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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 20, 2016	2015_327570_0031	032922-15	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE PORT HOPE
360 Croft Street PORT HOPE ON L1A 4K8

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

SAMI JAROUR (570), JULIET MANDERSON-GRAY (607), KELLY BURNS (554), MEGAN MACPHAIL (551)

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): November 30, December 1 -4 and December 7-10, 2015

The following intakes were included in this inspection: 007370-15, 022850-15, 031931-15, 033154-15, 033678-15, 033858-15 and 033962-15.

During the course of the inspection, the inspector(s) spoke with Residents, Residents' Council President, Representative of Family Council, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Registered Dietitian (RD), Dietary Manager, Dietary Aide, Housekeeping Aide, Environmental Services Supervisor, Maintenance Person, Physiotherapist (PT), Programs Manager, RAI-MDS Coordinator, Acting Assistant Director of Care (ADOC), Acting Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspectors toured the home, conducted dining room and resident care observations, observed medication administration and drug storage areas, reviewed resident health care records, observed and reviewed infection control practices, reviewed Residents and Family council minutes, applicable home policies, the home's complaint record, reviewed staffing schedules including Registered Nurses coverage.

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
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
11 [redacted]**WN(s)**
5 [redacted]**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. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (a), by not ensuring the home, furnishings and equipment are kept clean and sanitary.

The following observations were made during the dates of November 30, December 01, to December 04, 2015:

-Toilets – dark brownish staining was observed at the base of the toilet (stool) and around the surrounding flooring in five resident washrooms and one communal washroom.

- Carpets – dark staining was observed throughout the hallways in various resident home areas.

-Flooring: visible dust and debris was observed along laminate flooring where the flooring seams have been cracked and or split (need of repair); observed in resident rooms, spa rooms in August home area, the Penryn small activity room; in communal washrooms located on Mowat home area; as well as dark brown staining was observed on two residents' rooms flooring in Mowat;

- Vents: ceiling vent in one resident room on Mowat; as well as the Central Activity room (2nd floor) were observed to have dark greyish-black film along vent and surrounding ceiling;

- Tubs: were observed to have blackish staining inside the tub (on the acrylic surface) in spa room #1216.

Environmental Services Supervisor indicated (to the inspector) the following:
- The carpeting within the resident home areas spot cleaned on a nightly basis and deep cleaned semi-annually; Environmental Services Manager indicated that the staining on the carpets are permanent;
- No awareness of the soiling around base of toilets and flooring or inside the tubs;
- There should not have been dirt or debris on floors within the home, as resident room and washroom floors are cleaned on a daily basis.

Environmental Services Supervisor indicated that the expectation is the home be kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made during the dates of November 30, December 01, to December 04, 2015:

- Walls: observed scuffed (black marks), chipped paint, gouged or having damage (holes) in the Central Activity Room (located on the second floor); in dining rooms on Penryn, Mowat, Sylvan and Augusta; throughout hallways in resident home areas (Penryn, Mowat, Augusta and Sylvan); communal washrooms (Penryn, Augusta and Mowat); and in several resident rooms or washrooms located in all resident home areas.

- Flooring: the flooring seams of the laminate flooring was observed split or cracked in several resident washrooms located in resident home areas on Augusta and Mowat; in the activity room/greenhouse located on Penryn; communal washroom on Mowat; spa rooms #1218, 2216, 2218; and in the Central Activity Room (located on the second floor);

- Doors: the laminate cover (door guard) was observed to be chipped and cracked upon entry to spa room #1116; as well as the wooden door in the communal washroom on Augusta was chipped (porous surface); and two resident rooms located in Augusta; washroom doors were found difficult to open in three residents' washrooms in Augusta and Sylvan;

- Windows: missing handles (window opening crank) in dining rooms (Penryn, Sylvan, Augusta and Mowat) and in the bench sitting areas in hallways on Sylvan; it is to be noted that the area near the bench area lounge on Sylvan was extremely cool on November 30, and December 01-02, 2015 as cold air was blowing through the slightly ajar window in which there was no window handle to close it (this was brought to the attention of Personal Support Workers on November 30, 2015 and to the Environmental Services Supervisor on December 04, 2015);

- Ceiling Tiles: observed to have staining (query water damage) in five resident rooms on Sylvan and Mowat resident home areas.

- Tub: the acrylic surface of the tub was observed chipped in spa room #1218;

- Counter-Top Laminate: was observed chipped and worn in the Central Activity Room; in the dining rooms located on Sylvan and Mowat; and on the nursing station desk (outside edges) on Mowat;

- Window: the hallway window screen on Mowat was observed torn;

- Courtyard: the concrete walkway (off of Mowat dining room) was observed cracked; the walkway surface was observed uneven (such poses a trip/falls hazard);

- Carpet : was separating at the seam and lifting outside of one resident room in Penryn home area;

Interviews with Personal Support Workers, Housekeeping Staff, Registered Practical Nurses, Maintenance Person and the Environmental Services Supervisor all indicated that any maintenance repairs or deficiencies are to be written in the Maintenance Request Log (binder) so that the maintenance department is aware of issues needing repair.

A review of the Maintenance Request Logs, for the period of September 01, through to December 03, 2015, on all four home areas failed to provide documented evidence that the above required maintenance repairs/deficiencies were communicated by staff.

The Environmental Services Supervisor and the Maintenance Person indicated (to the inspector) the following:
- Environmental Services Supervisor, who oversees the operations of environmental services within the home (which includes maintenance) indicated no awareness of the day to day repairs required within the home, indicating she leaves such to the Maintenance Person;
- Maintenance Person indicated (to the inspector) he is only aware of areas needing repair if staff place a request in the maintenance request log; Maintenance Person indicated that the day to day maintenance repairs, such as scuffed, chipped or damaged walls, door frames or doors, chipped laminate counter tops are fixed as time permits; Maintenance Person indicated that the priority for repairs are those that pose a safety risk to residents or staff;
- Maintenance Person, as well as the Environmental Services Supervisor both indicated that there was no rationale for windows in the home not to have handles (opening cranks) and that such were missing upon their hire earlier this year; both indicated the

home doesn't have enough window cranks for replacement in resident rooms, hallways or dining rooms that do not have the window handles;
- Both indicated that the home does hire an external contractor to re-seal the floors when they are aware of flooring issues (e.g. cracked or split seams); the maintenance person indicated that he is aware of the floors in general needing to be re-sealed but not specifically of any identified resident rooms, washrooms or spa areas.

The Environmental Services Supervisor indicated (to the inspector) that the expectation is that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

3. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring the home's call system equipment are maintained in a safe condition and in a good state of repair.

On December 1, 2015, inspector #607 noted the call pad in the bedroom attached to bed not functioning in a resident room Penryn home area.

On December 1, 2015, inspector #570 noted in a resident's bathroom, in Sylvan home area, that the call bell cord was wrapped around the side bar next to toilet preventing the activation of the call bell system when pulled. RPN #134 indicated to inspector #570 that the call bell system cannot be activated in bathroom when wrapped around the grab bar and staff will monitor to ensure it is not wrapped.

On December 2, 2015, inspector #570 noted the call bell system was not functioning when activated from hand held controller attached to bed in a resident's room in Mowat home area. RPN #135 confirmed it is difficult to activate call bell as it requires several attempts to activate the system and indicated the cord will be replaced.

RPN #105 PSW #129 and PSW #137 indicated they do not check if call bells are in working order and they are unaware who is responsible to check if the call bells are in working order. PSWs indicated that they keep call bells within reach when residents are assisted to bed.

During an interview, Environmental Services Supervisor indicated that the home had a system in place to check on call bells on monthly basis and that has not been done as she was not aware of the policy until recently when it was brought forward. The Environmental Services Supervisor indicated that nursing staff should check the call

system on every shift as per policy.

Review of Extendicare policy related to Nurse Call System #RESI-08-02-01 provided to inspector by the Environmental Services Supervisor directs Registered Staff and Health Care Aide to:
- Check call system every shift to ensure call bell has not been disconnected and remains operational.
- Reports non-functional bells to maintenance for immediate repair.
- Documents checks of call system on Daily Care Record.

The Environmental Services Supervisor indicated (to the inspector) that the expectation is that the home's call system equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that procedures are developed and implemented for
- cleaning of the home including toilets, carpets, flooring, vents and tubs are kept clean and sanitary;
- maintaining the home, furnishings and equipment, including call system equipment, in a safe condition, and in a good state of repair, to be implemented voluntarily.

WN #2: 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 failed to comply with LTCHA, 2007, s. 20 (1), by not ensuring the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home's policy, Resident Abuse-Staff to Resident (#OPER-02-02-04) directs that all staff who have reasonable grounds to suspect that resident abuse has occurred is to immediately report such to the Administrator, Director of Care or designate (e.g. supervisor); the policy indicates that in Ontario, anyone who suspects or witnesses abuse are responsible under the LTCHA (Long Term-Care Homes Act) to report such to the Ministry of Health and Long Term Care (Director) using the ActionLine.

The home's policy, Resident Abuse-Staff to Resident, directs that the Administrator, Director of Care or designate that upon notification, will confirm that the resident is safe; provide emotional support for the resident; provide to the substitute decision maker (immediate if physical injury and or distress); notify police immediately if the abuse if a criminal offence has occurred; initiate an internal investigation and complete a preliminary report before going off duty; document pertinent details of the investigation, actions taken during the investigation and any actions taken as a result of the outcome of the investigation.

The home's policy, Resident Abuse-Staff to Resident, further directs that the Administrator or Director of Care will advise the employee that there has been a report of suspected or witnessed abuse toward a resident; and will immediately remove the employee from the work schedule with pay pending the investigation.

Related to Intake #031931-15, for resident #024:

The Acting Director of Care (formerly Assistant Director of Care) submitted a Critical Incident Report (CIR) to the Director on specified date and time, specific to witnessed incident of staff to resident verbal abuse; the incident was said to have occurred six days earlier.

The CIR indicated that Personal Support Worker (PSW) #113 was assisting PSW #112 with care of resident #024; PSW #113 indicated (to a Registered Nurse) that PSW #112 had an inappropriate verbal outburst toward resident #024 with an angry tone.

The Acting Director of Care (DOC) indicated (to the inspector) that Registered Nurse-

Charge Nurse #114 did not report the witnessed incident of staff to resident verbal abuse to her until six days later; DOC indicated that RN #114 overheard PSW #112's inappropriate verbal outburst toward resident #024 but failed to report the abuse incident. Registered Nurse, Charge Nurse #114 indicated (to the DOC) that she was going to report the abuse incident but had gotten busy. (as indicated by Written Notification #3)

The Administrator indicated (to the inspector) that during investigation of the abuse incident, it was determined that both RN-Charge Nurse #128 and Registered Practical Nurse-Unit Supervisor #115 had overheard the verbal outburst by PSW #112, but it was RN-Charge Nurse #114 that intervened.

Following a review of the home's investigation notes (provided to the inspector) and interviews with Personal Support Worker #112, Director of Care and Administrator, specific to the witnessed incident of staff to resident verbal abuse of resident #024, the following provides evidence that the home's policy, Resident Abuse-Staff to Resident was not complied with:

- A witnessed incident of staff to resident verbal abuse was not reported to the Administrator, Director of Care or designate despite PSW #113, RPN #115 and RN #114 witnessing the abuse incident;
- Substitute Decision Maker (SDM) of resident #024 was not notified of the witnessed verbal abuse incident until six days after the incident despite registered nursing staff being aware of the abuse incident.
- Registered Nurse #114 (nor RPN #115) did not provide any written documentation of the abuse incident prior to leaving their scheduled shifts on the date of the incident. [s. 20. (1)]

2. Related to Intake #022850-15, for resident #048:

The Acting Director of Care (formerly Assistant Director of Care) submitted a Critical Incident Report to the Director, on specified date and time, specific to witnessed incident of staff to resident verbal/emotional abuse; the incident was said to have occurred three days earlier (as indicated by Written Notification #3)

During a review of the home's investigation notes (provided to the inspector) and interviews with registered nursing staff (RPN #123, RN #128), Director of Care and the Administrator, specific to the allegation of staff to resident verbal/emotional abuse which was reported by resident #048, the following provides documented evidence that the

home's policy, Resident Abuse-Staff to Resident was not complied with:

- The allegation of staff to resident abuse was not immediately reported by RPN #123 to RN #128; incident was reported by the resident on specified date and time. RN #128, who was the charge nurse, indicated not receiving notification of the allegation by RPN-Unit Supervisor #123 until close to end of her evening shift (which ended at 23:00 hours); RPN #123 indicated she did not realize the incident had to be immediately reported to the Charge Nurse (RN #128);

- The allegation of staff to resident abuse was not immediately reported to the Administrator, Director of Care or designate; Registered Nurse-Charge Nurse #128 did not contact the Administrator or Director of Care of the allegation. The Director of Care indicated she became aware of the allegation of abuse on the next day of the incident via a note left by RPN #123; RN #128 indicated (to the inspector) that note left by RPN #123 was "ok" as the resident was not in any danger;

- The allegation of staff to resident abuse was not reported to resident #048's substitute decision maker for forty-eight hours despite the awareness of the allegation by registered nursing staff (RPN #123 and RN #128) and Acting Director of Care.

- During the home's investigation of the alleged incident of staff to resident abuse, reported by resident #048, seven of the ten Personal Support Worker's interviewed, by the Administrator and Director of Care, indicated being aware of incidents in which PSW #124 was described as "rough with resident care and speaking to residents in a rude or abrupt manner"; Administrator indicated that staff interviewed did not comment as to why incidents were not reported. [s. 20. (1)]

3. Related to resident #052

On specified date during this inspection, PSW #129 brought forward concerns to the inspector that an incident occurred approximately six week earlier involving resident #052 wanting to go the bathroom and another staff member PSW #139 told the resident that she had already taken them to the bathroom. PSW #129 indicated (to the inspector) that she did report this to the Administrator, but felt that the resident was abused emotionally. A review of an email sent to the Administrator on next day of the incident by staff #129 revealed that the administrator was aware of the above identified concern.

Resident #052 is cognitively well with a multiple medical diagnoses.

An interview with resident #052 on December 10, 2015 revealed that this is an ongoing issue and brought forward the name of another staff member who tells the resident that she had already taken them to the washroom when they ring. The resident was very tearful during the interview and stated "that they would not ask staff to take them to the washroom if they could have gone alone". An interview with the Administrator revealed that he was aware of the incident brought forward by PSW #129 and he completed an investigation, but did not speak with resident #052 or notified the resident's SDM.

Following a review of the home's investigation notes (provided to the inspector) and interviews with PSW #129 and Administrator, specific to the witnessed incident of staff to resident verbal/emotional abuse of resident #052, the following provides evidence that the home's policy, Resident Abuse-Staff to Resident was not complied with:
- Substitute Decision Maker (SDM) of resident #052 was not notified of the witnessed verbal/emotional abuse incident, despite the Administrator was made aware of the incident on the next day. (607)

Administrator indicated to Inspector #554 that all staff have been provided education and or re-education specific to prevention and reporting of abuse; Administrator further indicated it is the expectation that the home's policies are followed, specifically policies relating to zero tolerance of abuse. (554) [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 by ensuring that the licensee's written policy to promote zero tolerance of abuse is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 24 (1), by not ensuring the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically,

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by another other than a resident.

Related to Intake #031931-15, for resident #024:

The Acting Director of Care (formerly Assistant Director of Care) submitted a Critical Incident Report to the Director, on specified date and time, specific to witnessed incident of staff to resident verbal abuse; the incident was said to have occurred six days earlier.

Description of the CIR is as follows:

- Personal Support Worker (PSW) #113 was assisting PSW #112 with care of resident #024, as per the CIR, PSW #113, as well as Registered Nurse #114, and Registered Practical Nurse heard PSW #112's inappropriate verbal outburst toward resident #024 with an angry tone.

The Acting Director of Care (DOC) indicated (to the inspector) that Registered Nurse-Charge Nurse (RN) #114 did not report the witnessed incident of staff to resident verbal abuse to her until six days later; DOC indicated that RN #114 overheard PSW #112's inappropriate verbal outburst toward resident #024 during the evening, but failed to report the abuse incident; DOC indicated that RN #114 indicated (to the DOC) that she was going to report the abuse incident but had gotten busy.

An allegation of staff to resident verbal abuse was not reported to the Director until approximately six days following the initial reported allegation of witnessed verbal abuse involving resident #024.

The Administrator indicated the action of PSW #112 were considered abusive and that incident of abuse should have been immediately reported to the Director by RN #114. [s. 24. (1)]

2. Related to resident #052:

During this inspection, PSW #129 brought forward, to the inspector, concerns that an incident occurred approximately six weeks earlier involving resident #052 wanting to go the washroom and another staff member PSW #139 told the resident that she had already taken them to the washroom. PSW #129 indicated (to the inspector) that she did report this to the Administrator, but felt that the resident was abused emotionally. A review of an email sent to the Administrator dated November 1, 2015 by staff #129 revealed that the administrator was aware of the above identified concern.

Resident #052 is cognitively well with a multiple medical diagnoses.

An interview with resident #052 revealed that this is an ongoing issue and brought forward another staff name who often tells them that she had already taken them to the washroom when they ring. The resident was very tearful during the interview and stated "that they would not ask staff to take them to the washroom if they could have gone alone".

An interview with the Administrator indicated that he was aware of the incident brought forward by staff #129 and he completed an investigation, but did not report this to the Director as he felt the above identified incident had to do more with a staff to staff interaction, but during the home's investigation of the incident, it was clear the allegation which was reported by PSW #129 to the inspector was staff to resident verbal/emotional abuse. [s. 24. (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 by ensuring that any person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 53 (4) (c), by not ensuring that the actions taken to meet the needs of the resident with responsive behaviours include, assessment, reassessment, interventions and documentation of the resident's response to the interventions.

Related to Intake #033678-15, for Resident #023:

According to the clinical health record, resident #023 has a medical diagnosis that includes cognitive impairment with a history of exhibiting responsive behaviours. The resident is dependent on staff for activities daily living and can self-propel own wheelchair.

The Acting DOC indicated (to the inspector) that resident #023's had exhibited responsive behaviours and was seen by Psychogeriatric Assessment Services for the Elderly (PASE) twice during early 2015 with recommendations for medication changes and continued behaviour management. A further recommendation (by PASE) was to see resident #023 at the next PASE clinic.

The second PASE assessment and consult during early 2015 indicated that resident #023's identified responsive behaviours throughout the day and evening placed resident at risk for harm from co-residents.

Acting DOC indicated that resident #023's responsive behaviours continued to escalate; and that the in-home BSO Team (Behaviour Support) initiated a Behaviour Assessment

Tool (BAT) to review responsive behaviours exhibited by the resident.

Progress notes for resident #023 were reviewed for the period of five months. The progress notes documented that resident #023 had numerous documented incidents of exhibiting responsive behaviours.

Progress notes, for the above period of five months, indicate that interventions tried by staff were of short effect in decreasing or eliminating Resident #023's responsive behaviours. Effectiveness of interventions only lasted if staff were with resident one on one. Progress notes reviewed indicated that resident #023 would often exhibit responsive behaviours for periods of two-four hours or for the majority of the shift.

The physician's orders were reviewed for the same above period of five months and noted four orders related medication changes and an order for PASE assessment for responsive behaviours

The clinical health record, for Resident #023, provides documentation that the last assessment by PASE was during early 2015.

Personal Support Workers #108 and #109 both indicated (to the inspector) resident #023's responsive behaviours are challenging and that resident is difficult to redirect; both PSWs indicated residents residing on the resident home area are frustrated with Resident #023's responsive behaviours.

Registered Practical Nurse (RPN) #110, who supervises the resident home area where resident #023 resides indicated (to the inspector) that she was aware of the order for resident to be assessed by PASE due to responsive behaviours, but indicated somehow resident #023 was missed and not seen in PASE clinics. RPN #110 indicated that resident #023's responsive behaviours are disruptive to the resident home area and many co-residents are frustrated with resident #023's responsive behaviours

Acting Director of Care indicated (to the inspector) being aware that resident #023 was to be seen by PASE, but had not been assessed by PASE as per physician's order.

The licensee failed to ensure that actions taken to meet the needs of the resident with responsive behaviours included reassessment, as evidenced by the following:
- Progress notes reviewed for an identified period of five months detail resident #023's responsive behaviours during shifts (mostly the evenings and nights) for hours at a time;

the clinical health record (including physician's orders, progress notes and care plan) fail to provide any documented evidence that when resident #023 was exhibiting responsive behaviours and when interventions were ineffective, that alternative strategies were developed, implemented or that a reassessment of resident's care needs had occurred in an effort to decrease or eliminate resident's responsive behaviours or in an effort to provide quality of care and or services for resident #023.
- Interviews with Registered Nursing Staff, and the Acting Director of Care all indicated that the PASE had not assessed Resident #023, as per the physician's order. Registered Practical Nurse indicated resident was not on any waitlists (PASE) to be seen at the time of this inspection.
- There is no documentation to support that the physician was contacted when non-pharmacological and or pharmacological interventions were ineffective, despite the exhibited responsive behaviours of resident #023.

The Acting Director of Care indicated that resident #023 should have been reassessed by the physician noting pharmacological and non-pharmacological interventions had been ineffective, specifically as it relates to resident #023. [s. 53. (4) (c)]

2. Related to Intake #033678-15, for resident #046:

According to the clinical health record, resident #046 has a medical diagnosis that includes cognitive impairment with a history of exhibiting responsive behaviours. The resident is dependent on staff for activities daily living.

Acting DOC and RPN #110 indicated (to the inspector) that resident #046's responsive behaviours have recently escalated; and the in-home BSO Team (Behaviour Support) initiated a Behaviour Assessment Tool (BAT) to review responsive behaviours being exhibited by resident #046.

Progress notes for resident #046 were reviewed for an identified period of five months. The progress notes documented that resident #046 had numerous incidents of exhibiting responsive behaviours.

Progress notes, for the above five months period, detail several interventions tried by staff. Progress notes indicate that interventions were of short effect, being of poor effect or no effect in decreasing or eliminating resident #046's responsive behaviours. Progress notes reviewed indicated that resident #046 would often exhibit responsive behaviours for periods of hours, most of shift or the entire night.

The physician's orders were reviewed for the same above period of five months indicated three orders related to medication changes to manage responsive behaviours.

Personal Support Workers #108, #109 and Registered Practical Nurse (RPN) #110 indicated (to the inspector) resident #046's responsive behaviours are challenging and that resident is difficult to redirect and becomes accusatory of staff or co-resident's; PSWs, as well as RPN #110 indicated residents residing on the resident home area are frustrated with resident #046's responsive behaviours.

RPN #110, who supervises the resident home area where resident #046 resides and Acting Director of Care indicated (to the inspector) that they are aware of resident's escalating responsive behaviours but as of this time, no referrals have been made to an external psychogeriatric support program. Acting Director of Care indicated that a referral to an external resource (psychogeriatric) may be of benefit for resident #046.

The licensee failed to ensure that actions taken to meet the needs of the resident with responsive behaviours included reassessment, as evidenced by the following:
- Progress notes reviewed for a period of five months detail resident #046 exhibiting responsive behaviours during shifts (mostly the evenings and nights) for hours at a time; the clinical health record (including physician's orders, progress notes and care plan) fail to provide any documented evidence that resident #046 was reassessed when exhibited responsive behaviours were escalating and when interventions were ineffective.

The Acting Director of Care indicated that resident #046 should have been reassessed by the physician noting pharmacological and non-pharmacological interventions had been ineffective, specifically as it relates to resident #046. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that actions are taken to meet the needs of resident #023, resident #046 and any other resident with responsive behaviours, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s.131 (2), by not ensuring that drugs are administered in accordance with directions for use specified by the prescriber.

Resident #023's physician's orders for a specified medication were reviewed:
- On September 2015, the order indicated the specified medication at bedtime.
- One October 2015, the order was changed for the specified medication to be administered at bedtime "as needed".

The electronic medication administration record (eMAR), for resident #023, was reviewed for an identified period of two months. The eMAR documented that the specified medication was being given routinely at bedtime, despite the change in the order to PRN "as needed" at bedtime.

RPN #110 indicated (to the inspector) that according to the physician orders and a review of the eMAR, the discrepancies between physician's order and eMAR during the two months period resulted from registered nursing staff not following the physician's orders as it relates to administration of the specified medication to resident #023.

Acting Director of Care indicated (to the inspector) no awareness of the registered nursing staff not following the physician's orders related to the specified medication for resident #023 but would review the medication incidents with registered nursing staff. [s. 131. (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 by ensuring that drugs are administered to resident #023 and any other resident in accordance with the directions for use specified by the prescriber, 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).

[redacted]

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 229 (4), by not ensuring all staff participate in the implementation of the infection prevention and control program.

The following was observed during morning medication administration passes on Penryn and Sylvan resident home areas (RHA):

- RPN #123 was observed not performing hand hygiene before or after administration of medications to three residents in the hallways and or lounge of the RHA; RPN #123 was later observed administering insulin to a resident (in an identified room) and was not observed performing hand hygiene before or after; RPN #123 then prepared and administered medication to a fifth resident without performing hand hygiene before or after (note: alcohol based hand sanitizer was available on the medication cart, as well as on the lounge wall and beside the nursing care centre where the medications were being administered);

- RPN #127 was observed not performing hand hygiene before or after administration to medications to two resident (in the lounge of the RHA); during this same observation RPN #127 was observed inserting a resident's hearing aids without performing hand hygiene before or after, then observed preparing and administering medications for the same resident, then returning to medication cart and preparing medication for a fourth resident.

The home's policies, Routine and Standard Precautions (# IC-02-01-01) and Practicing Hand Hygiene (# IC-02-01-07) both direct that all staff will perform hand hygiene before

and after resident / environment contact, using alcohol based hand sanitizer (or washing of hands, if hands are visibly soiled).

The home's Infection Prevention and Control Manual indicates that the home follows PIDAC best practice guidelines (which includes Just Clean Your Hands-Ontario campaign, guidelines for Hand Hygiene).

Registered Practical Nurse's #123 and #127 both indicated (to the inspector) that they have received training (education) specific to hand hygiene and awareness that the home follows the "Four Moments of Hand Hygiene", which includes the need for hand hygiene before and after contact with residents (or their environment).

Assistant Director of Care, who is the co-lead for Infection Prevention and Control Program with in the home, indicated (to the inspector) the expectation is that staff perform hand hygiene before and after resident contact and as per the home's policies which includes the Just Clean Your Hands: Four Moments of Hand Hygiene (as well as the PIDAC, best practice guidelines for hand hygiene in long-term care). [s. 229. (4)]

[redacted]

[redacted]

Additional Required Actions:

WN

~~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 by ensuring that:
- all staff participate in the implementation of the infection prevention and control program related to hand hygiene before and after resident contact;

[redacted]

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. (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).

Findings/Faits saillants :

1. 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.

PSW #129 brought forward (to the inspector) concerns that an incident had occurred on an identified date involving resident #052 wanting to go the washroom and another staff member PSW #139 told the resident that she had already taken them to the washroom.

Resident #052 is cognitively well with multiple medical diagnoses.

An interview with resident #052 revealed that this is an ongoing issue and brought forward another staff name who often tells them that she had already taken them to the washroom when they ring. The resident was very tearful during the interview and stated "that they would not ask staff to take them to the washroom if they could have gone alone".

A review of the resident's care plan indicated that resident will ring upon urge to use the bathroom and requires extensive assistance with 1-2 staff with all aspects of toileting.

Interview with RAI-Coordinator confirmed that the staff telling the resident that they have already being toileted when they ring is care not being provided as per the care plan. [s. 6. (7)]

WN #8: 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 failed to comply with O. Reg. 79/10, s. 21, whereby the licensee did not ensure that the temperature in the home maintained at a minimum of 22 degrees Celsius.

The following was noted during observations from November 30, 2015 to December 2, 2015:
- Resident #007 indicated to Inspector #607 that it is freezing in their room.

- Resident #002 indicated to Inspector #607 that the temperature is not okay at the home, sometimes it is too hot, and sometimes it is too cold.
- Inspector #607 noted the temperature, in an identified room, was uncomfortable and elevated.
- Inspector #554 noted that the area near the bench area lounge on Sylvan (residents' home area) was extremely cool on November 30, and December 01-02, 2015 as cold air was blowing through the slightly ajar window in which there was no window handle to close it.

Review of Residents' Council minutes of September 2015 indicated concerns around the temperature in the dining room being too cold. The November 27, 2015 minutes indicated residents' concerns that the temperature of the building fluctuates a lot, sometimes it is too hot, and sometimes it is too cold.

Review of the home's Interior Temperature records, taken for the period of August 4, 2015 to December 9, 2015 failed to demonstrate that the temperature within the home is being maintained at 22 degrees Celsius; the records indicated multiple entries of temperature below 22 degrees Celsius ranging from 17 to 21 degrees Celsius.

On December 9, 2015, interview with the Environmental Services Supervisor and the maintenance person both indicated no awareness of the legislative requirement to maintain the temperature at the home at a minimum of 22 degrees Celsius.

The maintenance person indicated that when the temperature drops down and when receiving concerns of cold areas, he will reset the HVAC unit which is getting false readings due to faulty control/circuit board. The drop in temperature to 17 degrees Celsius on October 1, 2015 is related to the faulty control/circuit board.

On December 9, 2015 interview with Administrator confirmed awareness of the temperature fluctuations within the home specially during switching of the seasons and that at times the temperature was not being maintained at 22 degrees Celsius as documented in the daily temperature audit logs. [s. 21.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

Findings/Faits saillants :

1. Related to Intake #033678-15:

The licensee failed to comply with O. Reg. 79/10, s. 31 (3) (d), by not ensuring the staffing plan includes a back-up plan, for nursing and personal care staffing, to address situations when staff cannot come to work.

Resident #041 approached an inspector (#554), on December 01, 2015, to voice concerns regarding staffing levels within the home. Resident #041 indicated (to the inspector) that the home is often short staffed and as a result resident care is deficient during such times. Resident #041 indicated that when the resident home area (Augusta) is short staffed, residents do not receive the care they require, there is increased wait times for care, staff take longer to respond to call bells and resident's do not get the assistance they need at mealtimes (or do not get meals, in general, if residents are left in bed).

Personal Support Workers (PSW) #108 and #109 indicated (to the inspector) that the staff on Augusta (resident home area) are often working short staffed; both PSWs indicated that there is no plan in place for 'resident care' (division of the workload) when they are working short staffed; both PSWs indicated (to the inspector) that it is up to the direct care staff (PSWs) to figure out how resident care will be completed at times when they are working short. PSW #108 indicated that resident care is often not provided in a timely manner when they are short staffed, which intern is upsetting to the residents, residing on the resident home areas which are short staffed on such days.

RPN #110, who is in the role of supervisor of Augusta (resident home area), indicated (to the inspector) that she is not aware of a back-up staffing plan for times when the home is short staffed. RPN #110 indicated (to the inspector) the Personal Support Workers can often sort out the resident care assignments among themselves when working short staffed, but if needed; she would intervene and assist with division of resident care assignments.

Acting Director of Care (formerly Assistant Director of Care) indicated (to the inspector) not being aware of a staffing back-up plan, to address situations when staff cannot come to work (e.g. short staffed).

Administrator indicated (to the inspector) that the home does not have a staffing back-up plan, to address situations when staff cannot come to work. [s. 31. (3)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review indicated that some identified concerns directed to the environmental, recreational and the dietary departments were raised during the September 1, 2015, and November 27, 2015, Residents' Council meeting. Record review could not locate a written response related to these identified concerns from the above identified departments to Resident Council. Interview with the Program manager, the dietary manager and the Environmental Services Supervisor confirmed that written responses were not provided to these concerns within the designated 10 day time frame. [s. 57. (2)]

Issued on this 27th day of January, 2016

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

Original report signed by the inspector.