Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 6, 2015	2015_322156_0003	H-001938-15	Resident Quality Inspection

Licensee/Titulaire de permis

1508669 ONTARIO LIMITED
c/o Deloitte & Touche Inc. - 181 Bay Street Brookfield Place, Suite 1400 TORONTO ON M5J 2V1

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

WEST PARK HEALTH CENTRE
103 Pelham Road St Catharines ON L2S 1S9

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

CAROL POLCZ (156), BARBARA NAYKALYK-HUNT (146), BERNADETTE SUSNIK (120), ROBIN MACKIE (511)

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): February 3, 4, 5, 6, 10, 11, 12, 13, 2015

The following complaint inspection was completed simultaneously with this inspection H-00020-14; the following Critical Incidents inspections were completed simultaneously with the inspection H-0001282-14 and H-001549-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Manager of Food Services, Manager of Environmental Services, Manager of Recreation Services, registered staff, personal support workers (PSW), dietary staff, housekeeping staff, laundry staff, recreation staff, restorative staff, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

19 WN(s)
11 VPC(s)
6 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. 15. (1)	CO #001	2014_189120_0050	156

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

(A) A review of the clinical record for resident #38 indicated their skin was intact as documented November , 2014 Head to Toe assessment. The clinical record indicated a pressure ulcer was first observed December , 2014 . January , 2015 the resident was admitted to hospital. . The January , 2015 Head to Toe assessment indicated the pressure ulcer at the identified site had progressed required a referral to a medical specialist for wound care January , 2015. Further review of the clinical record did not indicate weekly skin and wound assessments were completed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. Interview with the DOC during the inspection confirmed the home was aware of the previous Order and had not implemented a clinically appropriate skin and wound assessment tool. The DOC confirmed the home had not ensured resident #38 received a weekly skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument for their altered skin integrity. [s. 50. (2) (b) (i)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment., to be implemented voluntarily.

WN #2: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.
A) The home policy "Falls Prevention and Management Program" RESI-10--02-01 dated April 2013 indicated that "if the resident remains in the home after a fall, registered staff with the support of care staff complete the following ongoing assessment of the resident for a minimum of 72 hours after a fall: a. Each shift the resident is to be assessed for pain, bruising, change in functional status, change in cognitive status, changes in range of motion, b. Based on the assessment if the resident's condition is deteriorating registered staff contact the physician for further directions or transfer the resident to the hospital for further assessment. c. At the end of each shift, communicate the current status of the resident to the oncoming shift. d. All assessments and actions during the 72 hour post fall follow-up are to be documented in progress notes".
Resident #22 had two falls in October, 2014. As per the progress notes, there was no post fall assessment completed by the day and evening shifts between identified dates and times in October, 2015. The Administrator confirmed on February 10, 2015 that the post fall assessments were not completed as per policy as the resident was not reassessed on all shifts during the 72 hours post fall.
B) The home's skin Care Policy, 03-01 indicated that on hire and annually care staff would receive education in preventative skin care as well as wound care for registered staff. The home had approximately 109 staff members and the DOC confirmed the home had only trained 13 of their front line staff on December 18, 2014. The DOC confirmed the registered staff perform wound care and had not received education in preventative skin and wound care as of February 12, 2015. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provided direct care to residents, received training relating to abuse recognition and prevention annually, or as determined by the licensee, based on the assessed training needs of the individual staff member. See s. 76 (7)
The DOC confirmed that the home did not provide abuse recognition and prevention training in 2014. [s. 221. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 all staff who provided direct care to residents, received training relating to abuse recognition and prevention annually, or as determined by the licensee, based on the assessed training needs of the individual staff member, to be implemented voluntarily.

WN #4: 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 home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

An activation station connected to the resident-staff communication and response system was not available in the hair salon, physiotherapy room, activity room in the basement, outdoor patio or sitting/lounge areas on 1st or 2nd floors. [s. 17. (1) (e)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents, to be implemented voluntarily.

WN #5: 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).

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 for cleaning of the home.

Housekeeping procedures and cleaning routines were provided to the Inspector by the Housekeeping Supervisor and reviewed. The procedures in conjunction with the routines identified what needed to be cleaned and the frequencies. The expectations for shower, tub room, bedroom and bathroom surface cleaning was daily with spot cleaning of walls, doors, baseboards and heaters as necessary. Privacy curtains were to be checked daily for stains and laundered as necessary. Chairs and tables were to be cleaned daily during dining room floor cleaning and flooring material buffed routinely, stripped and re-waxed according to wear. During the inspection on February 11 and 12, 2015, the following sanitation issues were observed over a two day period:

A) A heavy layer of dust/dirt noted on heaters in the basement activity area, some common washrooms, tub rooms and specified bedrooms. According to the home's procedures, the surfaces were to be cleaned weekly, however the accumulated amount observed appeared to have been collecting over the course of several weeks.
B) Privacy curtains were stained in identified rooms, 2nd floor tub room 21 and 1st floor tub room 11 (which was also torn and did not provide adequate coverage).
C) A heavy layer of dust was observed in the 1st and 2nd floor tub rooms (on privacy curtain tracks, on ceiling lift motor, on walls, light covers, exhaust grilles)
D) Food scrap cart that was parked in the 2nd floor dining room was heavily coated with dust and other matter on the lower half (bottom shelf and wheels, frame).
E) The return air grille in the 2nd floor dining room was heavily coated in dust.
F) The baseboards in the sitting area adjacent to nursing station on the second floor were visibly soiled.
G) Visibly soiled bedroom & bathroom door and wall surfaces (near beds, garbage receptacles, entrance, under light switches or near hand gel sanitizing stations) noted in identified rooms.
H) Second floor dining room had visibly soiled walls throughout the room, along with soiled table legs and over 50% of the chair frames.
I) Floor surfaces noted to be marked or discoloured in identified rooms, basement activity area, physiotherapy room, dish wash area, kitchen and kitchen dried storage room. According to records and the Housekeeping Supervisor, the floors on the 1st floor had not been buffed, stripped or re-waxed since 2013 and the floors on the 2nd floor since prior to 2013. No buffing or stripping and re-waxing floor care program had been implemented at the time of inspection. Other floor tiles were permanently stained around toilets from a product that seeped into the tiles that were not sealed.
J) The oatmeal storage bin was heavily laden with dust and dirt which was stored between the steamer and a table in the kitchen.
K) A heavy accumulation of debris was observed behind and under the hot water booster of the dish machine and in the back corner. Debris was observed under the dried goods shelving which was equipped with wheels. [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 for cleaning and disinfection of resident care equipment (devices such as bed pans and wash basins) in accordance with evidence based best practices.

According to the home's Director of Care and Housekeeping Supervisor, bed pans and

wash basins were being placed in bathing tubs where a disinfectant was applied. No specific details could be provided as to how the devices were handled, washed, disinfected and dried. No cleaning and disinfection procedures were posted in the tub rooms and the Extendicare polices and procedures for these devices were general. They identified that articles such as bed pans and basins be cleaned followed by disinfection. This is in accordance with best practices literature titled "Cleaning, Disinfection and Sterilization of Medical Equipment/Devices, 2013 developed by the Provincial Infectious Diseases Advisory Committee. The document further identified that personal care devices were to be de-contaminated in a separate designated area. The home management staff allocated the tub rooms for such a purpose; however the tub rooms were also being used to bath residents and would not be considered an appropriate "de-contamination" area for cleaning and disinfecting personal care devices. The home's two soiled utility rooms were designed for such a purpose; however they were not equipped to complete adequate cleaning and disinfection of any devices. The rooms were very small and each had a hopper and a non-functioning flushing/cleaning unit for bed pans and wash basins. No sinks, cleaning supplies or disinfection supplies were in the rooms. Discussion was held with the Director of Care and Housekeeping Supervisor regarding the use of the soiled utility rooms once alterations to accommodate the process could be made. [s. 87. (2) (b)]

Additional Required Actions:

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

WN #6: 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. 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 in place for remedial maintenance.

A review of the remedial and preventive maintenance program revealed that procedures were in place for both remedial and preventive processes however schedules were not adhered to for the preventive component and schedules had not been developed to address remedial issues. The maintenance person confirmed during the inspection that two resident rooms were preventively audited but that more should have been completed during the month of January, 2015 but were not due to other priorities and time constraints. It was clear that if more rooms were audited, more areas for remedial repair would have been identified. During the inspection on February 11 and 12, 2015, the following conditions were identified:

A) Furnishings - Night tables were damaged (chipped edges with exposed particle board) in identified rooms and others were beginning to wear in identified rooms. Vanity laminate was damaged in an identified room (large piece missing) and delaminating in another identified room. Wardrobes were damaged (splintered and sharp edges/holes) in identified rooms. Door latching hardware was missing from wardrobes in identified rooms. Table bases made of wood were badly damaged in 2nd floor dining room. One high back green chair had a deeply cracked seat and a table was missing laminate around the edges in second floor lounge.
B) Flooring material was not in good condition. Tiles were missing around toilet in an identified room, deeply cracked tiles at the entrance to an identified room, a section of flooring in the first floor shower room was cracked (along half wall on shower side), a welded seam was split in the hall near an identified bathroom, several tiles were lifting in an identified room, five deeply cracked tiles were noted in an identified room, and two in another identified room, six tiles were lifting under the vanity in an identified room and cracked and chipped tiles noted in one of the two elevators.
C) Walls, door and trim surfaces - Walls were peeled down to a paper layer in identified bathrooms. A large hole was in wall under the window in an identified room. Paint had peeled off the trim for identified rooms. Paint had peeled off from door surfaces in identified rooms and doors to both dining rooms. Baseboard gouged and damaged in tub room 28.
D) Plumbing Fixtures - Bathroom cold water faucets were not in good working order in identified rooms.

E) Windows – Window sills with plastic overlay cracked or missing a piece (some covered over with duct tape) in identified rooms, second floor dining room. Window hardware missing or broken in identified rooms, second floor lounge, second floor dining room and other areas.
F) Damaged handrails were sharp, gouged or splintered in identified rooms (nails sticking out). Plastic or vinyl handrail in hall between identified rooms was badly damaged (covered over in silver duct tape). Metal corner plate applied to the corner of handrail near the medication room on first floor was loose and not secured.
G) Heaters were damaged (bent frames with sharp edges) or missing covers in identified rooms, in the hall outside an identified room, hall near the elevator and unoccupied section of building and the basement activity area.
H) Door on identified washrooms did not latch when allowed to self close. Door in an identified room was found ajar, pulled closed and found ajar 15 minutes later.
I) The perimeter of the entire length of a wall in the kitchen (with two windows) was observed to have a heavy accumulation of a black substance (presumed to be mould) on the floor tiles along the baseboard. The floor tiles appeared to be lifting under the sink and the black substance was seen in between the tiles. Staff reported that water had leaked into the area in the past through the windows and that a leak did occur under the sink. The wall is an exterior wall and may have been and may continue to be prone to moisture infiltration from the exterior contributing to the mould growth.
J) The walk-in freezer door and trim surfaces were not in good condition. It was covered in mould and peeling paint.
K) The tub located on the first floor was observed to have four distinct circular marks on the bottom and inside of the tub. The finish had become eroded in these areas, exposing the metal beneath the white finish. The trim surrounding the tub on the second floor was not smooth as the paint was peeling away, creating an area that would be difficult to clean. [s. 90. (1) (b)]

2. The licensee did not ensure that the home's mechanical ventilation systems were functioning at all times except when the home was operating on power from an emergency generator. In October 2014, one of the homes fresh air supply units failed. Documentation dated October 16, 2014, revealed that a contractor evaluated the unit and provided a quote for the required repairs. The licensee did not have the contractor scheduled to return to the home until February 17, 2015, post inspection. The unit was designed to provide mechanical ventilation to the A1 side of the building (corridors). [s. 90. (3)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.
(A) Resident #282 was observed on February 6th, 2015 to not be wearing eyeglasses. A review of the clinical record, MDS assessment dated November [redacted], 2014, indicated the resident did not wear glasses; however the Resident Assessment Protocol (RAP) of the same date indicated the resident wore glasses. Interview of the PSW providing care to the resident stated the resident did not have glasses. Interview with the MDS RAI

coordinator confirmed the two assessments were not integrated and were not consistent with and complemented each other. [s. 6. (4) (a)]

(B) Resident #301 was observed on February 6th, 2015 not wearing eyeglasses and an observation of the resident's room did not reveal glasses available in the room. A review of the clinical record, MDS assessment dated October [redacted], 2014, indicated the resident did not wear glasses; however the Resident Assessment Protocal (RAP) of the same date indicated the resident had impaired vision, wore reading glasses and was able to see large print but not regular prints in newspaper or books. Interview of the PSW providing care to the resident stated they did not recall the resident to wear glasses. Interview with the MDS RAI coordinator confirmed the two assessments were not integrated and were not consistent with and complemented each other. [s. 6. (4) (a)]

C) Resident #5 was noted in the MDS Quarterly dated October [redacted], 2014 to have had a fall within the last 30 days and the RAP indicated that the resident had fallen from the wheelchair. As confirmed with the DOC on February 11, 2015, progress notes did not indicate that the resident had a fall during this time period and post fall assessments were not completed. Staff did not collaborate in the assessments of the resident so that their assessments were integrated, consistent with and complement each other. [s. 6. (4) (a)]

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

A) A review of the clinical record for resident #23 identified the resident had a history of three falls in each month in August, September and October of 2014. The resident had a recent unwitnessed fall from the wheelchair in December, 2014. The resident's most recent falls risk assessment, called the Morse Fall Scale, was completed in December, 2014 indicated the resident was at a high risk for falls with a score of 70.0. The resident's most recent plan of care contained interventions to have a chair alarm in place to monitor the resident while in the wheelchair and to have the resident identified with a star logo as part of the home's Falls Prevention and Management program. On February 6th, 2015, the resident was observed up in their wheelchair rocking back and forward. The chair alarm was noted to be secured to the back of the wheelchair but not attached to the resident and therefore had not alarmed when the resident leaned forward in their chair, posing a risk of falling from their chair. An observation of the resident's room, chart and wheelchair did not identify a logo of a star. Interview with the RPN on the unit also observed the resident and confirmed the resident's chair alarm was not attached to the

resident and there was no falling star in place as per the resident's plan of care. [s. 6. (7)]

B) A review of resident #5's plan of care indicated the resident would receive 1 mg of Dilaudid prior to their dressing change for their wound. According to the clinical record on January 23, 2015 the resident had their dressing changed at 1615 hours. On the same date at 1829 hours the resident complained of pain and was given 1 mg of Dilaudid at that time, after the dressing change.
The clinical record indicated on February 8th, 2015 the dressing was changed at 1813 hours and the resident was noted to have tolerated the procedure "fair with some tears shed". On the same date the resident was noted to have requested pain medication at 1830 hours and was provided at 1 mg of Dilaudid at 1909 hours, after the dressing change. An interview with the DOC confirmed the home had not ensured the care set out in the plan of care was provided to the resident as specified when the resident received their pain medication after the dressing change and not before as specified in the plan of care. [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 change or care set out in the plan is no longer necessary.

A) The plan of care for resident #22 indicated that staff were to apply eye glasses to the resident; however, the resident was observed walking in the hallway on February 10, 2015 and was not wearing eye glasses. Staff confirmed that the plan of care was not current as the resident did not wear glasses any more and had not for a long time. The resident was not reassessed and the plan of care reviewed and revised when the resident's vision care needs changed or care set out in the plan in relation to vision was no longer necessary. [s. 6. (10) (b)]

B) The plan of care for resident #22 was not updated when the resident's care needs changed. The resident had a fall in October, 2014. Review of the clinical record including the post fall assessment indicated that the resident was not wearing footwear at the time of the fall. The plan of care was not updated to include the wearing of footwear. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and that those doors were kept closed and locked when they were not being supervised by staff.

A set of glass doors located between the service corridor (by the dish wash area) and a corridor leading to the activity room in the basement were not equipped with any sort of locking mechanism. The doors were in an area that could be easily accessed by residents on a daily basis and no staff were supervising the doors during the inspection on February 11 and 12, 2015. [s. 9. (1) 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 all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and that those doors were kept closed and locked when they were not being supervised by staff, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee did not ensure that elevators in the home were equipped to restrict resident access to areas that are not to be accessed by residents.

One of two elevators in the home led to an area that was not to be accessed by residents. The elevator was equipped with two doors, one of which opened onto a service corridor leading to an open concept dish wash area. No controls or mechanisms were in place to prevent the doors from opening onto the service corridors without staff intervention (key or code). Residents were observed to be riding the elevator on both February 11 and 12, 2015. [s. 10. (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 ensure that elevators in the home were equipped to restrict resident access to areas that are not to be accessed by residents, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres.

A) On February 4, 2015, inspectors in the home observed that windows in resident care areas had screens but were able to be opened further than 15 cm in identified rooms. The Administrator confirmed that the home knew about the windows being non-compliant the previous week on Friday, January 30, 2015. No strategies to mitigate the risk to residents had been taken other than to notify the environmental manager to order parts to remedy the problem. The home's environmental manager informed inspectors on February 4, 2015 at 1500 that the immediate risk would be mitigated promptly by removing the cranks from all the windows to prevent opening. On the evening of February 4, 2015, the windows on first floor had chains applied to prevent opening more than 15 cm; with all the windows being completed on February 5, 2015. The Administrator confirmed that the home had been non-compliant up to February 4, 2015 and recognized the risk to residents. [s. 16.]

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 every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents were protected from abuse by anyone.

A) The home received a written report in September 2014 from a staff person, an eye witness who, in August 2014, observed another staff person grab cognitively impaired resident #23 by the arm to push the resident away from the staff person's space, resulting in the resident falling to the floor and striking their head, The same written report indicated that the eye witness had observed the same staff person push cognitively impaired resident #200 by the arm resulting in the resident falling to the floor on an evening in July 2014. Neither resident sustained visible injury. The DOC confirmed that the alleged abuser was interviewed but the alleged abuser could not recall either incident. Two other staff confirmed that they saw resident #23 on the floor but were not present to see the actual fall. The eye witness was interviewed on February 11, 2015 and re-confirmed that the staff person was observed to push to the floor two residents on two separate occasions. The DOC confirmed that the staff person remains working in the home as of February 11, 2015. The DOC stated that the alleged abuser was provided with a copy of the home's policy related to abuse but cannot confirm that the staff person read it. The DOC confirmed that no abuse education was provided to staff in 2014. The DOC confirmed that the same staff person was named in a September 2014 letter of complaint related to verbally abusing resident #204 and received discipline for the verbal abuse. [s. 19. (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 residents were protected from abuse by anyone, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

A) The home's policy entitled "Resident Abuse - staff to resident Oper-02-02-04" stated that abuse must be reported immediately and would result in termination of employment and directed that the Administrator/Director of Care immediately terminate the employee in cases of substantiated abuse. The DOC confirmed that a report of staff to resident verbal abuse was substantiated but the staff person was not terminated. The DOC confirmed that the home's abuse policy was not followed.
B) Staff witnessed two separate incidents of staff to resident physical abuse in July and August 2014 but did not report it to the home until September 16, 2014.
C) Staff witnessed staff to resident verbal abuse in August 2014 but did not report it to the home until September 16, 2014. The DOC confirmed the above information. [s. 20. (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 there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

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 did not ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

In an interview with DOC it was confirmed the home had not evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices the home's Skin and Wound care program as required under section 48 of this Regulation. [s. 30. (1) 3.]

2. 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) Two staff reported to the home that they had observed resident #023 on an evening in August 2014 laying on the floor after a fall. There was no documentation of the fall in the health record or on the shift report. The DOC confirmed that the fall had not been documented by the staff. [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 the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to be implemented voluntarily.

WN #14: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following right of the resident was fully respected and promoted: 1. Every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

A) During an interview with resident #33 they stated a PSW came into their room early in the morning, a few weeks ago, and told them they needed to get up for breakfast. The resident stated that when they told the PSW that they wanted to sleep longer, and not get up at that time, the PSW grabbed their blanket and pulled it off them telling them to 'get up'. The resident stated they felt the PSW did not respect their right to make their own decision regarding when to get up, was not dignified to have their blanket pulled from them and was not courteous when spoken to in a loud and 'bossy' tone. An interview with the DOC confirmed the home completed and internal investigation of the incident on February 10, 2015 and the home concluded the resident's right to be treated with courtesy and dignity in a way that recognized their individuality for morning sleep routines was not respected.
B)Resident #4 stated on February 3, 2015 that they were upset that their right to maintain their privacy in their room was not being respected. The resident reported that two named residents kept coming into the resident's room several times a day and invading their right to privacy. The resident was capable of making their own decisions and had a CPS (cognitive performance scale) of 1. The resident kept the door to the private room closed, and pulled the laundry cart in front of the door to deter the residents from coming in; however, often had to yell to get the residents to leave. Progress notes indicated that the resident complained about other residents coming into the room several times. Staff interviewed reported that the resident often would yell to get others to leave the resident's private room. The home had not implemented strategies to ensure that wandering residents did not go into the room of resident #4. Inspectors overheard the resident yelling to get residents out of the room on two occasions during the inspection. Interview

with registered staff and the Administrator on February 13, 2015 confirmed that the resident's right to privacy had not been respected. (156) [s. 3. (1) 1.]

2. C) Resident #205 reported to the home on September 17, 2014 that an identified staff nurse consistently refused to give the resident water with oral medication because the resident had personal water bottles on a shelf across the room. The resident reported to inspectors on February 10, 2015 that the identified staff nurse continued to refuse to give water with oral medications. The resident stated that having to get up from the bed to get a water bottle across the room caused the resident pain. This information was confirmed by the Administrator, DOC and a direct caregiver. [s. 3. (1) 1.]

WN #15: 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 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 applies is titled "In all other areas of the home". Resident rooms and the basement activity room were observed to be dark during the inspection on February 11, 2015. One resident also identified that their room was dark when their privacy curtain was pulled.

A) Resident rooms were either equipped with a central room light fixture or a fluorescent tube light fixture over the entrance door to the room. Each bed was equipped with an over bed light. Outdoor conditions on February 11, 2015 were bright, and most rooms were too bright to take an accurate illumination reading. The curtains on the windows could not be used to block out any light as they were too thin, allowing natural light to penetrate through them. It is suspected that the illumination levels do not meet the requirements based on the position of the ceiling or wall mounted light fixtures within the rooms.

B) The basement activity area was equipped with ceiling mounted fluorescent tube lights, and approximately 3 were burnt out. A lux of 100 to 150 was achieved when standing directly under one of the fully lit fixtures. The minimum required amount is 215.28 lux throughout the space. [s. 18.]

WN #16: 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 has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.
A) During this inspection several residents were heard to complain about the cold. Resident council minutes of January 15, 2014, February 19, 2014, April 16, 2014 and November 24, 2014 indicated that residents had complained of the home being cold. There have been no resident council meetings in 2015. [s. 21.]

2. B) The end of the corridor on one side of the building, on both the 1st and 2nd floors which led to an unoccupied part of the building was 17C on both February 11 and 12, 2015. These areas were equipped with one small baseboard heater (which was on), a set of double doors to the unoccupied former retirement home, an elevator, one door to an unheated stairwell and a closed window. The area was open to residents for wandering and had 2-3 chairs for sitting. An ambient air thermometer (hygrometer) was placed in the 2 areas (on a handrail across from the window) for 1/2 hour on each day. The first floor had a thermometer hanging on the wall which also read 17C. A cold breeze was noted to be blowing into the 2 areas from under the double doors separating the long term care home from the unoccupied section of the building which was unheated. [s. 21.]

WN #17: 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 has failed to ensure that a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and his or her SDM, if any: (a) within six weeks of the admission of the resident, and at least annually after that and (b) the SDM and any other person was invited to participate in these care conferences, and (c) a record was kept of the date, the participants, and the results of the conferences.

During an interview with the family member of resident #23 it was indicated a care conference had not been held since the resident's six week post admission date in November 11, 2013. The family member indicated the home had stated they would be invited to an annual care conference but has not been contacted as of February 6, 2015, nearly one year and three months past the resident's admission date. A review of the DOC's annual care conference schedule, referenced by the home as MDC's, for November, December 2014 and Janaury 2015 confirmed the resident had not received an annual care conference as of February 6, 2015. [s. 27. (1)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (b) were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A) The home was notified on September 16, 2014 of two incidents of alleged staff to resident physical abuse regarding residents #23 and resident #200. The health records did not indicate that the SDM's were notified. The DOC confirmed on February 12, 2015 that the SDM's had not been notified. [s. 97. (1) (b)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home has a licensed bed capacity of 101 beds. In August and September 2014, the home had an interim Administrator who was on site in the home between one and two days per week until a new administrator started in early October 2014. Three managers confirmed that there was no Administrator on site for 35 hours per week during those two months and that the interim administrator was only on site between one and two days per week. [s. 212. (1)]

Issued on this 14th 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) : CAROL POLCZ (156), BARBARA NAYKALYK-HUNT (146), BERNADETTE SUSNIK (120), ROBIN MACKIE (511)

Inspection No. / No de l'inspection : 2015_322156_0003

Log No. / Registre no: H-001938-15

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

Report Date(s) / Date(s) du Rapport : Mar 6, 2015

Licensee / Titulaire de permis : 1508669 ONTARIO LIMITED
c/o Deloitte & Touche Inc. - 181 Bay Street, Brookfield Place, Suite 1400, TORONTO, ON, M5J-2V1

LTC Home / Foyer de SLD : WEST PARK HEALTH CENTRE
103 Pelham Road, St Catharines, ON, L2S-1S9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Cindy Sheppard

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To 1508669 ONTARIO LIMITED, 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_323130_0003, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(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;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that all residents at risk of altered skin integrity receive a skin assessment by a member of the registered nursing staff (ii) upon any return from hospital, (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 (iv) is reassessed at least weekly by a member of the registered nursing staff.

Grounds / Motifs :

1. Previously issued as VPC March 2013 and as an order March 10, 2014.

The licensee has failed to ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) A review of the clinical record for resident #038 indicated their skin was intact as documented on the November 4, 2014 Head to Toe assessment. The clinical record indicated a Stage 2 pressure ulcer was first observed on December 22, 2014 to the resident's right gluteal fold. On January 15, 2015 the resident was admitted with to hospital with a diagnosis of decubitis ulcer infection with osteomyelitis, The January 23, 2015 Head to Toe assessment indicated the pressure ulcer had progressed to a Stage 4 in the identified area that required a referral to a medical specialist for wound care on January 29, 2015. Further review of the clinical record did indicate weekly skin and wound assessments were completed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. Interview with the DOC during the inspection confirmed the home was aware of the previous Order and had not implemented a clinically appropriate skin and wound assessment tool. The DOC confirmed the home had not ensured resident #038 received a weekly skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument for their altered skin integrity. (511)

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

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_323130_0003, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that any policy, procedure or system that the long term care home has put in place is complied with, specifically with regards to the following: a) Falls prevention and management program regarding completion of post fall assessments during the 72 hours post fall and b) Skin and wound care program regarding completion of education and training of staff.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with

The home's skin Care Policy, 03-01 indicated that on hire and annually care staff would receive education in preventative skin care as well as wound care for registered staff. The home had approximately 109 staff members and the DOC confirmed the home had only trained 13 of their front line staff on December 18, 2014. The DOC confirmed the registered staff perform wound care and had not received education in preventative skin and wound care as of February 12, 2015. (511)

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.
The home policy "Falls Prevention and Management Program RESI-10--02-01" dated April 2013 indicated that "if the resident remains in the home after a fall, registered staff with the support of care staff complete the following ongoing assessment of the resident for a minimum of 72 hours after a fall: a. Each shift the resident is to be assessed for pain, bruising, change in functional status, change in cognitive status, changes in range of motion, b. Based on the assessment if the resident's condition is deteriorating registered staff contact the physician for further directions or transfer the resident to the hospital for further assessment. c. At the end of each shift, communicate the current status of the resident to the oncoming shift. d. All assessments and actions during the 72 hour post fall follow-up are to be documented in progress notes".
Resident #22 had two falls in October, 2014. As per the progress notes, there was no post fall assessment completed by the day and evening shifts between identified dates in October, 2014. The Administrator confirmed on February 10, 2015 that the post fall assessments were not completed as per policy as the resident was not reassessed on all shifts during the 72 hours post fall.
(156)

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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to Carol.Polcz@ontario.ca by April 1, 2015 outlining how the home will ensure that all staff are trained and retrained annually related to the prevention of abuse.

Grounds / Motifs :

1. Previously issued as a VPC March, 2014.
The licensee has failed to ensure that all staff who provided direct care to residents, received training relating to abuse recognition and prevention: annually, or as determined by the licensee, based on the assessed training needs of the individual staff member. The licensee did not provide abuse recognition and prevention training in 2014.
(146)

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee shall install an activation station that is connected to the resident-staff communication and response system in all areas that are accessed by residents including the hair salon, physiotherapy room, activity room in the basement, outdoor patio or sitting/lounge areas on 1st or 2nd floors.

Grounds / Motifs :

1. The licensee did not ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

An activation station connected to the resident-staff communication and response system was not available in the hair salon, physiotherapy room, activity room in the basement, outdoor patio or sitting/lounge areas on 1st or 2nd floors. (120)

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

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. 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 prepare and submit a plan that summarizes at a minimum the following:

1. How the licensee intends to ensure that all areas of the home will be cleaned, starting with the areas identified in the grounds below? Include who will clean the areas, when and what additional resources will be required to meet the home's housekeeping procedures and frequencies (i.e. external contracted service, additional staffing hours, equipment etc.)
2. How the licensee intends to ensure that the housekeeping procedures and frequencies will be implemented long term.

The plan shall be submitted to Bernadette.susnik@ontario.ca by April 15, 2015. The plan shall be implemented by May 31, 2015.

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 for cleaning of the home.

Housekeeping procedures and cleaning routines were provided by the Housekeeping Supervisor and reviewed. The procedures in conjunction with the routines identified what needed to be cleaned and the frequencies. The expectations for shower, tub room, bedroom and bathroom surface cleaning was daily with spot cleaning of walls, doors, baseboards and heaters as necessary. Privacy curtains were to be checked daily for stains and laundered as necessary. Chairs and tables were to be cleaned daily during dining room floor cleaning and flooring material buffed routinely, stripped and re-waxed according to wear. During the inspection on February 11 and 12, 2015, the following sanitation issues were observed over a two day period:

A) A heavy layer of dust/dirt noted on heaters in the basement activity area, some common washrooms, tub rooms and identified bedrooms. According to the home's procedures, the surfaces were to be cleaned weekly, however the accumulated amount observed appeared to have been collecting over the course of several weeks.
B) Privacy curtains were stained in identified rooms, 2nd floor tub room 21 and 1st floor tub room 11 (which was also torn and did not provide adequate coverage).
C) A heavy layer of dust was observed in the 1st and 2nd floor tub rooms (on

privacy curtain tracks, on ceiling lift motor, on walls, light covers, exhaust grilles)
D) Food scrap cart that was parked in the 2nd floor dining room was heavily coated with dust and other matter on the lower half (bottom shelf and wheels, frame).
E) The return air grille in the 2nd floor dining room was heavily coated in dust.
F) The baseboards in the sitting area adjacent to nursing station on the second floor were visibly soiled.
G) Visibly soiled bedroom & bathroom door and wall surfaces (near beds, garbage receptacles, entrance, under light switches or near hand gel sanitizing stations) noted in identified rooms.
H) Second floor dining room had visibly soiled walls throughout the room, along with soiled table legs and over 50% of the chair frames.
I) Floor surfaces noted to be marked or discoloured in identified rooms, basement activity area, physiotherapy room, dish wash area, kitchen and kitchen dried storage room. According to records and the Housekeeping Supervisor, the floors on the 1st floor had not been buffed, stripped or re-waxed since 2013 and the floors on the 2nd floor since prior to 2013. No buffing or stripping and re-waxing floor care program had been implemented at the time of inspection. Other floor tiles were permanently stained around toilets from a product that seeped into the tiles that were not sealed.
J) The oatmeal storage bin was heavily laden with dust and dirt which was stored between the steamer and a table in the kitchen.
K) A heavy accumulation of debris was observed behind and under the hot water booster of the dish machine and in the back corner. Debris was observed under the dried goods shelving which was equipped with wheels.

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2015

Order # / Ordre no : 006 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee shall complete the following:

1. Complete a maintenance audit in accordance with the established maintenance procedures of all resident rooms, ensuite washrooms, common washrooms, common spaces, dining rooms and tub/shower rooms and document the findings.
2. Establish a schedule (time frames) and the person responsible to address the maintenance issues identified during the audit along with the issues identified in the grounds below.
3. Establish a plan as to how the licensee intends to ensure that the remedial and preventive maintenance programs will be implemented long term.

The schedule and plan shall be submitted to Bernadette.susnik@ontario.ca by April 15, 2015. The remedial issues identified in the grounds below shall be implemented by July 30, 2015. Should any compliance date require an extension, contact the Inspector at least 2 weeks prior.

Grounds / Motifs :

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 in place for remedial maintenance.

A review of the remedial and preventive maintenance program revealed that procedures were in place for both remedial and preventive processes however schedules were not adhered to for the preventive component and schedules had not been developed to address remedial issues. The maintenance person confirmed during the inspection that two resident rooms were preventively audited but that more should have been completed during the month of January, 2015 but were not due to other priorities and time constraints. It was clear that if more rooms were audited, more areas for remedial repair would have been identified. During the inspection on February 11 and 12, 2015, the following conditions were identified:

A) Furnishings - Night tables were damaged (chipped edges with exposed particle board) in identified rooms, and others were beginning to wear in identified rooms. Vanity laminate was damaged in an idientified room (large piece missing) and delaminating in another identified room. Wardrobes were damaged (splintered and sharp edges/holes) in identified rooms. Door latching hardware was missing from wardrobes in identified rooms. Table bases made of wood were badly damaged in 2nd floor dining room. One high back green chair had a deeply cracked seat and a table was missing laminate around the edges in second floor lounge.
B) Flooring material was not in good condition. Tiles were missing around toilet in an identified room, deeply cracked tiles at the entrance to another identified room, a section of flooring in the first floor shower room was cracked (along half wall on shower side), a welded seam was split in the hall near bathroom 11, several tiles were lifting in identified room, five deeply cracked tiles were noted in an identified room, and two in an identified room, six tiles were lifting under the vanity in an identified room and cracked and chipped tiles noted in one of the two elevators.
C) Walls, door and trim surfaces - Walls were peeled down to a paper layer in identified bathrooms and identified bedrooms. A large hole was in wall under the window in an identified room. Paint had peeled off the trim for identified rooms. Paint had peeled off from door surfaces in identified rooms and doors to both dining rooms. Baseboard gouged and damaged in tub room 28.
D) Plumbing Fixtures - Bathroom cold water faucets were not in good working order in identified rooms.
E) Windows – Window sills with plastic overlay cracked or missing a piece (some covered over with duct tape) in identified rooms, and second floor dining room. Window hardware missing or broken in identified rooms, second floor lounge, second floor dining room and other areas.

F) Damaged handrails were sharp, gouged or splintered in identified rooms (nails sticking out) and others. Plastic or vinyl handrail in hall between identified rooms was badly damaged (covered over in silver duct tape). Metal corner plate applied to the corner of handrail near the medication room on first floor was loose and not secured.
G) Heaters were damaged (bent frames with sharp edges) or missing covers in identified rooms, in the hall outside an identified room, hall near the elevator and unoccupied section of building and the basement activity area.
H) Door on identified washrooms did not latch when allowed to self close. Door in an identified room was found ajar, pulled closed and found ajar 15 minutes later.
I) The perimeter of the entire length of a wall in the kitchen (with two windows) was observed to have a heavy accumulation of a black substance (presumed to be mould) on the floor tiles along the baseboard. The floor tiles appeared to be lifting under the sink and the black substance was seen in between the tiles. Staff reported that water had leaked into the area in the past through the windows and that a leak did occur under the sink. The wall is an exterior wall and may have been and may continue to be prone to moisture infiltration from the exterior contributing to the mould growth.
J) The walk-in freezer door and trim surfaces were not in good condition. It was covered in mould and peeling paint.
K) The tub located on the first floor was observed to have four distinct circular marks on the bottom and inside of the tub. The finish had become eroded in these areas, exposing the metal beneath the white finish. The trim surrounding the tub on the second floor was not smooth as the paint was peeling away, creating an area that would be difficult to clean. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 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 6th day of March, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : CAROL POLCZ

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