were received by the physician for treatment. The resident's clinical record indicated that on a specified date in February 2015, the resident's signs and symptoms of a chest infection had resolved. A review of the resident's written plan of care a specified date in March 2015, indicated that the resident remained with a chest infection. An interview with

registered staff and the DOC confirmed that the resident's respiratory tract infection did resolve on a specified date in February 2015 and that the resident's plan of care was not reviewed and revised when their care needs changed.(214) [s. 6. (10) (b)]

4. The licensee failed to ensure that the resident's plan of care reviewed and revised when the care set out in the plan has not been effective, in relation to the following: [6(10)(c)]

Resident #401 plan of care was not reviewed or revised when the care identified in the plan of care was not effective in reaching the established care goals. The goal of care established for this resident was that identified behaviours would be managed and would show no increase in frequency through to the next review. On a specified date in 2015, clinical documentation and a Critical Incident System (CIS) report submitted to the Ministry of Health and Long Term Care indicated that the resident, while attempting to prevent co-resident from entering their room, demonstrated a responsive behavior. A clinical note written by a registered nursing staff member and an amendment to the CIS report confirmed that resident #401 demonstrated an indirect responsive behavior towards co-resident, in an attempt to prevent the co-resident from entering their room, causing the co-resident to fall. As a result of the fall the co-resident sustained fractures. Data collected during a MDS review completed on a specified date in 2015, indicated that the resident's behavioural symptoms had deteriorated compared to the status of the resident 90 days previously and the associated Resident Assessment Protocol (RAP) indicated that staff would care plan for the safety of the resident and the safety of co- residents. A review of the directions for care related to the resident's responsive behaviours indicated that there had been no new behavioural interventions initiated either after the incident when a co-resident received injuries as a result of the resident's responsive behaviours or after data collected on a specified date in 2015 indicated that the resident's behavioural symptoms had deteriorated and staff identified that their rationale for care planning was the safety of resident #401 and co-residents. Staff providing direct care to the resident and clinical documentation confirmed that care interventions identified to manage resident #401's responsive behaviours had not been reviewed or revised following the above noted incidents. (129) [s. 6. (10) (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 written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, that care set out in the plan of care is provided as specified in the plan, to 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 the resident's care needs change and to ensure that the residents' plan of care is reviewed and revised when the care set out in the plan has not been effective, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy protocol, procedure, strategy or system was complied with.

1. A review of the home's policy titled, Oral Assessment and Care (LTC-H-20 with a revised date of May 2013) indicated the following:

i) Under "Standard", An oral assessment will be completed upon admission, quarterly, annually and as required.

A) On an identified date in March 2015, resident #002 was observed to have white

mucus covering their tongue. A review of this resident's written plan of care on a specified date in March 2015, indicated under dental care deficit that the resident had no teeth and no dentures and that daily mouth care would be provided that included cleaning the resident's gums and mouth tissues as well as their tongue. A review of this resident's clinical record indicated that no oral assessment had been completed upon admission, quarterly, annually or as required. An interview with the DOC confirmed that the home does not complete oral assessments and that resident #002 did not have an oral assessment completed at the intervals specified in the home's policy.

B)On a specified date in March 2015, resident #011 was observed prior to the lunch hour to have unidentified material noted at the base of their teeth, at the gum line. A review of this resident's written plan of care on a specified date in March, 2015, indicated under oral hygiene that the resident required support of one staff to provide mouth care and that the resident had their own teeth. A review of this resident's clinical record indicated that no oral assessment had been completed upon admission, quarterly or annually. An interview with the DOC confirmed that the home does not complete oral assessments and that resident #011 did not have an oral assessment completed at the intervals specified in the home's policy. (129)

C) Resident #010 did not have an oral assessment when staff and clinical documentation confirmed that the resident was refusing to wear dentures or when the resident's chewing and swallowing abilities changed. (129)

D) Resident #004 did not have an oral assessment when staff and clinical documentation confirmed that the resident refused to wear partial dentures or when on on specified date in January 2014, the resident's family member indicated concern for the condition of the resident's teeth. (129)

ii) Under "National Operating Procedure", any abnormalities or refusals of care will be reported to the Nurse who will document and complete referrals as required.

A) A review of resident #002's oral hygiene task in POC specifically for, "mouth care completed by", was reviewed for a consecutive 25 day period in March 2015, and indicated that the resident refused mouth care on 13 occasions. An interview with front line nursing staff confirmed that refusals of mouth care by this resident have been reported to the Nurse and that not all ongoing refusals are reported as they are aware that the resident refuses. An interview with the DOC confirmed that the referrals mentioned in this policy would include referrals to a Dentist if the issue was related to

the resident's teeth or dentures; to Behavioural Support Ontario (BSO) if the issues were related to behaviour and to the physician if the issue was related to mouth/teeth pain. The DOC confirmed that the resident's refusal for mouth care was behaviour related and that referrals to the BSO were not completed and the home's policy was not complied with.(214)

B) A review of resident #011's oral hygiene task in POC specifically for, "Resident has own teeth, cleaned by", was reviewed for identified dates in March and April 2015, and indicated that the resident refused oral care on 18 occasions. An interview with front line nursing staff confirmed that refusals of oral care by this resident have been reported to the Nurse and that not all ongoing refusals are reported as they are aware that the resident refuses. An interview with the DOC confirmed that the referrals mentioned in this policy would include referrals to a Dentist if the issue was related to the resident's teeth or dentures; to Behavioural Support Ontario (BSO) if the issues were related to behaviour and to the physician if the issue was related to mouth/teeth pain. The DOC confirmed that the resident's refusal for oral care was behaviour related and that referrals to the BSO were not completed and the home's policy was not complied with.(214)

C) The DOC confirmed that the referrals mentioned in this policy would include referrals to a Dentist if the issue was related to the resident's teeth or dentures, to Behavioural Support Ontario (BSO) if the issues were related to behaviour and the physician if the issue was related to mouth/teeth pain. Staff did not comply with this direction when:
-Staff and clinical documentation confirmed that resident # 004 was refusing to wear upper and lower partial plates and the resident's family member expressed concern about the condition of the resident's own teeth. Clinical documentation confirmed that a referral to BSO related to the refusal of care behaviours or a referral to a Dentist was not completed for resident #004.

2. Staff did not comply with the directions contained in the home's Fall Prevention and Risk Management Program, identified as # LTC-E-60 and last reviewed in March 2014.

The policy directed that prevention strategies will be in place to meet the needs of the resident. Staff did not comply with this direction when:

Staff identified an ongoing risk of falling for resident #010 related to the resident wandering into other resident's rooms and provoking reactions from those residents

but did not put prevention strategies in place to prevent a reoccurrence of an incident that occurred on a specified date in March, 2015. Clinical documentation indicated that on the identified date resident #010 wandered into another resident's room, the co-resident took resident #010 outside of the room, but resident #010 attempted to re-enter the room and the co-resident demonstrated a responsive behavior. Staff documented that at the time of resident #010's fall water was noted on the floor in the area of the fall outside the co-residents room. The fall resulted in resident #010 sustaining injuries.

3. Staff did not comply with the directions contained in the home's Dementia Care policy identified as LTC-E-100 and last dated in February 2014.

The policy directed that the Responsive Behaviour Care Pathway will be used to determine interventions to manage responsive behaviours. This Pathway directed that when a resident presents with responsive behaviours that staff will review the resident for behavioural triggers using ABC model. Staff did not comply with this direction when:

A) Staff and clinical documentation indicated resident #004 demonstrated four known responsive behaviours. Staff confirmed that there had not been an attempt to identify triggers for these behaviours

B) Staff providing direct care to resident #010 and clinical documentation indicated the resident demonstrated five known responsive behaviours. Staff confirmed that there has not been an attempt to identify triggers for these behaviours.

C) Staff providing direct care to resident #401 and clinical documentation indicated the resident demonstrated three known responsive behaviours. Staff confirmed that there has not been an attempt to identify triggers for these behaviours.

ii) The policy and the Responsive Behaviour Care Pathway directed that staff were to implement an individualized care plan. Staff did not comply with this direction when:

Staff and clinical documentation confirmed that resident # 010 did not have an individual care plan to manage the behaviour which staff identified as placing the resident at risk for injury when they wander into co-resident's rooms provoking reactions from the co-residents.

iii) The policy and the pathway directed that if the behaviour is not reduced or resolved

a consult to appropriate resources, including Psychiatrist, Psychologist and/or Geriatric Mental Health. Staff did not comply with this policy, when:

A) Resident #004's clinical record indicated that this resident continued to demonstrate resistance/refusal of oral care that place the resident for increased risk of worsening oral health. Staff and the clinical record confirmed that referrals for assistance in the assessment and management of this behaviour were not made.

B) Resident #010 clinical records and observations made during this inspection indicated that this resident continued to demonstrate known behaviour and attempts to enter co-resident's rooms, placing the resident at risk for injury from co-residents. Staff and the clinical record confirmed that referrals for assistance in the assessment and management of this behaviour were not made.

C) Resident #401's clinical record indicated that this resident continued to demonstrate known responsive to co-residents wandering into their room, placing co-residents at risk for injury. Staff and the clinical record confirmed that referrals for assistance in the assessment and management of this behaviour were not made. (129) [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy protocol, procedure, strategy or system was complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of the plan of care for resident #301 identified they had an unwitnessed fall on an identified date in December 2014 and were found by front line nursing staff on the fall mat beside their bed. Resident #301 was transferred to hospital as a result of this incident sustained a fracture. A care plan intervention created on a specified date in June 2014 directed staff to keep resident #301's bed at the lowest level and locked in position when the resident was in bed. The physiotherapy assessment completed on a specified date in January 2015, identified a fall mat was to be in place and the bed was to be in lowest position. During an observation of resident #301's bed and in an interview with front line nursing staff on an identified date in April 2015, it was identified that the bed was not in the lowest position and that staff had been unable to put the bed in the lowest position for an unspecified time period when the resident was in bed. In an interview with the maintenance staff member on an identified date in April 2015, it was confirmed that resident #301's bed was not in a state of good repair and could not be put into the lowest position as directed in the plan of care due to a mechanical problem with the electric bed. (583) [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 equipment is maintained in a safe condition and in a state of good repair, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident-staff communication and response system was available in every area accessible by residents. Activation stations were not provided in the 1st and 2nd floor dining rooms, in any of the 4 home area lounges, the activity room on the 2nd floor, the sitting area on the 1st floor (also used as dining space) hair salon, or outdoor courtyard (at exterior entrance).(120) [s. 17. (1) (e)]

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 the resident-staff communication and response system is available in every area accessible by residents, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee did not ensure that the lighting requirements set out in the lighting table were maintained.

The home was built prior to 2009 and therefore the section of the lighting table that applied is titled "all other areas of the home". The home's corridors and resident bathrooms were identified to be in compliance. Non-compliance related to illumination levels in resident bedrooms was previously identified during an inspection completed in November 2012.

A hand held digital light meter was used (Amprobe LM-120) to measure the lux levels in one semi private bedroom. The meter was held a standard 30 inches above the floor and held parallel to the floor. Window coverings were drawn in the resident bedroom tested and all lights were turned on 5-10 minutes prior to measuring. The bedroom door to the corridor was closed. Areas that could not be tested due to natural light infiltration included dining rooms, sitting areas and common areas. Outdoor conditions were bright during the measuring procedure and compliance with the lighting table would need to be verified by the licensee for the areas not measured during the inspection.

A) Resident semi private bedroom #110 was measured on April 1 2015, and was equipped with similar light fixtures as all of the other rooms, whether private or semi-private. Each room had a wall mounted over bed light fixture consisting of fluorescent tubes. None of the rooms were equipped with bedroom ceiling fixtures. Both over bed lights were tested and were well above the minimum requirement of 376.73 lux. The areas around the bed and near the closet were not adequate. The foot of bed 2 was 100 lux and the area between the beds was 183 lux. The area in front of the closet was 100 lux. The minimum required lux level for the room in areas where activities of daily living take place such as sitting, dressing, walking is 215.28 lux.

The Executive Director did not have any lighting upgrade plans in place at the time of the visit to for resident bedrooms, but identified that shortly after the inspection, their corporate maintenance person had visited the home and established a plan to complete the upgrade to the lighting by the end of 2015.(120) [s. 18.]

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 lighting requirements set out in the lighting table are maintained, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) A review of resident #011's clinical record indicated that on a specified date in March 2015, a Physiotherapy Assessment was completed that indicated the resident required the use of a specialized wheelchair for the purpose of posture, functional mobility and positioning. A review of the resident's written plan of care on a specified date March 2015, indicated under the use of a personal assistance services device (PASD) that the resident required a specialized wheelchair and that they were to be checked every two hours and repositioned. An interview with front line nursing staff confirmed that the resident is checked every two hours and repositioned and more frequently if required; however; these actions were not documented in the resident's POC system, where care is documented and did not contain a task to document these actions. An interview with the DOC confirmed that the documentation for checking and repositioning this resident every two hours was not completed.

B) A review of resident #008's clinical record indicated that on a specified date in March 2015, a Physiotherapy Assessment was completed that indicated the resident required the use of a specialized wheelchair for the purpose of proper seating and positioning. A review of the resident's written plan of care in March 2015, indicated under the use of a personal assistance services device (PASD) that the resident required a specialized wheelchair and that they were to be checked every two hours and repositioned. An interview with front line nursing staff confirmed that the resident is checked every two hours and repositioned and more frequently if required; however; these actions were not documented as the resident's POC system, where care is documented, does not contain a task to document these actions. An interview with the DOC confirmed that documentation for checking and repositioning this resident every two hours, was not completed. (214) [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was monitored while restrained, in accordance with the requirements provided for in the regulations.

A) A review of the plan of care on a specified date in March 2015, for resident #009 identified they had a physical device ordered on a specified date in September 2014, which was assessed to be a restraint. The care plan, kardex and Point of Care(POC) tasks did not provide direction for staff to monitor resident #009 at least hourly while restrained or to release resident #009 from the physical device and reposition them at least once every two hours. In an interview with front line nursing staff on an identified date in April 2015, staff confirmed that for the duration that the resident had their physical device in place, the task in POC for documenting had not been. The front line staff confirmed there was no direction to complete this in the care plan and that it was not a required task to monitor or document in resident #009's POC. It was confirmed with the RAI coordinator on April 7, 2015, that from September 24, 2014 to April 7, 2015, the task in POC for documenting had not been created. (583) [s. 31. (3) (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 when a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that the resident is monitored while restrained, in accordance with the requirements provided for in the regulations and that residents are released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's dining service provided residents with any personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A review of the plan of care for resident #302 identified they were at high nutrition risk and required assistance with eating due to physical limitations and cognitive impairment. During an observation of resident #302 at the 1200 lunch service on a specified date in March 2015, they were observed to take 40 minutes to independently eat one third of their soup. At 1255 hour's staff cut up resident #302's main course, which had been sitting at table for an unspecified amount of time. At 1310 hours resident #302 requested eating assistance from Inspector #583 at which time greater than 75% of resident #302's entrée remained. In an interview with the ADOC it was confirmed through observation that resident #302 was not provided with the personal assistance and encouragement required to eat and help was requested from front line staff to assist the resident with the remainder of their meal. (583) [s. 73. (1) 9.]

2. The licensee of failed to ensure that the home had a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

During a dining observation on the second floor dining room on a specified date in March 2015, resident #305 was observed being fed in tilt leaning to the right with their foot off the foot rest, resident #306 was observed fed in tilt with their trunk sliding forward in the wheel chair, resident #307 was observed fed in tilt, resident #308 was observed being fed in tilt. A review of the plans of care for the residents identified that they required total assistance with feeding and had difficulty with chewing and swallowing. A review of the homes safe feeding strategies food services operations education materials identified to sit resident at 90 degrees, feet supported with chin tucked in. (583) [s. 73. (1) 10.]

3. The licensee failed to ensure that no residents who required assistance with eating or drinking were served a meal until someone was available to provide the assistance required by the resident.

A) During a lunch service observation on a specified date in March 2015, resident #303 and #305 were served thickened beverages when no staff members were available to feed the resident. The beverages were observed placed in front of the residents for greater than 10 minutes prior to staff assisting the residents. A review of

the plan of care for resident #303 and #305 identified they required total assistance with feeding of a modified texture diet and monitoring for chewing and swallowing problems.

B) During a lunch service observation on a specified date in March 2015, resident #304 was left unattended after being served beverages and entree. While resident #304 was left unattended another resident at the table began eating resident #304s food and mixing the entree into resident #304s' glass. Inspector #583 requested intervention from staff at which time a new meal and assistance was provided. A review of the plan of care for resident #304 identified they required total assistance with feeding of a modified texture diet and monitoring for chewing and swallowing problems. (583) [s. 73. (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 home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance and to ensure that no residents who require assistance with eating or drinking are served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

s. 90. (3) The licensee shall ensure that the home's mechanical ventilation systems are functioning at all times except when the home is operating on power from an emergency generator. O. Reg. 79/10, s. 90 (3).

Findings/Faits saillants :

1. The licensee did not ensure that procedures or schedules were in place for remedial or preventive maintenance.

A) The licensee did not have a procedure in place for maintaining closet and door hardware in good condition and did not have a schedule to address the disrepair. Numerous bathroom door knobs were observed to be loose on the 2nd floor and knobs were missing on bathroom doors in #245, 226 and 208 on an identified date in March 2015. Numerous resident closet doors and bathroom doors were not able to close properly due to missing or broken latching hardware. Preventive audits of resident bedrooms did not include these issues on the checklist as a "resident room housekeeping audit" form was used for both housekeeping and maintenance audits.

B) The licensee did not ensure that a procedure was in place for maintaining the condition of walls, doors and door casings. No schedules were in place for review to determine which areas of the building were going to receive wall repairs and painting and which areas already received repairs and painting. According to the ESM, touch-up painting takes place once every 3 months. The last touch-up painting took place before December 25, 2014 however, no records could be provided as to what areas had doors and walls painted or repaired and/or patched and what areas remained to be painted. Painting was suspended during the home's two outbreaks occurring between January 12 and March 13, 2015 and no painting was scheduled during the inspection. Wall and/or door damage observed during the inspection included but was not limited to rooms #102, 103, 127, 129, 133, 144, 149, 153, 201, 202, 237, 240, bathroom door casings were exposed down to metal in bathrooms #101, 133, 134, 151, missing baseboard along entire wall in bathroom #253 and wall patched and not painted, missing baseboard along one wall in bedroom #212, wall in bedroom #237

patched and not sanded or painted.

C) The licensee did not have a procedure in place for maintaining the walk-in freezer. The exterior and lower section of the wall along the floor of the walk-in freezer was rusty and severely deteriorated on both sides of the door. Air was felt blowing through these areas. A drainage pipe that exited the walk-in freezer was not adequately sealed to prevent air leakage. The walk-in freezer had not been routinely monitored and no schedule was in place to address the deterioration.

D) The licensee did not have a procedure in place for maintaining bathtubs. The white bathtub located in the Short Hills tub room had a rusted hole on one side where water was leaking down through it and onto the floor along the base of the shower wall behind it. The room was scheduled to be renovated and all fixtures removed by July 2015.

E) The licensee did not have a procedure in place for maintaining cabinets. All four soiled utility rooms were equipped with lower cabinets made of wood that was not sealed for easy cleaning. No schedule was in place to address the issue. (120) [s. 90. (1) (b)]

2. The licensee did not ensure that procedures were developed to ensure that the mechanical ventilation systems were functioning at all times except when the home is operating on power from an emergency generator.

The home's fresh air supply system was not operational at the time of the visit on an identified date in April 2015. The air vents were checked at 9:45 a.m. and several times throughout the day until 3 p.m. when the issue was reported to the ESM who checked the panel and found that the system had been shut off. He reported that he had found the system shut off on several occasions in the past as the registered staff and housekeepers both had access to the housekeeping storage room where the switch was located. In discussions with registered and non-registered staff, the air supply system cycled off and on, blowing either warmed or cooled air. During extreme cold weather, the system was not able to heat the incoming fresh air entirely, thereby causing residents and staff to feel cool in certain locations of congregation (near nurse's stations). Staff with a key to the housekeeping storage room shut off the system to create a more comfortable environment and did not report that they did so to the ESM. In doing so, the staff did not realize that the system should not have been shut down for such reasons. The licensee's procedure did not address the issue of staff access to the system and how the system would be managed to ensure it

remains functional.(120) [s. 90. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure procedures or schedules are in place for remedial or preventive maintenance, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the home's infection prevention and control program which included outbreak management, in relation to the following: [229 (4)]

1. The home's infection control policy "Antibiotic Resistant Organisms (ARO)" identified as # IPC-D-10 and dated January 2014 directed that if a resident is positive for an ARO the nurse will post signage and provide residents/families/visitors and staff information regarding any additional precautions to take and any personal protective equipment (PPE) that should be worn.

On a specified date in April 2015, during a tour of a resident home area, four resident rooms were observed to have yellow pocketed organizers hanging beside the door to their rooms. Staff confirmed that the organizers were to hold PPE because the residents in the rooms were identified as having infections. The staff person who was designated to coordinate the home's infection prevention and control program confirmed that the identified resident's in these rooms had ARO infections. Staff confirmed that there was no signage present to inform visitors or staff if additional precautions were required or if PPE was required when entering the room and having contact with the identified residents. A review of the identified resident's clinical records confirmed that all 4 of these residents were identified as having specified AROs. The home's infection control program directed nursing staff to ensure that signage was posted when a resident had been identified as having an ARO and this process, identified as part of the homes infection prevention and control program, was not adequately or consistently followed.

2. The home's infection control policy "Additional Precautions/Contact Precautions" identified as # IPC-B-20, with a revised date of August 2013 directed that when staff were expected to implement contact precautions while caring for a resident who had an infection, the necessary personal protective equipment (PPE) will be available at point of care.

Staff and the plans of care for three of four residents who were noted to have yellow pocketed organizers hanging beside the doors to their rooms on April 10, 2015 were confirmed to have infections that required the use of PPE.

A) Resident #402 was noted to have an infection and interventions for care included the implementation of contact precautions that included the use of gloves for all resident/environmental contact and long sleeve gowns to be worn for direct care when skin or clothing may become contaminated, as personal protective equipment.

B) Resident #403 was noted to have an infection and interventions for care included the implementation of contact precautions that included the use of gloves for all resident/environmental contact and long sleeve gowns to be worn for direct care when skin or clothing may become contaminated, as personal protective equipment.

C) Resident # 404 was noted to have an infection and interventions for care included the implementation of contact precautions that included the use of long sleeve gowns to be worn for direct care when skin or clothing may become contaminated, as personal protective equipment.

The staff person who was designated to coordinate the home's infection prevention and control program confirmed on a specified date in April 2015, that the yellow pocketed caddies that contain the PPE staff required had just been place outside of these resident's rooms and that PPE had not been available at the point of care during the course of this inspection. The home's infection control program directed that PPE was to be available at point of care and this direction, identified as part of the homes infection prevention and control program, was not adequately or consistently followed. (129) [s. 229. (4)]

2. The licensee did not ensure that there was access to point-of-care hand hygiene agents as per prevailing practices developed by the Infectious Diseases Advisory Committee titled "Best Practices for Hand Hygiene in All Health Care Settings, April 2014". The concept of "point-of care" is to locate hand hygiene products which are easily accessible to health care staff by being as close as possible to where the resident contact takes place and so that the care giver does not have to leave the zone of care.

No alcohol based hand rub was made available in rooms 251, 225, 243, 200, 208 and the dispenser in room 203 was empty during the three day period of observations on specified dates in March and April. According to a registered nurse, the hand rub was removed from one room due to resident behaviour and safety. When two personal support workers were approached and asked about the missing or empty dispensers, neither were aware of the issue and reported that they used the alcohol hand rub located in the corridors. When asked if they had portable or pocket alcohol-based hand rub, one had a product that was not provided by the licensee and the other had no product. Discussion was held with the infection control designate regarding the need to ensure that if resident's could not have the alcohol-based hand rub mounted on the wall in their room, that alternative solutions need to be implemented to ensure continued adherence to hand hygiene principles.(120) [s. 229. (9)]

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 there is access to point-of-care hand hygiene agents as per prevailing practices developed by the Infectious Diseases Advisory Committee titled "Best Practices for Hand Hygiene in All Health Care Settings, April 2014". The concept of "point-of care" is to locate hand hygiene products which are easily accessible to health care staff by being as close as possible to where the resident contact takes place and so that the care giver does not have to leave the zone of care, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007, 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 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 the following are satisfied: 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.

A) A review of resident #008's clinical record indicated that they required the use of a specialized wheelchair that was being used as a personal assistance services device (PASD) for the purpose of proper seating and positioning. A review of the resident's clinical record indicated that the resident was incapable of consenting to the use of the PASD and that no consent had been obtained by the substitute decision-maker of the resident, for the use of this PASD. An interview with the Physiotherapist and the DOC confirmed that no consent had been obtained for the tilt wheelchair PASD being used by this resident as the home does not have consents for the use of PASD's.

B) A review of resident #011's clinical record indicated that they required the use of a specialized wheelchair that was being used as a personal assistance services device (PASD) for the purpose of proper seating and positioning. A review of the resident's clinical record indicated that the resident was incapable of consenting to the use of the PASD and that no consent had been obtained by the substitute decision-maker of the resident, for the use of this PASD. An interview with the Physiotherapist and the DOC confirmed that no consent had been obtained for the tilt wheelchair PASD being used by this resident as the home does not have consents for the use of PASD's.(214) [s. 33. (4) 4.]

WN #18: 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 failed to ensure that resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds were assessed by a registered dietitian who is a member of the staff of the home.

A review of resident #004's plan of care identified they were at moderate nutrition risk and had an alteration in skin integrity. In a progress note completed by registered nursing staff on a specified date in March 2015, it was documented that resident #004 had an open area. During a review of the progress notes over a specified time period in March 2015 was it was identified that resident #004 was seen by the Nutrition Services Manager on a specified date in March 2015 but that an assessment by the Registered Dietitian (RD) had not been completed. In an interview with the RD on a specified date in April 2015, it was identified that an electronic nutrition care referral had not been sent to the RD and that an assessment was not completed in relation to resident #004's altered skin integrity. (583) [s. 50. (2) (b) (iii)]

WN #19: The Licensee has failed to comply with LTCHA, 2007, 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 failed to seek the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results.

An interview that was conducted on an identified date in March 2015, with the Residents' Council president indicated that the Residents' Council were not sought out for their advice in developing and carrying out the Satisfaction Survey. An interview with the Activation Manager confirmed that the advice of the Residents' Council was not obtained in developing and carrying out the Satisfaction Survey that was completed in 2014. (214) [s. 85. (3)]

WN #20: 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,
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included the final resolution.

A review of the plan of care identified that resident #007's family member made a verbal complaint to a staff on a specified date in June 2014, concerning the operation of the home. Documentation on the "Client Services Response Form (CSR) – CQI-E-60-05" identified on a specified date in June 2014 direction was provided to the ESM to provided resident #007 with a locked top bedside table to store valuables. On an identified date in March 2015, it was observed that resident #007 did not have a locked top table. In an interview on an identified date in March 2015 with resident #007, ESM and the ED, inspector #583 was unable to verify if the locked top table had been put in place. It was confirmed with the ESM and ED that the final resolution of the verbal complaint was not documented on the (CSR) record. (583) [s. 101. (2) (d)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this this requirement, the licensee failed to ensure that the following were documented:
6. All assessment, reassessment and monitoring, including resident's response.

A review of the plan of care for resident #009 identified they had a physical device ordered on on a specified date in September 2014 which was assessed to be a restraint. In an interview with registered nursing staff on a specified date in April 2015, it was shared that resident #009's condition was reassessed and the effectiveness of the restraining was evaluated at least every eight hours as required but the assessment had not been documented for the duration the device was in place. In an interview with the MDS Coordinator on a specified date in April 2015, it was identified that this documentation was completed in Point of Care (POC) using task titled "Monitor (Nurse) - Ontario - Restraint Utilization - Front closing seat belt while in chair". It was confirmed that this task had not been created in POC and that resident #009's reassessment and evaluation of the effectiveness of the restraining at least every eight hours was not documented by a registered nurse in the extended class. (583) [s. 110. (7) 6.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 128. Every licensee of a long-term care home shall ensure that a policy is developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern the sending of a drug that has been prescribed for a resident with him or her when he or she leaves the home on a temporary basis or is discharged. O. Reg. 79/10, s. 128.

Findings/Faits saillants :

1. The licensee failed to ensure that a policy was developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern the sending of a drug that had been prescribed for a resident with him or her when he or she leaves the home on a temporary basis or is discharged.

A review of the pharmacy's and home's policies on an identified date in April 2015, indicated that no policy was developed to govern the sending of a drug that had been prescribed for a resident when the resident is discharged from the home. An interview with the DOC confirmed that the home did not have a policy that identified this information.(214) [s. 128.]

Issued on this 27 day of July 2015 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : KELLY HAYES (583) - (A2)

Inspection No. / No de l'inspection : 2015_341583_0006 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-002110-15 (A2)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jul 27, 2015;(A2)

Licensee / Titulaire de permis :
REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR,
MISSISSAUGA, ON, L5R-4B2

LTC Home / Foyer de SLD :
GARDEN CITY MANOR
168 Scott Street, St. Catharines, ON, L2N-1H2

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : KIM WIDDICOMBE

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
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.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

The licensee shall ensure all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas of behaviour management and falls prevention management.

Grounds / Motifs :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in behaviour management. [76(7) 3]

The staff person identified as coordinating staff education was asked to provide documentation of training provided in 2014 in the area of behaviour management. Documents provided included training related to abuse, sexuality in dementia, person centered care, a sign in sheet which indicated five staff attended training related to sundowining/delirium/dementia as well as sign in sheets indicating that 44 staff attended a training program related to gentle persuasive approach to care. At the time of this inspection documents provided by the home indicated that 128 staff out of 177 staff identified as providing direct care to residents did not receive training in the area of behaviour management in 2014. (#129) (129)

2. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in accordance with O. Reg. 79/10, s. 221(1)1 in the area of falls prevention and management. [76(7) 6]

The staff person identified as coordinating staff education was asked to provide documentation of training provided in 2014 in the area of falls prevention and management. The home provided a number of meeting minutes, unrelated training information and emails in response to this request. At the time of this inspection the home was unable to provide evidence to confirm that any of the 177 staff identified as providing direct care to residents received training in the area of falls prevention and management. (#129) (129)

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

Aug 31, 2015(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(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).

Order / Ordre :

(A1)
The licensee shall complete the following:

1. Re-assess all bed systems using the Health Canada Guidelines tilted "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006".

2. Implement interventions to reduce or eliminate entrapment zones for those residents who have a therapeutic surface on their bed frame and who use one or more bed rails. Document the intervention in the residents plan of care.

3. All residents who use a bed rail shall be assessed for bed rail use by employing the guidelines identified in the FDA document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".

4. The result of the assessment shall be documented in the resident s plan of care and the information regarding the resident s bed rail use (which side of bed, size of rail, how many rails and why) shall be clearly identified so that health care staff have clear direction.

5. All health care workers shall receive education on the hazards of bed rail use.

Grounds / Motifs :

1. A) The licensee failed to ensure that where bed rails were used the resident was assessed in accordance with evidence-based practices to minimize risk to the resident, taking into consideration all potential zones of entrapment. Evidence based practices have been identified by the Ministry of Health and Long Term Care as those developed by Health Canada related to bed safety.
According to the home's registered staff and the physiotherapist, residents had not all been assessed for bed rail use by the time of inspection. Five random residents' health care records were reviewed with the physiotherapist, three of which identified that the resident required one or more bed rails but did not provide a reason, one without any bed rail information and one stated that the resident did not require any bed rails. According to records provided, 138 out of 200 residents were using either

a quarter, three quarter, rotating assist or full bed rail. For residents those residents who were assessed, no template or guidance form was being followed to ensure that all aspects of bed rail safety were evaluated, as per evidence based practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and endorsed by Health Canada). According to the guidance document, residents would need to be evaluated while sleeping in bed over a period of time by an interdisciplinary team to determine if the bed rail was a safe alternative for the resident after trialling other options. The licensee had only developed three questions strictly related to resident mobility to evaluate the resident and no other criteria. The staff tasked to complete the assessments did not implement their corporate Revera policy titled "Side Rails" (LTC-K-10-ON dated October 2013) which required that "all residents using side rails be assessed for the need for side rails and the associated risk with the utilization of side rails using the "Side Rail and Alternate Equipment Decision Tree
Residents were therefore not assessed in accordance with evidence based practices by an interdisciplinary team (PSW, RN, Physiotherapist) to ensure that each resident was reviewed consistently to minimize bed rail use risks. (#120)

B) A review of resident #301's care plan interventions initiated September 1, 2013 identified resident could use bed rail with one staff to move from side to side while in the bed. In an interview with front line nursing staff on April 10, 2015, staff confirmed that the resident used three quarter side rails when in bed. In a review of the plan of care and in an interview with the RAI Coordinator on April 10, 2015, it was confirmed that there was no assessment for resident #301 in relation to their bed rails and their bed system was not evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident. (#583)

(120)

2. The licensee failed to ensure that where bed rails were used that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A) Two residents were observed to be sleeping in identified beds with a therapeutic

air mattress on the bed frame in on two identified dates in March 2015. Both beds had two bed rails elevated. Neither bed had any accessories added to reduce the entrapment gap between the bed rail and side of the soft and flexible mattress. A review of the residents' health care record (plan of care, care plan etc) did not identify that the resident required specialized accessories when in bed when bed rails were in use as a step to prevent resident entrapment.

B) Resident bed systems were re-assessed for entrapment zone risks in November 2014 by an external contractor using a specialized tool as per Health Canada's Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006". According to the ESM, mattresses were replaced, mattress keepers partially installed and bed rails tightened after bed systems were noted to have failed one or more zones of entrapment. Upon re-assessment in November 2014, all but one bed passed all zones of entrapment. Over the course of the last 3 months however, bed systems were switched (mattresses removed from the originally tested frame). The original bed system assessment did not include a process to ensure that the mattress and bed frame remained together after it was tested and that nursing staff followed a strict protocol to ensure that the bed remained safe after making changes. As the home had approximately five different style of beds, the entrapment status of the beds at the time of inspection was unknown to the home staff and the associated potential risks to residents. The home did not have any immediate method in which to verify entrapment zone status and therefore adequate steps were not taken to reduce or prevent resident entrapment.

C) During the inspection, a tour of all resident rooms was completed and numerous unoccupied beds were observed to have elevated bed rails for no apparent reason. The practice of keeping bed rails elevated was described by some staff as habit. Residents returning to a bed with an elevated bed rail may not be required to have one and thereby be at a risk of entrapment (especially when the bed entrapment status was unknown). Leaving bed rails down unless directed for in the residents' plan of care was another step that was not taken by staff to reduce or prevent resident entrapment. (#120)

(120)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Sep 30, 2015(A1)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

(A1)
The licensee shall ensure that the plan of care is based on an interdisciplinary assessment of the resident s mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

Grounds / Motifs :

1. The licensee failed to ensure that every plan of care was based on, at a minimum, interdisciplinary assessment of behaviour patterns and any identified responsive behaviours, in relation to the following: [26(3) 5]

A) Resident #004's clinical record indicated that the resident demonstrated resistance/refusal behaviours with respect to the provision of oral care. Personal Support Worker documented in the Point of Care (POC) computerized record that over a 30 day period in March 2015, the resident refused to have mouth care provided on 18 of those days. Staff and the clinical record confirmed that an attempt to complete an assessment of the potential triggers for this behaviour was not made, a request/referral for support from Behavioural Support Ontario (BSO) staff available to the home in order to assist in the assessment and management of this behaviour was not made, a request/referral to dental services to assess the condition of the residents oral status was not made and staff in the home did not complete an oral assessment to determine possible causes for the resident refusing to have staff provide mouth/oral care. Staff confirmed that no additional assessments where documented in the clinical record and the plan of care for resident #004 was not based on an interdisciplinary assessment of responsive behaviours this resident demonstrated. Staff and the clinical record confirmed that the plan of care for resident #004 was not based on an interdisciplinary assessment of responsive behaviours this resident demonstrated around the provision of mouth/oral care.

B) Resident #010's clinical record indicated that the resident demonstrated four responsive behaviours that included, wandering, refusal/resistance related to oral care as well as verbal and physical responsive behaviours towards staff. Documentation made by PSW staff indicated the resident demonstrated verbal and physical responsive behaviours towards staff 10 times over a 14 day period in March 2015, demonstrated refusal/resistance to mouth/oral care on three days over a 28 day period in March 2015 and demonstrated wandering behaviours six times over a

14 day period in March and April 2015. Staff and the clinical record confirmed that an attempt to complete an assessment of the potential triggers for these behaviour was not made, a request/referral for support from BSO staff available to the home in order to assist in the assessment and management of these behaviour was not made, a request/referral to dental services to assess the condition of the residents oral status was not made and staff in the home did not complete an oral assessment to determine possible causes for the resident refusing to have staff provide mouth/oral care. Staff confirmed that no additional assessments were documented in the clinical record and the plan of care for resident #010 was not based on an interdisciplinary assessment of responsive behaviours this resident demonstrated.

C) Resident #401's clinical record indicated that the resident demonstrated responsive behaviours towards co-residents. Clinical notes written by registered staff indicated that on on an identified date in March 2015, this resident had a interaction with co-resident who entered their room, on an identified date in March 2015, this resident was upset with co-resident who was attempting to wander into their room and demonstrated a responsive behavior that indirectly caused the wandering resident to fall to the floor. On an identified date in March 2015, the resident was verbally responsive with a co-resident. Staff and clinical documentation confirmed that an attempt to complete an assessment of the potential triggers for this behaviour was not made and a request/referral for support from BSO staff available to the home in order to assist in the assessment and management of this behaviour was not made. Behavioural Support Staff in the home at the time of this inspection confirmed that they have not received a request for assistance in the assessment of this responsive behaviour. Staff confirmed that no additional assessments where documented in the clinical record and the plan of care for resident #401 was not based on an interdisciplinary assessment of responsive behaviour this resident demonstrated.(Inspector #129)

D) On an identified date in March 2015, resident #002 was observed to have white mucus covering their tongue. A review of this resident's written plan of care on an identified date in March 2015, indicated under dental care deficit that the resident had no teeth and no dentures and that daily mouth care would be provided that included cleaning the resident's gums and mouth tissues as well as their tongue. A review of the Point of Care (POC) documentation, specifically for, "mouth care completed by", was reviewed from March 1 - March 25, 2015 and indicated that the resident refused mouth care on 13 occasions. An interview with front line nursing staff confirmed that the resident does have a history of refusing mouth care. A

review of the resident's written plan did not identify this responsive behaviour of refusing mouth care including any potential behavioural triggers. An interview with the DOC confirmed that the resident's refusal to have mouth care completed was behavioural in nature and that their plan of care was not based on an interdisciplinary assessment of this responsive behaviour of refusal of mouth care or any potential behavioural triggers.(Inspector #214) (129)

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

Jul 31, 2015(A2)

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

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

Order / Ordre :

The licensee shall complete the following:

1. Develop a weekly cleaning and disinfection procedure for wash basins (personal care device) that includes the use of the dishwasher in the soiled utility rooms. The procedure shall include at a minimum how the machines are to be used (settings), how the machines will be loaded, what cleaning agents will be used and how the devices will be disinfected once cleaned. The machines shall not be used to clean both bed pans and washbasins at the same time.

2. Develop a daily cleaning and disinfection procedure for wash basins. The procedure shall describe the process of using either a liquid disinfectant or a disinfecting wipe after cleaning with soap and water in a resident's washroom, followed by how basins will be stored to prevent cross contamination.

3. Remove from resident rooms and washrooms all bed pans and have them thoroughly cleaned and disinfected. A procedure shall be developed that describes exactly how the bed pans are to be handled once used by a resident. The procedure shall describe how the bodily fluids will be disposed of in the resident's bathroom and that the bed pan is to be removed from the room and taken to a soiled utility room after each use for processing. Bed pans shall not be stored on walls in resident washrooms. Cleaned bed pans shall be stored in a clean utility room or closet until ready for use.

4. All health care staff shall be made familiar with the new procedures and given an in-service.

Grounds / Motifs :

1. As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee did not ensure that procedures were implemented and/or developed for cleaning and disinfecting resident care equipment (non-critical devices such as bed pans, wash basins and urinals and personal care articles such as nail clippers) in accordance with evidence based practices. Evidence based practices related to cleaning such devices and articles are identified in a document titled "Cleaning, Disinfection and Sterilization of Medical Equipment/Devices", 2013 developed by the Provincial Infectious Diseases Advisory Committee.

According to the home's bed pan cleaning and disinfecting procedure PPC-C-10-05, dated May 2013, personal support workers were tasked to clean the devices after each use and disinfect them weekly. No specific instructions were provided. A procedure for cleaning and disinfecting bed pans and wash basins located in each soiled utility room identified that they were to be cleaned and disinfected after each use, by using the hopper, a sink and a liquid disinfectant. However, the soiled utility rooms were not equipped with any liquid disinfectant and were equipped with a dishwasher, according to staff for the purpose of cleaning the devices. No instructions were developed for the use of the dishwasher and how the devices would be disinfected after they were cleaned. The frequency of deep cleaning the devices was established for the night shift personal support workers as twice per week, coinciding with the resident's bathing days. Confirmation could not be made that any dishwasher was used over a 3 day period. According to evidence-based practices, and in following outbreak control measures, bed pans and wash basins were to be cleaned and disinfected after each use.

According to the observations made on three identified dates in March and April 2015, staff did not implement the procedures that were developed for cleaning and disinfecting the devices and the licensee did not develop procedures to include the use of the dishwashers in the cleaning process.

A) Visibly soiled or dusty bed pans were found unlabeled and stored on top of toilet tanks or hanging on walls in washrooms 111 (unlabelled only), 127, 133 (on floor), 134 (on floor) on an identified date in April 2015 and in washrooms 201, 202, 207, 214, 215, 227, 237, 243, over a 3-day period.

B) Wash basins with water left in them were found in washrooms 101 (soap scum), 102, 107 (soap scum), 108, 111, 153, 201, 207, 227, 237. According to some staff, the basins were filled with soapy water for routine care and then the water was drained into the bathroom sink, rinsed and placed back under the vanity onto a shelf. Staff stated that no disinfectant was applied after use.

C) According to the licensee's "Night Shift Sanitization by HCA/PSW" form, urinals were to be replaced weekly. According to the infection control designate, the urinals were to be labeled, odour free, free of stains and stored properly. Urinals were expected to be labeled with the resident's name and the date they were replaced. During the inspection the following were identified; unlabeled urinal stored on top of a

toilet tank in an identified shared resident bathroom with a date of February 13, 2015 on it and was odourous, an unlabeled urinal with a brown stained rim with a date of February 28, 2015 stored on toilet tank in identified shared bathroom, soiled urinal on toilet tank in an identified bathroom and a yellow stained urinal on a night table in an identified bedroom dated February 23, 2015.

D) Nail clippers, those that were being used communally on residents, were being disinfected between use, however the staff were not following the manufacturer's instructions to clean the clippers before disinfecting them. The home's nail clipper cleaning procedure (PPC C-10-05) required staff to clean the clippers after each use and to disinfect them monthly (for those dedicated to each resident). In the all four bathing rooms, a container filled with a liquid disinfectant and nail clippers were observed. The solution had floating material in it and nail clippings on the bottom of all the containers. The containers had no label or safety information on them except for a statement that the nail clippers must only be left immersed for 10 minutes. During the inspection, it was noted that the clippers remained in the solution for many hours. (#120)
(120)

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

Sep 30, 2015(A1)

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

(A1)
The licensee shall prepare, submit and implement a plan to ensure that all resident's demonstrating responsive behaviours have behavioural triggers identified, where possible. The plan is to include, but is not limited to:

A) The development of a data collection tool mechanism with respect to the specific behaviour being demonstrated by residents.

B) Develop and implement of a training program for the staff, specifically related to the identification of responsive behaviours, the use of the above noted tool mechanism, how the data collected on the tool mechanism is to be analysed and how this information is be incorporated into the individual resident's plan of care.

C) A schedule for all residents in the home who demonstrate responsive behaviours to be assessed for possible behavioural triggers.

D) The development and implementation of a schedule of monitoring staff's performance in completing the established process for identifying possible behavioural triggers. The plan is to be submitted electronically to Long Term Care Homes Inspector kelly.hayes@ontario.ca by May 4, 2015.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours the behavioural triggers for the resident are identified, in relation to the following: [53(4) (a)]

A) Staff providing direct care to resident #004 and clinical documentation indicated the resident demonstrated four known responsive behaviours. Staff and the Resident Assessment Instrument/Minimum Data Set (RAI-MDS) coordinator confirmed that there had not been an attempt to identify triggers for these behaviours

B) Staff providing direct care to resident #010 and clinical documentation indicated the resident demonstrated five known responsive behaviours. Staff and the RAI-MDS coordinator confirmed that there has not been an attempt to identify triggers for these behaviours.

C) Staff providing direct care to resident #401 and clinical documentation indicated the resident demonstrated three known responsive behaviours. Staff and the RAI-MDS coordinator confirmed that there has not been an attempt to identify triggers for these behaviours.(#129) (129)

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

Sep 30, 2015(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27 day of July 2015 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : KELLY HAYES - (A2)

Service Area Office /
Bureau régional de services : Hamilton