Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 9, 2015	2015_201167_0004	H-001935-15	Resident Quality Inspection

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF WENTWORTH HEIGHTS
1620 UPPER WENTWORTH STREET HAMILTON ON L9B 2W3

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

MARILYN TONE (167), BERNADETTE SUSNIK (120), JESSICA PALADINO (586), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 28, 29, 30, February 3, 4, 5, 6, 10, 11, 12, 2015

The following inspections were conducted simultaneously with this Resident Quality Inspection and any non-compliance issued will be included in this report; Follow-Up Inspection H-001050-14
Critical Incident Inspections: H-000801-14, H-001168-14, H-001264-14, H-001803-15, H-001873-15, H-001874-15, H-001227-14, H-001424-14, H-001550-14, H-001746-14

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Resident Care (DRC), registered staff, personal support workers (PSWs), Neighbourhood Co-ordinators, Environmental Services Supervisor, maintenance staff, housekeeping staff, Food Services Supervisor (FSS), Dietary Aides, Registered Dietitian, Resident Assessment Instrument Co-ordinator(RAI Co-ordinator), Physiotherapist (PT), Kinesiologist, Recreation Co-ordinator, identified residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
20 WN(s)
5 VPC(s)
4 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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 did not ensure that where bed rails were used the resident was assessed in accordance with prevailing practices, to minimize risk to the resident.

The licensee commissioned a company to test resident bed systems on July 7, 2014, for entrapment zones 1-4. The results provided by the administrator identified that 81 beds failed one or more entrapment zones. The documentation however was lacking a bed system identifier (serial number or other coding system) so that the bed and mattress could be tracked if moved from the original room it was tested in. Since that time, it is unknown if beds and mattresses were moved around since a tracking system was not maintained. The Administrator could only confirm that the beds had not been replaced, that some received mattress keepers on all 4 corners and some had bed side rails removed to either remove the risk or mitigate the risk. The plan, as per the Administrator, was to order new mattresses that would possibly resolve some of the other entrapment risks.

According to the Administrator, residents who had a bed with an entrapment risk were identified and the immediate solution was to apply 4 corner mattress keepers to their beds to keep the mattress in place. A spread sheet maintained by the home and dated February 1, 2015, listed that many of the beds had not received 4 corner mattress keepers as of February 4, 2015. Approximately 51 were assessed as requiring at least one rail as an assistive device.

Based on a tour of the home on February 4, 2015, interventions to minimize possible risks to residents had not been implemented and residents had not been assessed in

accordance with prevailing practices adopted by Health Canada in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003" developed by the US Food and Drug Administration.

Resident in an identified room was observed to be in bed with their right ¾ length rail raised without any zone 2 or 4 mitigating accessory in place. The resident's bed system was assessed on July 7, 2014 and determined to have failed zones 2 and 4. The resident's plan of care identified that they were to have 1 bed rail up when in bed. No reason was provided. A bed rail use assessment could not be found in any of the available records.

Resident in an identified room was observed to be in bed with their left ¾ length rail raised without any zone 2 or 4 mitigating accessory in place. The resident's bed system was assessed on July 7, 2014 and determined to have failed zones 2 and 4. The resident's plan of care did not identify whether a bed rail was necessary. A bed rail use assessment could not be found in any of the available records.

Resident in an identified room was observed to be in bed with both of their ¾ length rails raised without any zone 2 or 4 mitigating accessory in place. The resident's bed system was assessed on July 7, 2014 and determined to have failed zones 2 and 4. The resident's plan of care identified that they were to have 2 full rails up when in bed for safety. No specific safety reason was provided. A bed rail use assessment could not be found in any of the available records.

Resident in an identified room was observed to be in bed with one ¾ length rail raised without any zone 2, or 4 mitigating accessory in place. The resident's bed system was assessed on July 7, 2014 and determined to have failed zones 2, 3 and 4. The resident's plan of care identified that they did not use bed rails. A bed rail use assessment could not be found in any of the available records.

Numerous unoccupied beds were observed to have at least one bed rail elevated. These beds were compared to the bed system assessment results and identified to have failed zone 2 or 4 or both. Residents returning to these beds either alone or assisted, would be at risk of zone 2 or 4 entrapment. None of the beds were observed with any entrapment mitigating bed accessories. The Administrator confirmed that they provided an in-service for health care staff, general information about entrapment zones and the risks of bed rail use in mid to late 2014. (120) [s. 15. (1)]

Additional Required Actions:

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

WN #2: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the home’s infection prevention and control program related to labeling of personal care items.

A) During stage one of the inspection, the following were observed:
i. On January 28, 2015, a used and unlabeled comb and a hairbrush, along with a used and unlabeled deodorant, were found in the spa room on an identified home area.
ii. On January 28, 2015, seven used and unlabeled combs, along with several used and unlabeled zinc oxide creams and white petroleum jelly, were found in the spa room on an identified home area.
iii. On January 28, 2015, several zinc oxide creams and used petroleum jelly, along with

two brushes that were used and unlabeled, and two used deodorants, were found in the spa room on an identified home area.
The DOC confirmed that all personal items were to be labeled.

B) During an observation of the noon medication pass on an identified home area, the registered nursing staff did not complete hand hygiene between residents during the medication pass. The registered nursing staff administered insulin to a resident and then proceeded to give oral medications to another resident without washing their hands or using point of care hand hygiene agents. [s. 229. (4)]

2. The licensee has failed to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission, unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of the screening were available.

Resident #303 was admitted to the home in 2014 and residents #301 and #302 were admitted in 2015. A review of their immunization records did not include tuberculosis within 14 days of admission, nor was there documentation to indicate that these residents had been screened 90 days prior to admission. Interview with the home's Infection Control Lead on February 5, 2015, confirmed that tuberculosis screening had not been completed within 14 days of admission for all three residents. [s. 229. (10) 1.]

3. The licensee has failed to ensure that residents were offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules.

Resident #303 was admitted to the home in 2014 and residents #301 and #302 were admitted in 2015. Their immunizations records filed in their charts were all blank, suggesting that pneumococcal, tetanus and diphtheria vaccines had not been offered to the residents. Interview with the home's Infection Control Lead on February 5, 2015, confirmed that these immunizations had not been offered to all three residents in accordance with the publicly funded schedules. [s. 229. (10) 3.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that there were written plans of care for residents #003 and #307 that set out the planned care for the residents.

A) Resident #003 used one bed rail in the raised position at all times when in bed as confirmed by observation and staff interview on February 04, 2015. Review of the written plan of care and kardex, which provided direction to the front line staff, confirmed the use of the bed rail was not included. The DRC confirmed that this information should have

been in the resident's plan of care.

B) A review of resident #307's progress notes revealed that the resident had numerous responsive behaviours, including but not limited to, attention-seeking behaviours and complaints about staff and care on a daily basis. This was confirmed by front line staff, a Neighbourhood Coordinator, the PT, the DRC and the Administrator. Review of the resident's documented plan of care revealed there was no information to suggest the resident had these behaviours. The DRC confirmed this should have been included in the plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plans of care for resident #102 and #307 provided clear direction to staff and others providing direct care to the residents.

A) In 2014, resident #102 sustained a fall that resulted in a fracture.
i. The MDS assessment completed for the resident dated December 27, 2014, indicated that the resident required two or more staff extensive assistance to assist the resident with transfers, walking in their room and toileting.
ii. An interview with the Physiotherapist on February 11, 2015, confirmed that the resident required assistance of two staff to walk and transfers with the assistance of two staff with a pivot transfer. They also confirmed that the resident currently used a wheelchair for mobility.
iii) A review of the document that the home refers to as the care plan for resident #102 indicated under elimination, that the resident uses the toilet themselves, but in another area the care plan indicated that the resident was to be checked and changed in bed - extra team member to assist with support to reduce discomfort from movement - if able to weight bear to have 2 person assist with transfers. The resident's care plan under transferring indicated that the resident transferred themselves and should be encouraged to use their walker, but in another area of the care plan it indicated that the resident was to be transferred using a two person pivot transfer with extensive assistance. The resident's care plan related to mobility indicated that the resident ambulates with a walker but in another area of the care plan it indicated that the resident was on bed rest and they were up in a broda chair when able. (167)

B) Resident #307 fell in 2014 and sustained a fracture as evidenced by an x-ray report and interview. Under the physiotherapy section of the resident's plan of care, it was documented that the resident complained of significant pain as a result of their fracture; however, under the Pain, Bowel/Bladder Elimination, and Monitor for Medical Conditions sections of the plan of care it was documented that the resident's fracture was on the

opposite side of their body not the side where the fracture was confirmed. There were inconsistencies in the resident’s plan of care related to their fracture, therefore did not provide clear direction to staff. This was confirmed by the DRC. [s. 6. (1) (c)]

3. The licensee has failed to ensure that resident #004 received care to maintain and manage their continence as noted in their plan of care.

i) The document that the home refers to as the care plan for resident #004 directed staff to dress the resident in a one piece outfit to prevent inappropriate elimination, maintain toileting routine when accepted to keep the resident continent, clean and dry, re-approach the resident when they were calm, re-approach until they accept care. The care plan also directed staff to take the resident to the wash room upon wakening, prior to and after meals and before going to bed and monitor the resident for wandering as may be looking for a bath room. Assist the resident to undress as they may be wearing a one piece.
ii) During observation of the resident on an identified date during the inspection at 1145 hours , resident #004 was noted to be wandering around the lounge area and it was noted that they had just walked away from a pool of urine on the floor beside a sofa in the lounge area. The resident was noted to have wet pants and was noted to have a strong odour of urine. The inspector reported this to the registered staff member who was present administering medications. The inspectors returned around 1215 hours and noted that the resident was still wet and asked the registered staff about this. The registered staff member indicated that the PSW staff had attempted to toilet the resident prior to lunch but they refused. The resident was seated on a chair in the dining room at a table with another resident at that time.
At 1315 hours, the inspectors again returned and observed the resident to be still seated in the dining room. A dietary staff was noted to lead the resident from the dining room and seat them on a sofa in the lounge. The resident was noted to be co-operative at that time. The resident had still not been toileted or changed.
At 1330 hours, the inspector approached two PSW staff who were doing paperwork at the nurses' station and asked if resident #004 had been toileted. They indicated that the resident usually refuses and they re-approach later.
The inspector told the PSWs that the resident had been wet for almost two hours. The two PSW staff then offered toileting to the resident and the resident was noted to be co-operative. The resident was taken to the spa room by the two PSWs to provide continence care.
iii) The staff did not attempt to reapproach the resident and offer toileting as directed in the resident's plan of care. Resident #004 was not provided with continence care as per

their plan of care

B)The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in their plan.

Resident #001's plan of care directed staff to give the resident their medications crushed and mixed in applesauce. During the noon medication pass on an identified date during this inspection, the inspector observed the registered staff member crushing the resident's medication and then proceeded to put the medications in water and thickened the water with thickener. The resident's plan of care did not indicate that the resident was on thickened fluids. The registered staff confirmed that they did not follow the resident's plan of care regarding medication administration.(506)

C) The licensee has failed to ensure that the care set out in the plan of care was provided to resident #200, #201 and #203 as specified in their plan.

Resident #200's plan of care indicated that the resident was to have weekly pain assessments completed every Sunday on the evening shift. The pain assessments were not consistently completed weekly as evidenced by the following:
i. In September 2014, completed three of an expected four pain assessments;
ii. In October 2014, completed three of an expected for pain assessments;
iii. In November 2014, completed three of an expected five pain assessment;
iv. In December 2014, completed two of an expected three pain assessments.
The Neighbourhood Co-ordinator confirmed that the weekly pain assessments were not completed weekly as set out in the resident's plan of care.

Resident #201's plan of care indicated that the resident was to have weekly pain assessments completed every Sunday on the evening shift. The pain assessments were not consistently completed weekly as evidenced by the following:
i. In September 2014, completed three of an expected four pain assessments;
ii. In October 2014, completed three of an expected four pain assessments;
iii. In November 2014, completed three of an expected five pain assessments;
iv. In December 2014, completed one of an expected three pain assessments.
The Neighbourhood Co-ordinator confirmed that the weekly pain assessments were not completed weekly as set out in the resident's plan of care.

Resident #203's plan of care indicated that the resident was to have weekly pain assessments completed every Sunday on the evening shift. The pain assessments were

not consistently completed weekly as evidenced by the following:
i. In October 2014, completed none of an expected four pain assessments;
ii. In November 2014, completed two of an expected five pain assessments;
iii. In December 2014, completed two of an expected four pain assessments;
iv. In January 2015, completed two of an expected four pain assessments.
The Neighbourhood Co-ordinator confirmed that the weekly pain assessments were not completed weekly as set out in the resident’s plan of care.(506) [s. 6. (7)]

4. The licensee has failed to ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed.

A) Resident #200 had a stage III pressure ulcer on their coccyx on an identified date in 2014. Record review and interview with the Neighbourhood Co-ordinator on February 6, 2015, confirmed that the wound was a stage III pressure ulcer and the resident's plan of care was not updated until four months later. Interview with the Neighbourhood Co-ordinator confirmed that the plan of care should have been reviewed and revised as the care set out in the resident's plan changed.

B) Resident #201 was identified as having a stage II pressure ulcer on their coccyx on an identified date in 2014. Record review indicated that the resident’s wound was not assessed again until ten days later. There was no treatment plan developed to manage the resident’s wound and it was noted that the treatment record did not include identification of the resident’s wound. Interview conducted with the Neigbourhood Co-ordinator on February 6, 2015, confirmed that the home did not review and revise the resident’s care plan when the resident’s care needs changed.(506)

C) Resident #203 was identified as having two skin tears one which was identified on on an identified date in 2014 and the other which was identified about two weeks later. Record review indicated that the resident’s wound was not assessed again until about three weeks after that. There was no treatment plan developed to manage the resident’s skin tears and it was noted that the treatment record did not included identification of the resident’s wound. Interview conducted with the Neigbourhood Co-ordinator on February 6, 2015, confirmed that the home did not review and revise the resident’s care plan when the resident’s care needs changed.(506) [s. 6. (10) (b)]

5. The licensee failed to ensure that resident #004’s plan of care was reviewed and different approaches considered when the care set out in their plan of care was not effective.

i. Resident #004 was noted to display the following responsive behaviours: aggression towards staff and other residents, inappropriate voiding patterns and resistance to care.
ii. During observation of the resident during this inspection on identified dates, they were noted to appear unshaven, hair not combed and had an odour of urine.
iii. On an identified date, the resident was noted to be walking in the lounge area at 1145 hours and was noted to have been incontinent of urine on the floor near a sofa. The resident was noted to be visibly wet from the incontinence. At 1330 hours, the resident had taken lunch in the dining room and was seated on a sofa in the lounge area. The resident’s pants were visible wet and there was a strong odour of urine about them. When the inspector asked staff why the resident had not yet been toileted or changed they indicated that the resident refused.
iii. A review of the Resident Care Flow records completed by PSW staff revealed that there had been no documented baths or showers for resident #004 for over two months. Staff interviewed indicated that the resident frequently refused baths and showers.
iv. The licensee did not ensure that the resident’s plan of care was reviewed and different approaches considered to manage the resident’s hygiene and grooming needs when their plan of care was not effective. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 003, 004 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 on February 5, 2015.

A) The kitchen/activity room in the Scottsdale home area had a functional stove top and no staff present. Two controls for the stove top elements had been removed, but two remained in place and were functional.
B) The physiotherapy room in the main corridor on the ground floor was left unattended with a hot collator within the room that was steaming hot. No locks were provided on the doors to the room for staff to be able to make the collator inaccessible when the room was unoccupied.
C) The Stone Church housekeeping room which contained cleaning and disinfecting chemicals was closed but was pushed open. The door was tested a 2nd time and it did not lock. After a housekeeper pulled on the door, it locked on the 3rd try. It was clear that the door hardware or locking mechanism was not functioning consistently to ensure the door would remain locked once closed.
D) The Scottsdale servery was unsupervised and left accessible to residents with several spray bottles in an unlocked cabinet. One bottle was labeled as a sanitizer and the other was not labeled, but appeared to have the same pink solution inside. The servery doors were equipped with hardware to keep the rooms inaccessible when not supervised by staff, but were not engaged. [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 and secure environment for it's residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy and procedure for wound/skin care was complied with.

The home's Nursing Manual policy for Wound/Skin Care (section 4, subsection 04-78, last revised January 2015) indicated that the interdisciplinary team shall:
i. Complete a skin assessment, on each bath day, and record on the resident's flow sheet.
ii. The registered team member will initiate the Wound Protocol Checklist within 24 hours of a wound being reported.
iii. The Wound Care Nurse will complete the Wound Assessment Tool on a weekly basis.
iv. The registered team member will contact the physician for orders specific to the wound.

Resident #200, #201 and #203 were noted to have areas of altered skin integrity.
A. During a review of resident #200's clinical record, it was noted that the above tasks were not completed for resident #200. The Neighbourhood Co-ordinator confirmed that the home's Wound/Skin Care policy was not complied with.
B. During a review of resident #201's clinical record, it was noted that the above tasks were not completed for resident #201. The Neighbourhood Co-ordinator confirmed that the home's Wound/Skin Care policy was not complied with.
C. During a review of resident #203's clinical record, it was noted that the above tasks were not completed for resident #203. The Neighbourhood Co-ordinator confirmed that the home's Wound/Skin Care policy was not complied with. [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 where the Act or 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 b)the licensee shall ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s policy/procedure titled [Personal Expression Understanding and Reporting Tab 02-15 of the Nursing Manual] related to resident responsive behaviours included the following:
1. Written approaches to care including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviour, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required.
On February 11, 2015, the DRC provided a new policy that had just been provided to the home by their corporate office and indicated that this policy had not yet been rolled out. This policy was titled [Personal Expression Program using the Layered Natured Framework and the P.I.E.C.E.S Approach - Tab 05-05 of the Nursing Manual].
5. The DRC also confirmed that the policy related to Responsive Behaviours that the home was currently using was deficient in a number of these required areas. [s. 53. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following are developed to meet the needs of residents with responsive behaviours; 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviorus, whether cognitive, physical, emotional, social or other 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours 3. Resident monitoring and internal reporting protocols 4. Protocols for the referral of residents to specialized resources where required, to be implemented voluntarily.

WN #7: 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).

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 developed and/or implemented for cleaning of the home, including furnishings and staff areas which included floors, contact surfaces and wall surfaces.

A) All four serveries in the home were toured on February 4th and 5th, 2015 and observed to be visibly soiled. The lower cabinet surfaces in all serveries were visibly soiled, accumulated food debris was observed under and around the steam tables and around the white refrigerators, the walls were visibly soiled with what appeared to be food debris in and around the large garbage receptacles in 2 serveries. Several serveries had ground in dirt build up in the blue flooring material.

The home's cleaning procedure titled "Cleaning Schedules- 09-17" identified that staff were to follow a cleaning schedule that indicated the frequency of cleaning work areas and listed walls and serveries. However the cleaning schedule that was observed posted in each servery did not include walls on the check list. The schedule identified that floors and cabinet surfaces were to be cleaned daily and that staff sign the schedule when completed. Two schedules, one in Scottsdale servery and one in Carrington servery were both missing indicators or confirmation that required surfaces were cleaned between February 1-3, 2015 and the Rymal servery was missing confirmation for February 2 & 3, 2015. A dietary aide reported that there was no time to clean all required surfaces on a daily basis and the Food Services Supervisor acknowledged that the dietary routines did not allow adequate time for sufficient cleaning and was in the process of re-arranging the routines.

B) During a tour of the four dining rooms in the home on February 4th & 5th, 2015, 10 chairs in the Scottsdale and 11 chairs in the Carrington dining rooms were observed to have visibly dirty seats over a two day period. Dietary services procedures did not include dining room chair cleaning requirements. Dietary aides were observed to clean table tops and not chairs on February 4, 2015. In the housekeeping policies and procedures binder, a schedule titled “Deep Clean Check Sheet 03-02” identified that dining rooms were to be deep cleaned once per month but did not include specifics. Another check list kept by the housekeepers indicated that the dining rooms were to be cleaned daily, but did not identify what exactly was to be cleaned. In speaking with the Environmental Services Supervisor and a housekeeper, the floors were cleaned daily, not necessarily the walls, chair frames or seats.

C) The Carrington shower room wall tiles were observed to appear very dirty on February 4, 2015. The surface of the tile was coated in what appeared to be mould and soap scum. When the tiles were wiped with a sheet of paper towel, the biofilm was removed. A discussion was held with a housekeeper who reported that the wall tiles were not necessarily cleaned daily, it depended on the individual housekeeper and their time and whether they noticed unclean areas. No procedures were found in the housekeeping policies for tub and shower room cleaning requirements. The housekeepers “Deep Clean Check Sheet 03-02” identified that shower and tub rooms were to be deep cleaned once per month. [s. 87. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the organized program of housekeeping under clause 15(1)(a) of the Act, procedures are developed and implemented for cleaning of the home, including furnishings and staff areas which included floors, contact surfaces and wall surfaces, to be implemented voluntarily.

WN #8: 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. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents’ personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, the licensee did not ensure that there were schedules and procedures in place for preventive and remedial maintenance.

During a tour of the home on February 4 & 5, 2015, areas of disrepair were noted in various tub rooms, shower rooms and serveries with no short term plans scheduled to address the disrepair. The home's maintenance policies and procedures were limited and did not include how the various interior surfaces of the home and furnishings would be maintained. The Environmental Services Supervisor (ESS) confirmed that a preventive component of the program included heating, ventilation and air conditioning, lift equipment, certain appliances and fire safety systems but not the interior of the home such as walls, doors, floors, ceilings, fixtures, furnishings, toilets, sinks and other surfaces/items. A remedial maintenance request system was reviewed with the ESS which included an electronic system that captured an issue requiring attention and the date it was addressed. However, any issues that were not reported by the employee would not be identified and subsequently addressed.
During the visit, the following was identified:

A. The casings around bedroom and bathroom doors were peeled down to the metal for the Scottsdale shower room, Stone Church common washroom, Carrington common washroom, Rymal common washroom, bathrooms 107, 121, 145, 226, 261 and 266, bedrooms 127, 134, 266, Carrington shower and utility rooms.
B. Door surfaces were peeled down to metal for the Stone Church tub room, various fire

doors, all of the utility room doors and some common washroom doors.
C. The top surface of a wood cabinet in the Scottsdale tub room was not in good condition. It was rough with exposed particle board across the entire top surface.
D. Corner wall tiles in the Scottsdale and Rymal tub rooms were missing or damaged, with sharp edges.
E. A partition wall between the shower and the toilet areas in the Scottsdale, Rymal, Carrington and Stone Church shower rooms were missing numerous ceramic wall tiles, exposing metal and plaster and in some cases sharp edges. Two wall tiles were no longer tight-fitting and were pushed inwards in the Stone church shower surround.
F. Stained ceiling tiles were noted in the common washroom and servery in Scottsdale, in bathrooms 105, 166, 152 and in bedrooms 107, 112. Two ceiling tiles were missing in the Carrington tub room, according to staff, from water dripping down from a tub room above.
G. Lower cabinet door surfaces along the bottom edge were rough with exposed particle board in the Rymal, Scottsdale and Stone Church serveries.
H. Large holes were observed in two separate walls in the Carrington servery.
I. Multiple ceramic wall tiles located along the length of a wall and just above the coved baseboard were chipped along the bottom, creating a very sharp edge in the Stone Church and Carrington tub rooms.
J. No exhaust was detected (tissue held up to exhaust vent) in the Scottsdale shower and Carrington Shower rooms on either February 4th or 5th, 2015. Both rooms were noted to be stuffy many hours after showers were given.
K. Counter tops located in the serveries of Carrington and Rymal were damaged with exposed particle board (next to a steam well). The administrator was aware of the issue and identified that they would be replaced but did not have any specific plans.
L. The flooring material in the Rymal tub room was in poor condition. It had a 1 cm wide and over 10 cm long crack along the wall beside the toilet. Duct tape and caulking had been used to keep the floor from splitting any further. [s. 90. (1) (b)]

2. The licensee has failed to ensure that procedures were implemented to ensure that devices were kept in good repair.

A foam mattress, which was a medical device according to Health Canada, was observed to be in poor condition on February 4, 2015. The outer layer of the water resistant liner was peeled back in a large circle in the center of the mattress, exposing an inner layer that was not water resistant. The inner foam core was depressed in the center, creating a concave surface. A foam mattress in an identified room also had a liner that was in poor condition and a foam core with a concave surface. A spring

mattress with a vinyl cover in another identified room was found to have a fine crack along the width of the mattress and smelled of urine. The home's policy titled "Bed and Mattress Disinfecting/Carbolizing" (03-13) identified that staff who were responsible for cleaning the mattresses had the duty to report irregularities such as cracks, tears or worn areas immediately so that the mattress could be replaced. The process was not implemented. [s. 90. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the organized program of maintenance services under clause 15(1)(c)of the Act, r. 90(1)b schedules and procedures are in place for routine, preventative and remedial maintenance and r.90(2)b procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids are kept in good repair, excluding the residents' personal aids or equipment, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident's right to give or refuse consent to any treatment, care or service was respected and promoted.

On an identified date in 2014, progress notes revealed that resident #307 was upset and voiced to staff that staff member from a contracted service at the home, forced them to get up when they did not want to and it caused their pain to worsen. At that time, the resident had an undiagnosed injury and was complaining of significant pain, as well as experiencing anxiety related to the pain. The home's investigation notes and interview with the Administrator and the staff member involved confirmed that they did in fact get the resident up after the resident refused. The staff member did not respect resident #307's right to refuse a treatment. [s. 3. (1) 11. ii.]

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

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident’s plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident’s bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident’s bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee did not ensure that resident beds were capable of being elevated at the head and had a headboard and a foot board. A bed in an identified room (double/queen sized bed) and a single bed in another identified room did not have a foot board and no controls to elevate the head of the bed. [s. 12. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee did not ensure that the home was maintained at a minimum temperature of 22 degrees Celsius on February 5, 2015. The Scottsdale and Carrington tub rooms were noted to be cool on February 4, 2015, during an initial walk through. On February 5, 2015, the rooms continued to feel cool and were subsequently measured with a digital ambient air thermometer (hygrometer) and a digital probe thermometer (for comparison) which was left in each room for several minutes (5-10 minutes). The air temperature indicated 18.1C and 18.4C respectively. The tub rooms were observed to be in full use by staff and residents on both February 4th and 5th, 2015. When the Environmental Services Supervisor was approached regarding the lack of heat, he suspected the circuit breaker was not on. A few minutes later, he confirmed that the circuit breaker for the heaters servicing the tub rooms had been turned off at the panel in a mechanical room. Once turned back on, the heater in Scottsdale was confirmed to be functional. [s. 21.]

WN #12: 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:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for resident #004 was based on at a minimum, interdisciplinary assessment of the resident with respect to (18) special treatments and interventions.

i) During observation of resident #004's room over the course of five days during this inspection, it was noted that the resident had one three-quarter rail elevated on their bed on the side of their bed beside the window.
ii) Personal support worker and registered staff interviewed confirmed that the resident used one bed rail in bed to assist with mobility and that the bed rail did not restrict the resident from exiting the bed.
iii) The Minimum Data Set (MDS) assessment dated as completed on December 20, 2014, indicated the use of bed rails for the resident to assist with bed mobility or transfer.
iv) The document that the home refers to as the care plan and the kardex used by the PSWs to direct care did not include identification of the use of a bed rail for mobility as indicated in the MDS assessment completed for the resident and confirmation of bed rail use by staff. [s. 26. (3) 18.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team providing the resident's care was held for resident #004 at least annually to discuss the plan of care and other matters of importance to the resident and his or her substitute decision maker.

i) During a review of the health file for resident #004, it was noted that there was no annual care conference completed for the resident since 2012.
ii) During an interview with the Neighbourhood Co-ordinator and the Administrator, it was confirmed that a care conference had not be held for the resident since 2012. [s. 27. (1) (a)]

WN #14: 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 all actions taken with respect to a resident under a program including interventions and resident responses to interventions were documented with regards to bathing.

During a review of the Resident Care Flow Records for resident #004, it was noted that there was no documentation in the section under bathing to indicate if the resident received a bath/shower/bed bath or refused on their bath days for over two months.
i. The document that the home refers to as the care plan indicated that the resident was to alternate between a bath and a shower on bath days.
ii. During interviews with PSW staff in the resident's home area, it was confirmed that the resident would often refuse to be bathed or showered.
iii. During an interview with the registered staff, it was confirmed that the staff were to document refusals of bathing on the Resident Care Flow Record and notify the registered staff on duty. The registered staff also confirmed that if PSW staff notified them that the resident had refused their bath, it would be expected that they would document this in the resident's progress notes. Over the past two months there was no documentation found in the progress note related to the resident's refusal of baths or showers. [s. 30. (2)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in writing was provided within 10 days of receiving Residents' Council advice related to concerns or recommendations.

During a review of the Residents' Council minutes for the home, it was confirmed that no written response was provided to the Council within 10 days of the Council having expressed concerns or recommendations to the licensee.
It was noted that the home did have a form that was to be completed by the appropriate manager when a concern involved their department and to be signed by the Administrator.
It was confirmed by the Administrator that this form has not been consistently used over the past year and therefore the responses in writing have not been provided to the Council within 10 days. [s. 57. (2)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in writing within 10 days of receiving Family Council advice related to concerns or recommendations was provided.

It was noted that the home currently holds "Neighbourhood " meetings on each home area with families instead of a "Family Council" for the whole home. This was decided by family members and was included in the minutes of the October 2013 Family Council meeting.
During a review of the minutes of the Stonechurch family meetings held in January 2014, November 2014 and September 2014, it was noted that there were concerns expressed by family members related to nutritional services, nursing services and environmental services. These concerns were included in the minutes of the meetings but there was no documented response provided to the family members as required.
It was confirmed by the Administrator that the minutes were not forwarded to them for review and therefore no formal responses were made. [s. 60. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure communication to residents of any menu substitutions.

The home's lunch menu for February 3, 2015, included macaroni and cheese with fresh zucchini or bacon and tomato sandwich with cucumber salad. Observation and interview with dietary staff confirmed that instead of fresh zucchini and cucumber salad, the home was served fresh peas and four bean salad as their vegetable options. None of the daily menu boards posted outside of the home's four dining rooms, or the weekly summary in the main hallway, were updated to reflect the menu changes. Interview with the Director of Food Services confirmed the home was not appropriately communicating menu substitutions to the residents. [s. 72. (2) (f)]

WN #18: 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that food and fluids were being served at temperatures that were palatable to residents.

Resident #300's documented plan of care stated that the resident suffered from insomnia and therefore was encouraged to sleep in public areas and if so, was not to be awakened by staff. During the lunch meal service on February 3, 2015, the resident was observed sleeping from 1205 hours to 1245 hours at their table. The resident's soup was in front of them during the time they were sleeping. At 1247 hours a staff member brought the resident utensils and the resident began eating their soup. The staff did not reheat the soup for the resident. Interview with dietary staff and the RD confirmed the soup was likely cold and therefore unpalatable. [s. 73. (1) 6.]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff received training on the Residents' Bill of Rights.

On an identified date in 2014, a contracted service provider at the home was involved in an incident in which they did not respect a resident's right to refuse. On February 11, 2015, the contracted staff member stated that they had not received any formal training from the home, including the Residents' Bill of Rights. This information was confirmed by the Administrator. The Administrator also confirmed that the home did not currently require all contract employees to complete the home's mandatory training, and that the home did not currently have a formal policy in place regarding the training of external contract employees. [s. 76. (2) 1.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that residents' written records were kept up to date at all times.

i. Resident #205 was the victim of an abuse incident related to an incident report that was submitted to the Director in 2014. During a review of the resident's clinical record it was noted that there was no documentation in the resident's clinical file to say that the resident was involved in the incident and that the resident was assessed for injuries and the outcome of the occurrence.
ii. Resident #204 was the aggressor in an incident of abuse related to an incident report that was submitted to the Director in 2014. During a review of the resident's clinical record it was noted that the resident was being seen by the Behavioural Support Ontario (BSO) resource clinical coach. The clinical coach recommended that the resident be referred to the Psychogeriatric Resource Consultant for assessment and consultation and to consider referring the resident to a Psychogeriatrician. The Neighbourhood Co-ordinator confirmed that the referrals did not take place. An interview with the registered staff member who worked on the identified date, when the referrals were received confirmed that they spoke with the physician about the referrals and the physician decided to make medication changes instead of initiating the referrals at this time. The registered staff member confirmed that this information should have been documented in the resident's clinical file. [s. 231. (b)]

Issued on this 7th day of April, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére 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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARILYN TONE (167), BERNADETTE SUSNIK (120), JESSICA PALADINO (586), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2015_201167_0004
Log No. / Registre no:	H-001935-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 9, 2015
Licensee / Titulaire de permis :	OAKWOOD RETIREMENT COMMUNITIES INC. 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF WENTWORTH HEIGHTS 1620 UPPER WENTWORTH STREET, HAMILTON, ON, L9B-2W3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	VANDA KOUKOUNAKIS

To OAKWOOD RETIREMENT COMMUNITIES 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)

Linked to Existing Order / Lien vers ordre existant: 2014_267528_0021, CO #001;

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 :

The licensee shall complete the following;

1. Develop a comprehensive bed safety assessment tool using the US Federal Drug and Food Administration document as a guide titled “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003”.
2. An interdisciplinary team shall assess all residents using the bed safety assessment tool and document the results and recommendations.
3. Update all resident health care records to include why bed rails are being used, how many, the size and any accessories that are required to mitigate any identified entrapment risks.
4. Health care staff providing care to residents shall be provided with and follow directions related to each resident's bed rail use requirements.
5. Institute a monitoring program that will ensure that residents who require accessories to reduce entrapment zones will continue to be provided with those accessories.
6. Accurately document the results of any future bed assessments and continuously maintain the document when changes to the bed system occurs (i.e. mattress changed, rail replaced).
7. Establish an identification system for the beds and mattresses. Label all mattresses with the same identifier used to identify the bed frame when the bed is being measured/assessed.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used the resident was assessed in accordance with prevailing practices, to minimize risk to the resident.

The licensee commissioned a company to test resident bed systems on July 7, 2014, for entrapment zones 1-4. The results provided by the Administrator identified that 81 beds failed one or more entrapment zones. The documentation however was lacking a bed system identifier (serial number or other coding system) so that the bed and mattress could be tracked if moved from the original room it was tested in. Since that time, it is unknown if beds and mattresses were moved around since a tracking system was not maintained. The Administrator could only confirm that the beds had not been replaced, that some received mattress keepers on all 4 corners and some had bed side rails removed to either remove the risk or mitigate the risk. The plan, as per the Administrator, was to order new mattresses that would possibly resolve some of

the other entrapment risks.

According to the Administrator, residents who had a bed with an entrapment risk were identified and the immediate solution was to apply 4 corner mattress keepers to their beds to keep the mattress in place. A spread sheet maintained by the home and dated February 1, 2015, listed that many of the beds had not received 4 corner mattress keepers as of February 4, 2015. Approximately 51 were assessed as requiring at least one rail as an assistive device.

Based on a tour of the home on February 4, 2015, interventions to minimize possible risks to residents had not been implemented and residents had not been assessed in accordance with prevailing practices adopted by Health Canada in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003" developed by the US Food and Drug Administration.

Resident in an identified room was observed to be in bed with their right ¾ length rail raised without any zone 2 or 4 mitigating accessory in place. The resident's bed system was assessed on July 7, 2014 and determined to have failed zones 2 and 4. The resident's plan of care identified that they were to have 1 bed rail up when in bed. No reason was provided. A bed rail use assessment could not be found in any of the available records.

Resident in an identified room was observed to be in bed with their left ¾ length rail raised without any zone 2 or 4 mitigating accessory in place. The resident's bed system was assessed on July 7, 2014 and determined to have failed zones 2 and 4. The resident's plan of care did not identify whether a bed rail was necessary. A bed rail use assessment could not be found in any of the available records.

Resident in an identified room was observed to be in bed with both of their ¾ length rails raised without any zone 2 or 4 mitigating accessory in place. The resident's bed system was assessed on July 7, 2014 and determined to have failed zones 2 and 4. The resident's plan of care identified that they were to have 2 full rails up when in bed for safety. No specific safety reason was provided. A bed rail use assessment could not be found in any of the available records.

Resident in an identified room was observed to be in bed with one ¾ length rail

raised without any zone 2, or 4 mitigating accessory in place. The resident's bed system was assessed on July 7, 2014 and determined to have failed zones 2, 3 and 4. The resident's plan of care identified that they did not use bed rails. A bed rail use assessment could not be found in any of the available records.

Numerous unoccupied beds were observed to have at least one bed rail elevated. These beds were compared to the bed system assessment results and identified to have failed zone 2 or 4 or both. Residents returning to these beds either alone or assisted, would be at risk of zone 2 or 4 entrapment. None of the beds were observed with any entrapment mitigating bed accessories. The administrator confirmed that she provided an in-service for health care staff regarding general information about entrapment zones and the risks of bed rail use in mid to late 2014.

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 29, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
O. Reg. 79/10, s. 229 (10).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the following immunization and screening measures are in place: 1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. 3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
The plan shall include a review of all residents at the home to ensure that immunization against pneumococcus, tetanus and diphtheria has been offered.
The plan shall include education of staff related to the immunization requirements and an auditing process to be ensure compliance.

The plan shall be submitted electronically to: Marilyn.Tone@ontario.ca by March 23, 2015.

Grounds / Motifs :

1. S.229(10) was previously issued as a VPC June 9, 2014

The licensee has failed to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission, unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of the screening were available.

Resident #303 was admitted to the home in 2014 and residents #301 and #302 were admitted in 2015. A review of their immunization records did not include tuberculosis within 14 days of admission, nor was there documentation to indicate that these residents had been screened 90 days prior to admission. Interview with the home's Infection Control Lead on February 5, 2015, confirmed that tuberculosis screening had not been completed within 14 days of admission for all three residents. (586)

2. The licensee has failed to ensure that residents were offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules.

Resident #303 was admitted to the home in 2014 and residents #301 and #302 were admitted in 2015. Their immunizations records filed in their charts were all blank, suggesting that pneumococcal, tetanus and diphtheria vaccines had not been offered to the residents. Interview with the home's Infection Control Lead on February 5, 2015, confirmed that these immunizations had not been offered to all three residents in accordance with the publicly funded schedules. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that care set out in the plans of care for residents #200, #201, #203 related to the completion of their pain assessments weekly are completed as required; the care set out in the plan of care for resident #004 related to toileting and continence management is provided to the resident as specified; and the plan of care for resident #001 related to the administration of medications is followed as specified in their plan.

Grounds / Motifs :

1. S.6(7) was previously issued as a WN on May 17, 2011, a VPC on February 20, 2014 and a VPC on June 9, 2014.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #200, #201 and #203 as specified in their plan.

Resident #200's plan of care indicated that the resident was to have weekly pain assessments completed every Sunday on the evening shift. The pain assessments were not consistently completed weekly as evidenced by the following:
i. In September 2014, completed three of an expected four pain assessments;
ii. In October 2014, completed three of an expected four pain assessments;
iii.In November 2014, completed three of an expected five pain assessment;
iv.In December 2014, completed two of an expected three pain assessments.
The Neighbourhood Co-ordinator confirmed that the weekly pain assessments were not completed weekly as set out in the resident's plan of care.

Resident #201's plan of care indicated that the resident was to have weekly pain assessments completed every Sunday on the evening shift. The pain

assessments were not consistently completed weekly as evidenced by the following:
i. In September 2014, completed three of an expected four pain assessments;
ii. In October 2014, completed three of an expected four pain assessments;
iii.In November 2014, completed three of an expected five pain assessments;
iv.In December 2014, completed one of an expected three pain assessments.
The Neighbourhood Co-ordinator confirmed that the weekly pain assessments were not completed weekly as set out in the resident's plan of care.

Resident #203's plan of care indicated that the resident was to have weekly pain assessments completed every Sunday on the evening shift. The pain assessments were not consistently completed weekly as evidenced by the following:
i. In October 2014, completed none of an expected four pain assessments;
ii. In November 2014, completed two of an expected five pain assessments;
iii.In December 2014, completed two of an expected four pain assessments;
iv.In January 2015, completed two of an expected four pain assessments.
The Neighbourhood Co-ordinator confirmed that the weekly pain assessments were not completed weekly as set out in the resident's plan of care.

(506)

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in their plan.

Resident #001's plan of care directed staff to give the resident their medications crushed and mixed in applesauce. During the noon medication pass observed during this inspection, the inspector observed the registered staff member crushing the resident's medication and then proceeded to put the medications in water and thickened the water with thickener. The resident's plan of care did not indicate that the resident was on thickened fluids. The registered staff confirmed that they did not follow the resident's plan of care regarding medication administration. (506)

3. The licensee has failed to ensure that resident #004 received care to maintain and manage their continence as noted in their plan of care.

i) The document that the home refers to as the care plan for resident #004 directed staff to dress the resident in a one piece outfit to prevent inappropriate

elimination, maintain toileting routine when accepted to keep the resident continent, clean and dry, re-approach the resident when they are calm, re-approach until they accept care. The care plan also directed staff to take the resident to the wash room upon wakening, prior to and after meals and before going to bed and monitor the resident for wandering as may be looking for a bath room. Assist the resident to undress as they may be wearing a one piece.
ii) During observation of the resident on an identified day during this inspection, resident #004 was noted to be wandering around the lounge area and it was noted that they had just walked away from a pool of urine on the floor beside a sofa in the lounge area. The resident was noted to have wet pants and was noted to have a strong odour of urine. The inspector reported this to the registered staff member who was present administering medications. The inspectors returned around 1215 hours and noted that the resident was still wet and asked the registered staff about this. The registered staff member indicated that the PSW staff had attempted to toilet the resident prior to lunch but they refused. The resident was seated on a chair in the dining room at a table with another resident at that time.
At 1315 hours, the inspectors again returned and observed the resident to be still seated in the dining room. A dietary staff was noted to lead the resident from the dining room and seat them on a sofa in the lounge. The resident was noted to be co-operative at that time. The resident had still not been toileted or changed.
At 1330 hours, the inspector approached two PSW staff who were doing paperwork at the nurses' station and asked if resident #004 had been toileted. They indicated that the resident usually refused and they re-approach later. The inspector told the PSWs that the resident had been wet for almost two hours. The two PSW staff then offered toileting to the resident and the resident was noted to be co-operative. The resident was taken to the spa room by the two PSWs to provide continence care.
iii) The staff did not attempt to re-approach the resident and offer toileting as directed in the resident's plan of care. Resident #004 was not provided with continence care as per their plan of care. (167)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2015

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

1. The licensee shall ensure that the plans of care for all residents in the home who are experiencing skin breakdown are reviewed and revised as necessary to ensure that the information contained in the plan of care is current and accurate.
2. The licensee shall develop an auditing system to ensure that the plans of care for residents with skin breakdown are current.

Grounds / Motifs :

1. S.6(10)b was previously issued as a VPC on December 4, 2012 and again on February 20, 2014.

The licensee has failed to ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed.

A) Resident #200 had a stage III pressure ulcer on their coccyx on an identified date in 2014. Record review and interview with the Neighbourhood Co-ordinator confirmed that the wound was a stage III pressure ulcer and the resident's plan of care was not updated until four months later after first noted. Interview with the Neighbourhood Co-ordinator confirmed that the plan of care should have been reviewed and revised as the care set out in the resident's plan had changed.

B) Resident #203 was identified as having two skin tears, one which was identified on an identified date in 2014 and the other two weeks later. Record review indicated that the resident’s wound was not assessed again until three weeks after that. There was no treatment plan developed to manage the resident’s skin tears and it was noted that the treatment record did not include identification of the resident’s wound. Interview conducted with the Neigbourhood Co-ordinator on February 6, 2015, confirmed that the home did not review and revise the resident’s care plan when the resident’s care needs changed.

C) Resident #201 was identified as having a stage II pressure ulcer on their coccyx on an identified date in 2014. Record review indicated that the resident’s wound was not assessed again until eight days later. There was no treatment plan developed to manage the resident’s wound and it was noted that the treatment record did not include identification of the resident’s wound. Interview conducted with the Neigbourhood Co-ordinator on February 6, 2015, confirmed that the home did not review and revise the resident’s care plan when the resident’s care needs changed. (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 30, 2015

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

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
Ontario, ON
M5S-2B1
Fax: 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
Ontario, ON
M5S-2B1
Fax: 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 9th day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARILYN TONE

Service Area Office /
Bureau régional de services : Hamilton Service Area Office