Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Feb 22, 2017	2016_414110_0010	028607-16	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

THE WILLOWS ESTATE NURSING HOME
13837 YONGE STREET AURORA ON L4G 3G8

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

DIANE BROWN (110), IVY LAM (646), JANET GROUX (606), JOVAIRIA AWAN (648), LYNN PARSONS (153), MATTHEW CHIU (565), SIMAR KAUR (654)

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): September 26, 27, 28, 29, 30 and October 3, 4, 5, 6, 7, 2016.

The following critical incident and complaints were inspected during this Resident Quality Inspection:
Complaint log #010508-15 related to inadequate home furnishings; poor food quality; lack of menu variety; posted menu not followed; housekeeping and maintenance concerns.
Complaint log #021868-16 related to plan of care not followed
Critical incident log #028936-16 related to an allegation of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, RAI & Clinical Coordinator, Environmental Services Manager (ESM), Physiotherapist, Life Enrichment Coordinator, Life Enrichment Aides, Registered Nursing staff, Personal Support Workers, Housekeeping aide, Dietary aides and office manager (OM)

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
Reporting and Complaints
Responsive Behaviours

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

- **9 WN(s)**
- **6 VPC(s)**
- **0 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 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 resident has been treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

On an identified date and time, resident #067 was observed at 1138 hours (hrs) to be sitting in his/her wheelchair in front of the first floor nursing station an identified resident home area. PSW #128 was observed approaching the resident in a specified manner, unlocking resident's wheelchair brakes and moving the resident from the lounge, down a hallway, to the resident's assigned table in the dining room in another identified resident home area. The staff member did not address or engage the resident during the interaction.

Interview with PSW #128 confirmed he/she had not spoken to the resident or acknowledged the resident with what he/she was doing. The PSW stated a specified proper way to interact with the resident and he/she should have bent down to resident #067's eye level and said we are going to lunch. The PSW confirmed his/her interaction with the resident was not respectful.

Interview with the DOC revealed that staff are expected to acknowledge residents when adjusting their wheelchair, like unlocking the brakes and prior to portering during the above mentioned interaction. The DOC confirmed that the manner in which PSW #128 interacted with resident #067 was not respectful. [s. 3. (1) 1.] (110)

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 resident has been treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity, to be implemented voluntarily.

WN #2: 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. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

During stage one of the Resident Quality Inspection (RQI), resident #002's specified care was triggered from the Minimum Data Set (MDS) assessment.

Review of the MDS assessment revealed the following conflicting information related to resident #002's specified care:
- Has the identified assistive devices.
- Has an identified health condition; does not have the identified assistive devices.
- A specified daily care for the identified assistive devices or another specified daily care for the resident.

Interview with the RAI & clinical coordinator revealed that this was a MDS coding error, and that the line for "does not have the identified assistive devices" should not have been checked off. He/she further revealed that the staff likely checked it off because they saw the first part of the sentence which was true, but they did not look at the second part that it was not.

Further review of the resident #002's current plan of care revealed that the resident has specified interventions for his/her identified assistive devices and staff should assess the resident's specified health condition daily.

Interviews with PSW #126, #122, #121, and RN #119 revealed that staff provide resident with set-up help for a specified care related to the specified health condition, and the resident would perform the care his/her own.

RN #119, RAI & clinical coordinator, and the DOC revealed that resident #002's written care plan did not provide directions on what assistance staff were to provide resident #002 regarding the specified health condition.

Further interview with the DOC confirmed that it was the home's expectation that the written plan of care for the specified care would include whether resident had the identified assistive devices, what assistance staff should provide, whether resident is able to perform the specified care and what set-up assistance staff need to provide.

The DOC and the RAI & clinical coordinator confirmed that the written plan of care did not provide clear direction to staff related to the specified care for resident #002. [s. 6. (1) (c)] (646)

2. Review of resident #002's current written plan of care, under an identified area of focus, included an intervention for three identified devices.

Review of another identified area of focus in the same plan of care revealed that two of the above mentioned devices were not included for the resident.

Interviews with resident #002, PSW #121 and #122, RN #119, RAI & clinical coordinator, and the DOC revealed resident #002 does not currently use these two identified devices. The DOC further stated one of them has never been utilized in the home.

Further interview with the RAI & clinical coordinator, and the DOC stated one of the identified devices is an intervention that was a generic, automatically populated intervention from the electronic health record library, and the staff member had not edited resident #002's plan of care specific to his/her care needs.

The DOC confirmed that the written plan of care related to resident #002's above mentioned devices did not set out clear direction to staff who provide direct care to the resident. [s. 6. (1) (c)] (646)

3. A review of resident #002's written plan of care identified the resident in the falling star program, a program for residents at risk for falls.

Record review of progress notes in resident #002's health record identified the resident had a history of falls on multiple identified dates.

Staff interviews with PSW #126 and RPN #146 confirmed the resident was at risk for falls and fall prevention interventions were in place. Staff revealed that interventions included a specified care for the resident.

PSW # 126 confirmed the specified care for the resident and an identified device was not used. RPN #146 revealed that when the specified care was provided to the resident, the identified device was used for added safety.

A review of the resident's written plan of care failed to identify the specified care and the use of the identified device for the resident.

The DOC confirmed that the written plan of care related to resident #002's fall prevention interventions did not set out clear direction to staff related to the specified care and the use of the identified device. [s. 6. (1) (c)] (110)

4. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Record review of resident #067's progress notes identified that resident #067 had identified responsive behaviours. A physician referral to the behavioural support outreach (BSO) program was initiated on an identified date. Further record review revealed that BSO was onsite, observed the resident and interviewed staff on several occasions during an identified period, and that a behavioural support services mobile support team functional assessment report, dated an identified date, was available in the home. Review of the assessment report identified the specified recommendations for resident #067.

A review of the resident's written plans of care following the BSO assessment period until an identified date, six months later, failed to identify BSO recommendations for resident #067.

Resident #067 was observed on two identified dates, in multiple time periods, sitting unoccupied in his/her wheelchair in an identified home area.

Interview with PSW #124 revealed an awareness of BSO's involvement with resident #067 and the location of the BSO's report, however was unaware of all recommendations.

Staff interviews with PSW #120 and #128 also revealed that they were unaware of all BSO recommendations. PSW #128 confirmed that all front line staff may not have received the information during shift report and may not be aware of BSO's recommendations.

Interview with RN #143 stated that once BSO completed the assessment registered staff were to share the recommendations with the nursing team at shift report and update the care plan. The RN stated that the team present at time of shift report would be aware of the BSO recommendations and that the team did not include the activation department. RN #143 further confirmed that the resident's care plan had not been updated based on the BSO recommendations.

Interview with life enrichment coordinator (LEC), who oversees the activation department, stated he/she was aware that BSO was involved with resident #067 but had not received notice or a copy of BSO's report for the resident. The LEC revealed she/he was the lead for responsive behaviours in the home up until about two years ago when BSO became the lead. The LEC confirmed there was a lack of collaboration between BSO their involvement and recommendations with residents and other departments like activation in the home .

The DOC revealed he/she believed the LEC was the lead for the responsive behaviors program, including coordination with BSO and confirmed there was a lack of collaboration between nursing and activation related to BSO's assessment and recommendations of residents whom had been referred. [s. 6. (4) (a)] (110)

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

Record review of resident #007's MDS assessments and plan of care revealed the resident had been incontinent. An identified scheduled toileting plan was put in place for the resident.

Interview with evening shift PSW #130 indicated the resident had been incontinent. The staff member did not follow the scheduled toileting plan to toilet the resident or ask the resident for toileting during a specified time period. The staff member further indicated that the resident would call for assistance when he/she wanted to go, and there was no scheduled time.

Interview with RN #119 indicated that the resident may not have had enough time to get to the bathroom and voided in his/her brief. The scheduled toileting plan had been implemented for the resident in order to promote his/her continence. Since the resident's continence care needs had not changed, staff should follow the toileting plan for the resident.

Interview with the DOC confirmed that staff should follow the scheduled toileting plan to ask the resident for toileting and assist the resident. The home had failed to ensure the schedule toilet plan set out in the plan of care was provided to the resident as required. [s. 6. (7)] (565)

6. Interview with resident #007 revealed that staff did not regularly provide a specified care to the resident and the resident would require help with the care.

Record review of resident #007's plan of care indicated the identified interventions for the specified care.

Interview with PSW #128 indicated that the staff member did not follow the identified interventions for the specified care. Interview with RN #119 indicated the resident might be able to participate in the specified care but he/she required the identified assistance and interventions for the care.

The DOC confirmed that the staff member should follow identified interventions for the specified care set out in the plan of care, and that the care was not provided to the resident specified in the plan. [s. 6. (7)] (565)

7. During stage one of the RQI, falls prevention triggered for resident #006.

Review of resident #006's clinical records revealed that the resident had a risk of falls. Records revealed resident had a fall on an identified date and resulting in an identified injury.

Record review of resident #006's plan of care revealed the identified interventions for the resident and he/she should not be left unattended during a specified care.

Interview with the PSW #123 revealed that he/she witnessed the fall on the identified date as he/she provided the specified care to the resident and left him/her unattended. The resident tried to get up and fell on the floor before the staff came back to assist him/her.

Interview with the resident revealed he/she was unable to recall the fall on the identified date.

Interview with the RPN #125 and DOC confirmed that the resident required a specified assistance and was not supposed to be left unattended during the specified care. DOC confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)] (654)

8. During stage one of the RQI, resident #002 was triggered related to incontinence.

Review of the resident's MDS assessment revealed that the resident required specified number of staff assistance for an identified care.

Review of the current PSW/HCA Daily Work Sheet on two identified dates revealed that resident #002's specified continence status and required the specified number of staff assistance for the identified care.

Review of resident #002's written plan of care revealed the specified number of staff assistance and interventions for the identified care.

Observation on September 30, 2016, revealed that PSW #107 provided the identified care to resident #002 not using the above mentioned number of staff assistance and interventions. When the resident pulled the call bell, two other staff responded provided assistance to help the resident.

Observation on October 3, 2016, revealed that PSW #107 assisted the resident with the care without using the above mentioned number of staff assistance and interventions. PSW #107 came to assist the resident on his/her own after resident #002 pulled the call bell.

Separate interviews with PSW #107, and PSW #121 revealed that they did not provide the resident with the specified number of staff assistance when providing the care. Further interviews with PSW #107 and PSW #122, separately, revealed that they are aware that according to the PSW/HCA daily work sheet, the resident required the specified number of staff assistance. According to staff this specified assistance was in the past when the resident had a specified health status.

Interviews with PSW #122, RN #119, and RAI & Clinical Coordinator revealed that the resident required the specified number of staff assistance for the care and he/she should be monitored in a specified manner that according to the resident's identified preferences.

Interview with the RAI & Clinical Coordinator further revealed that the resident's plan of care needed to be revised to clarify that.

Interview with DOC confirmed that it was the home's expectation that the staff follow the plan of care for residents as specified, and that the staff was not providing the care as set out by the resident's written plan of care when providing resident #002 with the above mentioned care. [s. 6. (7)] (646)

9. Record review of resident #002's health record including progress notes and care plan identified the resident was at risk for falls.

The written plan of care identified a fall prevention intervention that when providing an identified care to the resident, a specified number of staff assistance is required at all time. This intervention had been in place since 2014. The plan of care also identified the use of an identified falls prevention supply.

Record review and staff interview with PSW #107 identified that resident had a fall on an identified date while being provided with the identified care. PSW #107 confirmed that only one staff was present and the plan of care was not followed.

On an identified date and time, resident #002 was in an identified resident home area with PSW #126. PSW #126 completed the identified care with the resident and was interviewed. PSW #126 confirmed that he/she had toileted resident #002 on his/her own. PSW further confirmed that he/she removed the resident's identified falls prevention supply and the resident was not using it. RPN #146 later confirmed that resident #002 was not using the identified falls prevention supply.

An interview with the DOC confirmed that resident #002 was at risk for falls and that staff #107 and #126 had not provided care as set out in the plan of care for the resident. [s. 6. (7)] (110)

10. Record review of the 'Residents Life Enrichment Admission Assessment' identified that resident #067 was interested in a variety of identified activities and had an identified past interest.

A review of resident #067's written plan of care stated the specified directions for the

resident to attend activities.

Record review of residents health record, progress notes identified that at the post admission conference, resident's SDM requested certain identified activities for the resident #067. A report from BSO dated an identified date, two months later, stated a specified comment related to getting stimulation for the resident. A further progress note on an identified date six months later from the DOC revealed that the resident's SDM had a request related to the resident's activities.

Staff interview with PSW #124 revealed that resident was social when he/she came into the home and now does not attend many programs.

Record review of the Program Calendars for two identified months revealed three identified programs.

Resident #067 was observed prior to and during these three programs that he/she was not invited/encouraged or taken to the programs, while some other residents sitting along with resident #067 were invited.

Interviews with life enrichment aides #144 and #145 confirmed they had not invited resident #067. Interview with LEC confirmed that resident #067 should have been invited to the three identified programs.

Record review of resident #067's 'multi—month participation report' for an identified four-month period identified that resident #067 was not attending all programs of interest. Interview with the LEC confirmed that resident #067 should have been invited and encouraged to attend more programs of interest and that the resident's plan of care was not followed.

The DOC confirmed that resident #067 should have been invited to the identified programs, that the resident's plan of care was not followed. [s. 6. (7)] (110)

11. The licensee failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care.

Interview with resident #007 revealed that staff did not regularly perform an identified care to the resident and the resident would need help with doing it.

Record review of resident #007's plan of care indicated the specified directions for the identified care.

Interview with PSW #128 indicated he/she did not follow the specified directions for the care. The staff member confirmed he/she had access to the resident's plan of care and was not aware of its contents related to the specified directions, and therefore he/she did not assist the resident.

Interview with the DOC confirmed the expectation for direct care staff was to read the resident's plan of care and be aware of its contents, but the staff member was not. [s. 6. (8)] (565)

12. The licensee failed to ensure the resident's plan of care was reviewed and revised when the resident's care needs changed and care set out in the plan of care was no longer necessary.

This inspection was initiated from stage one related to misplacement of the call system for resident #009. Stage two observations and staff interviews revealed the resident does not use the call bell in an identified resident home area.

Record review of resident #009's progress notes MDS assessment identified that the resident required a specified intervention and device for continence care. The progress note stated the care plan was updated. Record review of the PSW/HCA Daily Work Sheets for resident #009 did not indicate the specified intervention for continence care. Record review of the resident's current plan of care indicated another specified intervention for the resident's continence care.

Interviews with PSW #137 and #115 revealed resident #009's continence care needs had changed requiring the specified intervention and device as mentioned in the progress notes and MDS assessment. PSW staff further confirmed that the intervention stated in the plan of care was not received by the resident.

Interview with registered staff RPN #117 revealed resident #009 was provided with the specified intervention and device for continence care as mentioned in the progress notes and MDS assessment. RPN #117 further revealed he/she was unable to demonstrate directions available in the plan of care to staff for the provision of resident #009's

continence care. RPN #117 confirmed the plan of care for resident #009 did not reflect the current continence care provided to the resident by staff.

Interview with the DOC stated the home's expectation for each resident's plan of care was to reflect the current care provided to residents and staff were expected to provide care as set out in the care plan. The DOC acknowledged the plan of care interventions did not reflect the current provision of continence care by staff for resident #009. The DOC further acknowledged the plan of care for resident #009 had not been reviewed and revised when the resident's continence care needs changed. [s. 6. (10) (b)] (648)

10. The licensee has failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective.

Review of resident #004's plan of care and progress notes revealed that the resident had physical and cognitive impairments and was at risk for falls. The resident fell on three identified dates and sustained two identified injuries from two of the falls.

Further review of the falls prevention plan of care indicated the identified interventions were put in place for the resident and had not been revised after the last two falls.

Interviews with PSW #114 and #115 indicated they were not aware of changes in the resident's falls prevention plan of care for the last couple of months. Interviews with RN #119 and the PT indicated the resident's physical functions had declined. After the first fall, a post-fall assessment conducted by the PT indicated the resident was referred to restorative walking program. Since then, the resident fell again, and the staff members further indicated that the falls prevention plan of care had not been effective and the resident kept falling.

Interviews with RN #119 and the DOC confirmed the plan of care for the resident's fall prevention was not revised when the care set out in the plan had not been effective. [s. 6. (10) (c)] (565)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: 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 is complied with.

Record review of a memo to staff regarding "Falling Stars – Falls Prevention Program" dated June 7, 2016, revealed that the falling star program was put in place to heighten staff awareness of residents who are at risk for falls. A large laminated star should be placed on the resident's wheelchair or walker to signify risk for falls.

Review of resident #004's plan of care and progress notes revealed the resident had physical and cognitive impairments and was at risk for falls. The resident fell on three identified dates and sustained two identified injuries from two of the falls. Further review of the plan of care revealed the resident was identified with the falling star program.

On September 29, and 30, 2016, the inspector observed that resident #004 was sitting

on a wheelchair in the common area. The resident's wheelchair did not have a laminated star to identify the resident with the falling star program.

Interviews with PSW #116, RN #119 and the DOC indicated the procedure for identifying a resident with the falling star program includes attaching a laminated star to the resident's wheelchair. The staff members confirmed that resident #004 was identified with the falling star program and his/her wheelchair should have the star to alert staff with the resident's risk for falls, but it was not done as required. [s. 8. (1) (a),s. 8. (1) (b)] (565)

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

Record review of the homes' policy "Managing Responsive Behaviours" # SM-1.4 effective date, July 2013, referred to staff ensuring each resident that has been identified to have potential or actual responsive behaviours shall be immediately referred to a physician or other individual specializing in psycho-geriatric medicine, e.g Behavioural Support Nurse, Nurse Practitioner. The policy continued to state the following direction: Point #3 the multidisciplinary care team shall review the nursing care plan for each resident that has been identified to have potential or actual responsive behaviours to ensure each actual or potential behavioural trigger has been detected, discussed and appropriate supportive measures and BSO interventions have been put in place.

Point #5 the nursing care plan shall identify the resident's behavioural triggers and be reflective of the individualized supportive measures and BSO strategies that are provided to manage these triggers.

Record review of resident #067's physician orders identified an order referring the resident to the BSO program. Record review further revealed that BSO was onsite, observed the resident and interviewed staff on several occasions during an identified period, and that a behavioural support services mobile support team functional assessment report, dated an identified date, was available in the home. The assessment report was located in a BSO binder at the nursing station. The report stated a specified comment related to getting stimulation for the resident and included recommendations for the resident's activities.

Interviews with RN #143 and LEC confirmed that the plan of care had not been updated to reflect BSO's recommendations and that the multidisciplinary team, including activation was not notified of made aware of the BSO report and interventions, contrary

to the home's policy.

An interview with the DOC confirmed the home's policy "Managing Responsive Behaviours" policy #SM-1.4 was not followed as required. [s. 8. (1) (b)] (110)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place related to the Falling Stars – Falls Prevention Program and Managing Responsive Behaviours are complied with, 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 :

The licensee has failed to ensure that the home had a resident-staff communication response system that was easily accessed and used by residents at all times.

During stage one of the RQI, on an identified date, inspector observed that resident #003's call bell was not accessible to him/her while sitting in a reclining chair by the window.

During multiple observations of resident's room, the call bell was not observed accessible to him/her. Two days later, resident #003 was observed sitting on a recliner chair in his/her room besides the window watching television. The call bell was hanging near the head board of resident's bed on the other side of the room. During another observation on the following day, the call bell was observed tied into resident's bed frame, while resident #003 was sitting on a recliner chair on the other side of the room.

Record review of resident #003's plan of care stated the specified interventions related to the call bell use.

Interview with the resident #003 revealed he/she frequently does not have access to the call bell. It is only once in a while he/she has the call bell within reach.

Interview with the PSW #110 confirmed that he/she forgets at times to place the call bell within reach of resident but it should be accessible to resident as he/she required specified assistance for transfers.

Interview with the RN #112 and DOC indicated the home's expectation is to have the call bell accessible to resident #003 when the resident is in his/her room. [s. 17. (1) (a)] (654)

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 had a resident-staff communication response system that was easily accessed and used by residents at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

The licensee has failed to ensure that hazardous substances were kept inaccessible to residents at all times.

During Stage one initial home tour, it was identified that the second floor dirty utility closet was unlocked. Disinfectant chemicals were observed in an exposed cabinet under the sink. Two chemical bottles labelled 'oxivir' were observed open with a clear pipe running up to the sink. The bottles were noted to be partially full of chemicals, exposed to air, and in plain view.

Observations conducted on September 26 and October 5, 6, 2016, identified the second floor dirty utility room in the east hallway unlocked, with the key in plain view. The utility room was observed with disinfectant chemicals stored in an exposed cabinet under the sink. Two bottles labelled 'oxivir' were noted open with a clear pipe running up to the sink.

Observation and interview with PSW staff #138 on an identified date revealed the dirty utility room in the east hallway on the second floor was unlocked with the key to the room inserted in the doorknob. During this observation period, PSW #138 acknowledged the two bottles of disinfectant 'oxivir' chemical under the sink with the cabinet area exposed. PSW #138 reported the room was to be locked when staff were not using it. PSW #138

confirmed the room had been unlocked at this time.

Interview with ESM revealed the dirty utility room in the east hallway was expected to be locked at all times. Observation of the key hanging on the door frame, and the two bottles of 'oxivir' disinfectant under the sink in the exposed cabinet were acknowledged by the ESM. The ESM confirmed the improper storage of hazardous chemicals posing a risk to residents related to the accessibility of the key to the room on the door frame. ESM further revealed the home's expectation was to lock the door when not in use by staff.

Interview with the DOC revealed the home's expectation for the all utility and storage areas with hazardous chemical storage was to restrict resident access by keeping doors locked when not in use by staff. The DOC further confirmed the improper storage of the 'oxivir' disinfectant cleaner under the exposed sink in the second floor east hallway utility room posed as hazardous risk to residents due to the accessibility of the key to the room on the door frame. [s. 91.] (648)

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 hazardous substances were kept inaccessible to residents at all times, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the

Infection Prevention and Control program.

Review of a complaint received by the MOH reported concerns regarding multiple identified care and home's services issues.

Interview with the SDM revealed he/she had concerns about the home's infection control practices. He/she stated that on an identified date, he/she observed RPN #147 performed an identified inappropriate action while administering medication to an unidentified resident.

Interview with RPN #147 revealed he/she has done it and confirmed it was an infection control issue. He/she further revealed the appropriate action specified by the home's practice.

Interview with the DOC confirmed above mentioned inappropriate action was against the home's practice and confirmed it was an infection control issue. [s. 229. (4)] (606)

2. The inspector observed the hand sanitizer dispensers located by the main entrance of the home non-functioning on September 27, 2016, at 0905hrs and on September 28, 2016, at 0845hrs. On September 29, 2016, a third observation was completed along with the OM.

Interview with the OM revealed it is the home's practice to ensure all hand sanitizer dispensers are functioning at all times.

Interview with the ESM revealed it is the home's practice to monitor and ensure all hand sanitizers are functioning and confirmed this was not done [s. 229. (4)] (606)

3. During the initial home tour of the RQI, Inspector observed the following: September 26, 2016, at 0930 hrs.

First floor shower room:
Observed unlabeled items on shelf in washroom: Two unlabeled used razors and one container of unlabeled shaving cream.

Second floor tub room:

Observed that there were three nail clippers sitting on top of cupboard in a clear re-sealable bag – one nail clipper was labelled with resident #023's name and an identified room number and the other two nail clippers were labeled with two other identified room numbers scratched into the metal.

October 3, 2016, at 0917 hrs. First Floor shower room:
Observed two unlabeled used razors and one container of unlabeled shaving cream on the shelf.

Second Floor Tub Room:
Observed three nail clippers (one labeled with resident #023's name and room number and the other two nail clippers labeled with two different resident rooms) stored in a plastic bag with an unlabeled nail stick and emery board sitting in front of the nail clipper storage organizer.

October 6, 2016, at 1141 hrs.
Second floor tub room:
In the nail clipper organizer on 2nd floor tub room:
Three identified drawers – each drawer had one nail clipper labeled with an identified room number, with no labeled name
Another identified drawer – a nail clipper with specific resident's name. A second smaller nail clipper labeled with specific resident's name and one piece of cut nail in the drawer
Another identified drawer – no nail clipper
Another identified drawer – nail clipper labeled with an identified room number on one side and a specific resident's name on the other side.

Interview conducted with PSW #122 confirmed that the two razors found on the first floor shower room are used razors. He/she confirmed that it is the home's expectation that razors are labeled and stored in residents' rooms, not the shower room. PSW #122 proceeded to discard the razors.

Interview conducted with PSW #110 confirmed it is the home's expectation that the nail clippers are stored in the labeled drawers with specific room numbers in the tub room. He/she confirmed that these nail clippers should not be put together in a bag and should not be used for residents. He/she revealed that these are extra nail clippers, as the individual drawers with the two identified room numbers already have nail clippers in them. He/she stated that these are extra nail clippers but they should not be stored in a plastic re-sealable bag in the tub room. PSW #110 proceeded to remove the plastic bag

of nail clippers and revealed that she will discard them.

Interview with the DOC revealed that it is the home's expectation for disposable razors to be thrown out after each use in the sharps container. The DOC further revealed that each resident should have their own shaving cream canister, and that they should be labeled. The DOC revealed that there is a nail clipper organizer labeled with each resident's room numbers in each tub room. He/she revealed that it was the home's expectation that residents' nail clippers are labeled with residents' names, and they are to be stored in their specific drawers in the nail clipper organizer.

The DOC confirmed that staff members were not following the home's process for handling residents' personal use items. [s. 229. (4)] (646)

4. During observations of medication administration passes on two identified dates, RPN #113 and #125 were observed giving medication to some residents by using medication cup and spoon. On multiple occasions, RPN #113 and #125 administered medication to residents in an identified manner that the spoons were being contaminated.

Interviews with the RPN #125 and DOC confirmed that the spoons used for the medication administration should not be kept and used as mentioned above to prevent cross contamination. The DOC confirmed that the staff did not participate in the implementation of infection control program. [s. 229. (4)] (654)

5. During the initial facility tour in stage one of the RQI, the hand sanitizer dispenser in the common bathroom used by residents on the first floor was observed to be empty and non-functional. Subsequent observations made through September 27-30, 2016, and on October 4, 6, and 7, 2016, identified the same hand sanitizer remained empty and non-functional.

Interview with the environmental services manager (ESM) #109 revealed the hand sanitizer had not been refilled by housekeeping staff, and confirmed the staff did not have access to hand sanitizer when providing resident care in the common bathroom on the first floor. The ESM #109 confirmed staff were unable to perform hand hygiene as required in common bathroom used by residents on the first floor.

The home failed to ensure staff were able to participate in the implementation of the infection prevention and control program related to the empty and non-functional hand

sanitizer in the first floor shared resident bathroom. [s. 229. (4)] (648)

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 staff participate in the implementation of the Infection Prevention and Control program, 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

During stage one observations, the shared bathroom for residents #002 and #008 was identified for a lingering smell of urine during observations completed on September 27 and 28, 2016.

Multiple and continuous observations for the same bathroom on September 29, 30, October 03, 04, and October 5, 2016, identified a persistent lingering urine odour throughout the inspection period.

Record review of the September 2016 deep cleaning scheduled identified the bathroom was deep cleaned on September 19 and 21, 2016. Review of the home's Environmental Services manual did not identify a policy or process to manage incidents of lingering offensive odours.

Interviews with PSW #107, housekeeping staff #101 and the ESM #109 confirmed a persistent lingering urine odour in the bathroom, and indicated they were unaware of the persistent urine odour prior to this inspection.

Interview with resident #002 revealed he/she was aware of the persistent lingering odour in the bathroom. Resident #002 described the odour as unpleasant.

Interviews with housekeeping staff #101 and ESM #109 revealed housekeeping was unaware of the urine odour in the bathroom. Both staff #101 and ESM #109 confirmed the presence of the urine odour in the bathroom during the inspection period. Interviews with staff #101 and ESM #109 were unable to demonstrate the lingering persistent urine odour in the bathroom had been resolved, and that a process to address persistent lingering odours in resident bathrooms was available. [s. 87. (2) (d)] (648)

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. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

The licensee has failed to ensure that procedures are developed and implemented to ensure that, all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

During the RQI, the following concerns were identified in three resident washrooms:
On September 27, 2016, inspector observed that:
- In the washroom of room A, the grab bar by the toilet was observed to be rusty with the top of the bar feeling rough, and the coating peeling off at both ends of the grab bar.
- In the washroom of room B, the grab bar across from the toilet was loose.
On September 28, 2016, inspector observed that:
- In the washroom of room C, the towel bar across from the toilet was loose.

Follow-up observations on September 28, 29, 30, and October 3, 2016, revealed these items remained the same as indicated above.

Interviews with PSWs #122, #126, and #127, revealed that, if they had noticed any issues that needed repair or maintenance in the home, including grab bars and towel bars in resident washrooms, they would write it in the maintenance book at the nursing station, or would verbally tell the maintenance staff. Interviews with PSWs #122, #126, and #127 further revealed that they have not noticed any loose or corroded grab bars or towel bars in resident washrooms.
Reviewed second floor maintenance book from December 5, 2015, to September 22, 2016, – did not see issues observed above to be noted.
Interview with Maintenance staff revealed that it was not on the monthly checklist to check the grab bars and towel bars in residents' washrooms, and that he/she would only check it if it was reported. When shown the grab bars and towel bar, PSWs #122, Maintenance staff, and ESM confirmed that: The grab bar by the toilet in room A's washroom was scratched with the coating peeled; the bar across from the toilet in room B's washroom was loose from the wall; and the towel bar across from the toilet in room C's washroom was loose from the wall.

The ESM and maintenance staff confirmed that the above mentioned items should be repaired. Further interview with ESM and maintenance staff, confirmed that the home did not have a schedule to routinely examine washroom fixtures, including grab bars and towel bars, to ensure that they are maintained and kept free of corrosion. [s. 90. (2) (d)] (646)

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the complaint had been investigated and

resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint.

Review of a complaint received by the MOH reported concerns regarding multiple identified care and home's services issues.Review of a letter from the SDM indicated one of his/her concerns was resident #056's missing identified assistive devices.

Interview with the SDM revealed he/she gave the above letter to the home on an identified date. Interviews with the ED and DOC indicated they did not receive the above letter.

Review of resident #056's progress notes revealed documentation on three days before the identified date that resident #056's identified assistive devices were missing. Further review of a document entitled "shift to shift report" -2nd floor-May 12, 2015, indicated resident #056's identified assistive devices were missing.

Interviews with the RAI Coordinator, RN #102 and RN #136 revealed they had received a verbal complaint from the SDM of the missing identified assistive devices and confirmed that the follow up to locate the missing identified assistive devices was not initiated immediately.

Interview with the ED confirmed it is the home's practice to follow up on any concerns immediately and to inform the POA of their follow up action. The ED further confirmed that the verbal complaint received by the above mentioned staff had not been responded to in 10 business days as required. [s. 101. (1) 1.] (606)

2. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response had been made to the person who made the complaint, indicating:
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

Review of a complaint received by the MOH reported concerns regarding multiple identified care and home's services issues.

Review of a letter from the SDM indicated one of his/her concerns was resident #056's missing identified assistive devices.

Review of resident #056's progress notes revealed documentation on an identified date that resident #056's identified assistive devices were missing. Review of a document entitled "shift to shift report" -2nd floor-May 12, 2015, indicated resident #056's identified assistive devices were missing. Further review of this document revealed the identified assistive devices were found seven days later. The progress notes did not indicate any documentation that the SDM was informed that the dentures were found.

Interview with the SDM revealed he/she gave the above letter to the home on an identified date, was not informed of the outcome of the home's follow up and that the dentures had been found.

Interview with the RAI Coordinator, RN #102 and RN #136 revealed they were unable to remember what follow up was initiated because the incident occurred a long time ago and confirmed that they did not recall the SDM being informed. [s. 101. (1) 3.] (606)

3. The licensee has failed to ensure that (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Review of a complaint received by the MOH reported concerns regarding multiple care and home's services issues.

Review of a letter from the SDM indicated one of his/her concerns was resident #056's missing identified assistive devices.

Review of resident #056's progress notes revealed documentation on an identified date that resident #056's identified assistive devices were missing. Review of a document entitled "shift to shift report" -2nd floor-May 12, 2015, indicated resident #056's identified assistive devices were missing. The home was unable to provide any other documents regarding the missing identified assistive devices.

Interview with the RAI Coordinator, RN #102 and RN #136 revealed the home's practice is complete a documented records of any concerns they receive and confirmed this was incomplete.

Interview with the ED and DOC revealed a documentation record is kept of any concern received by complainants. [s. 101. (2)] (606)

Issued on this 24th day of February, 2017

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

Original report signed by the inspector.