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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 25, 2015	2015_267528_0012	H-002312-15	Resident Quality Inspection

Licensee/Titulaire de permis

ST. PETER'S CARE CENTRES
125 Redfern Ave HAMILTON ON L9C 7W9

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

ST. PETER'S RESIDENCE AT CHEDOKE
125 Redfern Avenue HAMILTON ON L9C 7W9

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

CYNTHIA DITOMASSO (528), BERNADETTE SUSNIK (120), DIANNE BARSEVICH (581), LEAH CURLE (585), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 20-24, 27-30 and May 1, 4, 5, 2015

This inspection was completed concurrently with:
i. Complaint Inspection Log #'s: H-000806-14, H001150-14, H-001335-14, H-001853-14, H-001960-15, H-002050-15; H-001750-14 Aug.19/15
ii. Critical Incident Inspection Log #'s: H-001039-14, H-001224-14, H-001154-14, H-001145-14, H-001149-14, H-001210-14, H-001313-14, H-001300-14, H-001422-14, H-001835-15 **H-001474-14, H-001486-14, H-001620-14, ~~H-001835-14~~, H-001990-15, H-001992-15,** H-000753-14
iii. Follow-Up Inspection Log #'s: H-001260-14, H-001261-14, H-001262-14, H-001263-14, H-001458-14 Aug 19/15

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Care Supervisors (RCS), Coordinator of Continuous Quality Improvement (CQI) and Education, Maintenance Supervisor, Food Service Managers (FSMs), Registered Dietician (RD), Physiotherapists (PTs), physiotherapy assistants (PTAs), dietary aides, Registered Nurses (RNs), Registered Practical Nurses (RPNs), personal support workers (PSWs), housekeeping staff, residents and families.

The inspectors also toured the home, observed the provision of care and services, reviewed documents including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
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

During the course of this inspection, Non-Compliances were issued.
26 WN(s)
12 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #003	2014_205129_0014	168
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #004	2014_205129_0014	168
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2014_205129_0014	528

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A. During the course of the inspection, resident #15 was observed with a splint. In

interview with direct care staff, both the registered staff and the personal support worker (PSW) stated the resident required the splint daily to assist with proper positioning when wearing shoes. Review of the written plan of care did not indicate the splint was to be applied daily by staff. Interview with both the registered staff and the PSW both confirmed there were no clear directions for the application and removal of the splint, as it was not documented in their written plan of care and Kardex. (581)

B. Resident #16 had a front fastening seat belt, and was able to release and apply the belt independently. Review of the plan of care indicated that the lap belt was used as a personal assistance services device (PASD) for positioning purposes, and in another section, stated the resident was able to release the device on their own. The Positioning and/or Restraining consent form stated the belt was not a PASD, as the resident was able to release the device. Registered staff confirmed the resident was able to release the device and that the care plan did not provide clear direction to staff. (585)

C. The initial New Admission Notification identified that resident #92 had three contact persons, for the purpose of this report to be identified as contact #1, contact #2 and contact #3. The admission progress notes identified that the resident's Power of Attorney (POA) was responsible to make health care decisions.
i. The resident was admitted to the home with a Continuing POA for Property; however, without a POA for Personal Care as communicated by contact #2.
ii. A request was made, in April 2014, by contact #2 to be the main contact person for the home, related to the resident's care.
iii. According to the progress notes the Resident Advisor called contact #2 two days later, to follow up and communicated that the POA, as assigned, indicated that contact #1 was the POA for personal care and finances; therefore, the request for contact #2 to be the main contact was not the resident's request.
iv. The Admission Record, an electronic record, identified contact #1 as the billing contact, POA for care, POA for finances and emergency contact #1. Contact #2 was identified in this record as a Substitute Decision Maker (SDM) and billing contact and contact #3 as a SDM.
v. In April 2014, the request of contact #2, to be the main contact person, was communicated to contacts #1 and #3, by the home, who were in support of the communication strategy and this information was to be updated for nursing staff and the electronic record.
vi. The Admission Record, was reprinted four days later, identified contact #1 as billing contact, POA for care and POA for finances, contact #3 as SDM and contact #2 as SDM, billing contact and emergency contact #1. It was however noted that the words

"emergency contact #1" were crossed out, but the date and time of the edits were not recorded.
vii. The discussion regarding POA was raised again at a family meeting later that month, at which time, contact #2 was informed that the home reviewed the documents provided which appointed contact #1 as POA for both care and finances and the meeting notes indicated that "the practical ramifications of this appointment were explained".
viii. The Admission Record, with a print date of two days after the family meeting, identified contact #1 as billing contact, POA for care and POA for finances, contact #2 as billing contact and contact #3 only as a contact.
ix. Interview with the Resident Advisor identified that the issue of POA was clarified at the family meeting and it was confirmed that the resident did not have a POA for care and that all contacts were SDM's and could make decisions on the resident's behalf. Clarification was provided to the contact #2 the same day, with support of their role as the main contact person for the resident, as agreed to by contacts #1 and #3.
x. The Resident Advisor confirmed that all POA documents provided to the home would be maintained in the resident's business file. A review of the business file, on April 29, 2015, contained only a Continuing POA for Property as confirmed by the DOC.
xi. There were no additional hard copy Admission Records available in the clinical record reviewed; however, the electronic profile (which was used to create the Admission Record) accessible at the time of this inspection identified contact #1 as POA for finance, SDM and billing contact, contact #2 as billing contact and SDM with a notation of being the primary contact and contact #3 as SDM.
xii. Discussion with registered staff confirmed that they would review the electronic profile (which was used to create the Admission Records) to communicate the resident's decision makers.
The plan of care did not provide clear direction to staff regarding the decision makers of the resident. (168) [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

The plan of care for resident #23 indicated that the resident was to avoid foods or beverages that tend to irritate their medical condition, such as alcohol, chocolate, caffeine, acidic or spicy foods. A review of the resident's assessment by the Registered Dietitian, kardex and diet kardex did not include these recommendations. The resident and a PSW were interviewed and did not report these interventions as part of their care needs. The Registered Dietitian confirmed they were not aware of this intervention and it

was not included in their dietary assessment of the resident. The Registered nursing staff who included the intervention to the plan confirmed the intervention was not based on an assessment of the resident's individual needs. (585) [s. 6. (4) (a)]

3. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and are consistent with and complemented each other.

In February 2015, the Bladder and Bowel Continence Assessment for resident #80 identified that the resident was continent of bowels with normal bowel patterns. In August 2014, the physician ordered suppositories as needed by the resident every three days. A progress note in August 2014, identified that the resident's SDM was administering suppositories to the resident every three days routinely, regardless of home's and physician's numerous requests for the SDM to stop.
The Medication Administration Records (MARs) from February to April 2015, included administration of suppository by staff twice and by the resident's SDM once.
An interview with the SDM during the course of the inspection confirmed that she continued to administer the suppository every three to four days, and does not tell the staff.
An Interview with the DOC confirmed that the home was aware of the SDM administering the suppository against the home and physician's recommendations. It was identified in the interview that staff should be documenting the administration of the suppository in the clinical health record.

Registered staff and the SDM were not collaborating in the implementation of the plan of care, related to the administration and documentation of suppositories. [s. 6. (4) (b)]

4. The licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM were provided the opportunity to participate fully in the development and implementation of the plan of care.

A. Resident #92, who was not able to make decisions regarding care, was admitted to the home on an antipsychotic medication. A review of the clinical record identified that there was a change to this medication, an increase, a few weeks after admission. SDMs were not informed of this change in dosage until the medication was observed to be administered and questioned by a SDM over one week later. The SDM communicated that they had not been given the opportunity to participate in this change to the resident's

treatment and did not consent to the change in dosage. The physician was informed of the wishes of the SDM and the medication order was changed as requested. (168)

B. In December 2014, the plan of care for resident #41 identified that the resident required a ceiling lift for comfort and safety. At that time, SDM were notified of the resident's requirements and nursing staff suggested an internal transfer to a room with accessibility to a ceiling lift; it was documented that the SDMs were not receptive to the room change.
i. The next day, a follow up call was placed to one of SDMs regarding the room change. A progress note described that the "daughter was informed that the move will take place before the beginning of the weekend", to which the daughter stated "Oh, I thought it was our decision." Registered staff documented that the nursing leadership was informed of SDMs response and to make plans for the internal move.
ii. A call was placed to the second SDM that evening, who declined the internal transfer.
iii. The next morning, as the resident's belongings were being moved to the new room, one of SDMs arrived on the unit; and at request of the family, the belongings were moved back to the resident's original room.
iv. Interview with the PSW who was working on the day of the room change indicated that the registered staff instructed PSWs to go ahead with the internal transfer. On April 30, 2015, an interview was held with registered staff and the DOC. Registered staff confirmed that the resident's belonging were moved without the consent of both SDMs and the DOC confirmed that the practice of the home is to contact a resident's SDM for consent prior to an internal room change.
v. The resident's SDM were not provided the opportunity to fully participate in the development and implementation of resident #41's internal transfer. (528) [s. 6. (5)]

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

A. The plan of care for resident #22 indicated that they required the use of a table top and seat belt PASD to ensure proper positioning as a result of poor trunk control. The plan of care directed staff to undo and reapply the PASD "at least hourly". On April 24, 2015, the resident was monitored for a period of four hours, during which both PASDs were not released and reapplied. A PSW caring for the resident for the first three hours of the observation indicated the PASDs were not removed and reapplied during the observation. Interview with registered staff confirmed the plan stated staff were to check the PASDs hourly. (585)

B. The plan of care for resident #14's identified that the resident was a high nutritional risk and were followed by the RD for evaluation and recommendations quarterly and as needed. A review of the clinical health record revealed that the resident was last assessed by the RD in November 2014. At the time of the inspection, five and a half months passed since the resident was last assessed by the RD. The RD was interviewed and confirmed the resident was not assessed quarterly as outlined in their plan of care. (585)

C. The plan of care for resident #98 identified that staff were to allow the resident time to turn self from side to side using the bed rail, as this was less painful for the resident who was able to move themselves. In January 2015, the resident communicated that an identified staff member hurt them as they did not provide any verbal indication that they would be rolling them and just moved them while in bed, which aggravated a previous injury. Interview with staff confirmed that the bed rail was raised during the provision of care but that the positioning from side to side was completed by staff, not the resident and that the care on the identified date was quick as they were running late for breakfast. Care was not provided according to the plan of care related to allowing them to turn self from side to side, as confirmed during staff interviews. (168) [s. 6. (7)]

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

A. Resident #94 was known to demonstrate responsive behaviours. In November 2013, the resident had a change in these behaviours that now involved a co-resident. The behaviour occurred again in December 2013, July and August 2014. The plan of care was not reviewed or revised to include this change in the resident's behaviour until August 2014 as confirmed during an interview with registered staff. The staff member confirmed that the plan of care should have been revised at the time that the behaviour was first identified. (168)

B. Review of the written plan of care for resident #20 indicated they went to bed at 2230 hours. The resident stated that they would like to go to bed between 2100 and 2130 hours. Interviews with the registered staff and PSW stated the resident was transferred to bed between 2100 and 2130 hours. The registered staff confirmed that the plan of care was not reviewed and revised to include the change in the resident's preference of bed time. (581)

C. Review of the written plan of care for resident #19 indicated the resident required extensive assistance with bathing, specifically two staff assitance using a hoyer lift for transfer to a shower chair. Interviews with the registered staff and PSWs stated that the resident was transferred with two person assistance side by side and did not require the use of a hoyer lift. Registered staff confirmed that the plan of care was not reviewed and revised when the resident’s care needs changed.

D. Review of the plan of care for resident #19 identified that the resident was to weight bear with physiotherapy only. Observation of the resident and interviews with staff revealed the resident was actually weight bearing independently and with limited assistance of staff. Registered staff confirmed that the plan of care was not reviewed and revised when the resident’s weight bearing status changed. (581)

E. The plan of care for resident #81 indicated the resident was to be toileted using a commode chair transferred on and off the toilet. Interviews with registered staff and PSWs stated that the resident was no longer toileted and was provided incontinent care in bed. Registered staff confirmed that the plan of care was not reviewed and revised when the resident’s care needs changed (581)

F. The plan of care for resident #81 indicated the resident was bathed in the shower room, or if the resident was resistant to care or refused they would be assisted at the bathroom sink for bathing. Interviews with staff stated that the resident was on a seven day bed bath routine as recommended by Behavioural Supports Ontario (BSO) staff and was no longer given showers. Registered staff confirmed that the plan of care was not reviewed and revised when the resident’s bathing schedule changed. (581)

G. Resident #43 had a history of responsive behaviours including but not limited to, inappropriate touching. Review of the plan of care identified that the resident was on one to one monitoring to prevent further incidents; however, during the course of the inspection the resident was observed without one on one staff assistance. Interview with registered staff on April 30, 2015, confirmed that one to one monitoring was initiated after an incident in September 2014, but that resident had not required one to one monitoring since October 2014. The plan of care was not revised when the resident no longer required one to one staff monitoring. (528)

H. In September 2014, resident #45 wandered into resident #46's room, resulting in an altercation between residents and injury to resident #46.
i. In an attempt to prevent further altercations, interventions were immediately identified

for both residents, as outlined in the home's investigation notes.
ii. Resident #46 was documented as having anixety, fear and anger as a result of the incident and staff were to ensure a wander guard and motion detector were put in place to prevent resident #45 wandering into resident #46's room. Eleven days later resident #46 was transferred to a different home area.
iii. Review of the written plan of care for resident #46 did not include the yellow wander guard and motion detectors. Interview with registered staff confirmed that the written plan of care was not updated to include the interventions the home put in place to try and protect resident #46, while both residents remained on the same home area. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the that:
i. the staff and others involved in the different aspects of care of the resident collaborate with each other 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
ii. the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that any plan, policy, procedure or strategy put in place, was complied with.

A. The licensee did not ensure that the policy "Falls Prevention and Post Fall Management Program” # 9-1, revised on January 20, 2014, was complied with.

The policy stated that a Neuro-vital assessment would be initiated if a fall was unwitnessed or a resident hit their head, a Fall Incident Report would be completed for all falls under the Risk Management tab in Point Click Care and a Fall Risk Assessment Form and a Post Fall Assessment would be completed after each fall incident.

i. From October 2014 to February 2015 resident #081 had multiple falls. Review of the plan of care revealed that three of the unwitnessed falls had had a Head Injury Routine (HIR) started but not completed as per the home’s policy. This was confirmed by the DOC.

ii. In December 2014, resident #081 had three unwitnessed falls. Review of the plan of care indicated that a Neuro-vital assessment was not initiated as per the home’s policy. This information was confirmed by the ADOC.

iii. Resident #81 had multiple falls in December 2014. Review of the plan of care indicated that a Fall Incident Report was not completed for one falls, as per the home’s policy. This information was confirmed by the ADOC.

iv. In January 2015, resident #081 fell with no injury. Review of the plan of care indicated that a Post Fall Assessment and a Fall Risk Assessment was not completed as per the

home’s policy. This information was confirmed by the DOC. (581)

B. The licensee did not ensure that the policy for "Continence Care Management, 6-2", last revised December 2013 was not complied with in the fall of 2014, when resident #41 was admitted to the home.

i. Policy "Continence Care Management, 6-2", last revised December 2013, directed staff that on admission residents who are incontinent are to be using the Bladder and Bowel Continence Assessment to identify causes, types, potential to restore, and patterns.
ii. Review of the clinical health record for resident #41 did not include the Bladder and Bowel Continence Assessment on admission.
iii. The 24-hour admission care plan indicated that the resident was occasionally incontinent of bladder and required extensive assistance of staff, but did not identify any toileting plan.
iv, Eleven days after admission, family expressed concerns related to toileting patterns, at which time, registered staff identified a toileting schedule for the resident.

The 24-hour admission care plan for resident #41 related to continence was not based on a Bladder and Bowel Continence Assessment, as per policy. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided with foods and fluids that were safe.

A. On April 20, 2015, during a lunch meal observation in the Elm dining room, puree salad was served and appeared runny, pooling on the plate. The dietary aide serving stated the salad appeared appropriate, as salad gets runny when mechanically altered in the home’s blender.

B. On April 22, 2015, during a lunch meal observation in the Dogwood dining room, puree tomatoes, macaroni and cheese, and broccoli was prepared and available for meal service. The items appeared runny, and pooled on the plate. Two dietary aides and a Food Service Manager (FSM) confirmed the items appeared runny.

C. On April 22, 2015, during lunch meal service, resident #020 was provided a thickened drink which appeared nectar consistency. The resident’s plan of care indicated they required pudding thick fluids. The PSW assisting the resident confirmed they prepared the beverage, and was not able to report what consistency of fluid the resident required. Registered staff stated the fluid appeared to be an appropriate consistency for the resident. A Food Service Manager (FSM) confirmed the fluid was not pudding thick consistency, and provided instruction to the staff how to prepare the fluid to the appropriate consistency. The PSW confirmed they were not aware how much thickener was required to safely prepare the beverage.

D. On April 23, 2015, during lunch meal service in the Dogwood dining room, puree salad was served, and appeared runny, pooling on the plate. The dietary aide confirmed the salad appeared runny.

E. On April 24, 2015, during lunch meal service in the Aspen home area, puree beef cabbage was noted to not hold its shape. The dietary aide first reported it appeared to be an appropriate texture; however, when asked, confirmed it did not hold its shape. The FSM confirmed the item was not an appropriate consistency. (585) [s. 11. (2)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

A. In September 2014, resident #45 was physically aggressive towards resident #46 which resulted in physical and emotional harm to resident #46.
Review of the plan of care for resident #45 identified that the resident was cognitively impaired with a history of wandering and verbal and physical aggression . Interventions included but were not limited to, allowing the resident to wander, monitoring the resident hourly, providing assistance and directional cues to assist the resident in finding their room. The investigation notes outlined that prior to the incident, resident #45 entered resident #46's room "on a regular basis" which upset resident #46.
Review of the plan of care for resident #46 identified that the resident sustained superficial injury. Although resident #46 was noted to have a history of cognitive impairment, progress notes documented eight days after the incident identified that the resident continued to be anxious, angry, and fearful of the resident #45.
The home did not protect resident #46 from physical and emotional abuse by resident #45, as a result, resident #46 sustained superficial injury and emotional upset. [s. 19. (1)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

According to the progress notes resident #90 demonstrated responsive behaviours including verbal and physical aggression and wandering. The plan of care included the presence of these behaviours and the interventions in place.
i. A progress note in the summer of 2014, identified that the resident was in resident #91's room. Resident #91 was found to be in a state of undress at the time that resident #90 was in the room. Resident #91 had been recently assessed to be dependent on staff for care such as bed mobility, dressing, transfers and hygiene.
The following day resident #90 was observed wandering into resident #91's room several times.
Two days later staff were alerted to resident #90's interest in resident #91's room and staff were instructed to monitor the resident and the co-resident's room every 15 minutes and identified that staff would "continue to monitor".
ii. In the early winter of 2014, resident #90 was found in the room of resident #91. Resident #91, who remained dependent of staff for the provision of care was, in bed, in a state of undress. Staff interviewed confirmed that resident #91 would not have been able to remove the bed linens and disrobe independently.
Interview with PSW staff confirmed that resident #90 was drawn to resident #91's room and a second room in close proximity potentially due to location. Staff also recalled that resident #90 had an alarm in place on their bedroom door to alert staff to their exiting their room, although could not recall when this interventions was initiated.
A review of the plan of care for resident #90 did not include the behaviour of wandering into resident #91's room and then finding the resident in a state of undress, as identified on two occasions, nor did it include the specific monitoring interventions, to reduce the opportunity for potentially harmful resident interactions, as initiated in the summer or 2014, or the use of a door alarm as confirmed during an interview with registered staff. (168) [s. 26. (3) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that includes: mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. The plan of care for resident #61 indicated that the resident was on a toileting schedule. The residents clinical records included paper documentation which staff were to complete to verify the toileting routine was being provided. A review of a 50 day period from August to October 2014 revealed incomplete documentation for 137 of the 500 entries. Staff interviewed confirmed familiarity with the resident's plan of care, and reported that staff would fail to document care as the form was in addition to routine daily documentation. The licensee failed to ensure the resident's responses to interventions related to toileting were documented. (585)

B. In January 2014, resident #061 had a plan of care to receive a therapeutic treatment to their eye three times per day, only when the resident's SDM was present. Review of the resident's medical administration record (MAR) revealed incomplete documentation four out of 22 times. Review of progress notes revealed some occurrences when treatment was not provided as the SDM was not present in the home; however, not all missed occurrences were accounted for in the progress notes. Regular registered staff indicated that if the resident's SDM was not present care was provided as per their plan, and confirmed documentation did not consistently reflect that care.

C. Resident #16 was identified as being at nutritional risk due to a low body mass index. Clinical progress notes were reviewed and revealed that in March 2015, a FSM provided the resident with a sample nutritional supplement to prevent further weight loss. Subsequent progress notes did not include the resident's response to the intervention. The resident was interviewed and was unable to recall if the FSM followed up with them; however, reported they did not like the sample that was provided. The FSM confirmed they followed up was aware the resident did not like the supplement; however, they did not document the response to the intervention. (585) [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration had been implemented.

A. In the fall of 2014, resident #24 was re-admitted to the home from hospital stay. Within 24 hours, a head to toe assessment identified two new areas of altered skin integrity. Review of the plan of care did not include a referral to the RD regarding the altered skin integrity. Interview with registered staff confirmed that an RD referral was not sent by nursing staff and; therefore, the resident was not assessed by the RD related to the new area of altered skin integrity. [s. 50. (2) (b) (iii)]

2. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. Upon readmission to the home in the fall of 2014, resident #24 was noted to have two new areas of skin breakdown. Review of the plan of care did not include weekly assessments of the areas after the initial head to toe assessment. Interview with registered staff confirmed weekly skin assessments by registered staff were not completed after new areas of skin breakdown were identified. [s. 50. (2) (b) (iv)]

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:
i. the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration has been implemented
ii. the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #8: 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 :

1. The licensee failed to ensure that all hazardous substances at the home were labeled properly and kept inaccessible to residents at all times.

On April 20, 2015, the door to a supply room on the third floor was open and there were three containers of hazardous cleaning material in the room. The Director of Operations confirmed the door should be locked at all times and locked the door. [s. 91.]

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 hazardous substances at the home are labeled properly and kept inaccessible to residents at all times, to be implemented voluntarily.

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. (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 failed to ensure that a documented record was kept in the home that included: the nature of the written complaint; the date it was received; the type of action taken to resolve the complaint; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response and any response made by the complainant.

A. The family of resident #97 sent a letter of complaint to the home in June 2014, concerning care and services provided. This letter was acknowledged by the Administrator and DOC and a meeting was held to address the concerns identified, within appropriate time frames. Interview with the DOC confirmed that the complaint and the actions taken as a result, were not recorded in the home's Resolution Issues Log. It was confirmed that the concerns were resolved; however, that the complaint was not included it in the documented record which the home maintained, to include each verbal and written complaint. (168)

B. In December 2014, the family of resident #41 discussed concerns with the DOC relating to communication and customer service of a particular staff member. However, review of the home's Resolving Issues Log from 2014/2015, did not include the families staff concerns.
Review of the home's Policy " Responding to Resident Issues, 1-120", last revised January 2014, stated that all issues and concerns identified by residents/families will be addressed within 10 business days, if not possible in 10 business days a timely follow-up will be completed.
Interview with the DOC, confirmed that the home was aware of the concerns and outlined actions taken to address the issues with the particular staff member. The DOC confirmed that the concerns raised by resident #41's family was not included in the home's Resolving Issues Log and a response was not provided to the family. (528) [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record iss kept in the home that includes: the nature of the written complaint; the date it was received; the type of action taken to resolve the complaint; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response and any response made by the complainant, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer’s instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act, the physical device was applied by staff in accordance with manufacturer's instructions.

On April 20, 2015, resident #60 was observed sitting in a wheel chair with a lap belt applied. A gap of four to five inches was noted between the resident's pelvis and the belt. The plan of care was reviewed and indicated the resident had a double closure side clip seat belt as a restraint. Registered nursing staff confirmed the belt was used as a restraint, that it appeared loose and should not exceed a gap of two fingers, as outlined by the manufacturer. The registered staff and proceeded to adjust the belt to fit appropriately. (585) [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act, the physical device is applied by staff in accordance with manufacturers instructions, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

On April 23, 2015, the RPN was observed administering medication on Dogwood home area. At 1155 hours, the RPN entered a resident's room and left the medication cart in the hallway unattended. The medication cart was noted to be unlocked. While the RPN was in the resident's room, the Inspector was able to open and close medication cart drawers without the RPN being aware and two cognitively impaired residents self propelling themselves through the hallway. When the RPN returned to the medication cart within approximately two minutes, she acknowledged that the cart should have been locked. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas where drugs were stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that before they discharged a resident under subsection 145 (1), they ensured that the resident and the resident's substitute decision-maker(s) (SDM) and any person directed was informed and given an opportunity to participate in the discharge planning and that their wishes were taken into consideration.

Resident #92 was no longer able to make decisions regarding their care and did not have an appointed POA for personal care; however, had three SDMs. According to the clinical record, the resident was discharged from the home in 2014, due to a reported change in care requirements related to responsive behaviours. A review of the clinical record and interviews with management staff confirmed that the DOC and physician met with one of the SDMs at the time of the resident's discharge; however, confirmed that the other two SDMs were not consulted or given the opportunity to participate in the discharge planning. Interview with one of the three SDMs confirmed that they were not consulted regarding the discharge of the resident despite the fact that they were identified as the first contact for the resident, as consented to by the other two SDMs. (168) [s. 148. (2) (c)]

2. The licensee failed to ensure that before they discharged a resident under subsection 145 (1), they provided a written notice to the resident, the resident's substitute decision-maker, which set out a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements for care, that justified the licensee's decision to discharge the resident.

Resident #92 was discharged from the home in 2014, due to a reported change in care requirements related to responsive behaviours, according to the clinical record. A review of the record and other resident files did not include a written notice to the resident, or SDM, setting out a detailed explanation of the supporting facts, as they related both to the home and the resident's condition and requirements for care, that justified the decision to discharge the resident. Interview with the SDM who was onsite at the home at the time of the discharge and the SMD who was identified to be the main contact person both confirmed that a written notice was not received. Interview with the DOC confirmed that to her knowledge a written notice was completed or provided related to the discharge. (168) [s. 148. (2) (d)]

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 before they discharge a resident under subsection 145 (1), they ensure that the resident and the resident's substitute decision-maker(s)(SDM) and any person directed are informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration, to be implemented voluntarily.

WN #13: 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 failed to ensure that the resident was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

On an identified date in August 2014, resident #93 was reported to be verbally responsive during care, swore at staff and continued to demonstrate responsive behaviours during bathing activities. Following the care the resident reported, to the charge nurse, that the staff member yelled at them and were "not nice to me". The home conducted an internal investigation regarding the allegation and determined that the employee raised their voice during the provision of care to the resident. The staff member did not speak to the resident with courtesy and respect on the identified date, as confirmed during interviews. (168) [s. 3. (1) 1.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices to minimize risk to the resident.

The plan of care for resident #81 identified that the resident required one three quarter bed rail raised when in bed to assist with bed mobility. Registered staff and PSWs stated that the resident used the bed rail to assist in turning and positioning. Review of the plan of care did not include an assessment of the bed rails as confirmed in an interview with the DOC. [s. 15. (1) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee did not ensure that the lighting requirements set out in the lighting table were maintained. The home was built prior to 2009 and therefore the section of the lighting table that applied is titled "all other homes".

A. A hand held light meter was used (Sekonic Handi Lumi), held a standard 30 inches above and parallel to the floor, to measure the lux levels in dining rooms on each home area as they appeared dark. Verification of lighting levels were not completed of resident bedrooms, tub rooms, bathrooms or corridors as they appeared well illuminated. Verification of lounge spaces on each home area and, main reception area and main sitting areas on the main floor were not measured due to natural light infiltration that could not be controlled for. Discussion was held with the maintenance supervisor that the areas that could not be measured would have to be verified by the licensee after sunset to determine compliance with the lighting table. The areas on the main floor were equipped with pot lights which were spaced 8-10 feet apart creating dark areas with small focused illuminated areas that would not meet minimum lighting requirements as set out in the lighting table.

B. Dining rooms in all home areas were equipped with semi-flush ceiling mounted lights with opaque lenses. All dining rooms with the exception of Elm (light fixtures were different) failed to meet the minimum requirement of 215.28 lux. The lux levels directly under the fixtures ranged between 170-180 and 100 between fixtures (as meter was held while walking between tables). (120) [s. 18.]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the PASD described in subsection (1) that was used to assist a resident with a routine activity of living was included in the plan of care.

During the course of the inspection, resident #16 was observed in a wheel chair, with a device applied. Interview with the resident indicated that they were unable to release the device on their own, and required the assistance of staff. Review of the resident's plan of care did not include the use of the device. Registered staff and a PSW both reported the resident was unable to release the device independently, and that it was used for positioning. Registered staff indicated the device was not on the home's list of approved PASD's, and therefore, was not classified as a PASD. The Registered staff confirmed the device was not included in the resident's plan of care. (585) [s. 33. (3)]

2. The licensee failed to ensure the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied:

1. Alternatives to the use of a PASD had been considered and tried where appropriate.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Review of the clinical health records indicated that one three quarter bed rails was raised when resident #081 was in bed to assist in bed mobility and repositioning. Registered staff and PSWs stated they used one bed rail raised when in bed to assist with turning and repositioning. Review of the written plan of care did not include an assessment to determine the reason for the use of the bed rails, nor any documented approvals or consent for its use. The DOC confirmed the resident was not assessed to determine if the bed rails were being used as a PASD or a restraint nor did they have documented consent or approval for the device in place. [s. 33. (4)] [s. 33. (4)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who cannot brush their own teeth received physical assistance or cueing.

The plan of care for resident #21 indicated that the resident required limited assistance with personal hygiene due to visual deficit, poor coordination and poor judgement. Directions for staff included that with set up provided the resident would be able to complete the task of brushing their teeth. On April 20, 2015, the resident stated that due to visual impairments and coordination, if the staff did not assist with oral care, then the resident can not complete it. On April 27, 2015 at 1100 hours, the resident's toothbrushes appeared dry and unused. Interview with the PSW confirmed that they did not set the resident up to brush their teeth to complete oral care, as outlined in the plan of care. [s. 34. (1) (b)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents’ satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the continence program included an annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff.

The DOC confirmed in an interview that there was no annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision makers and direct care staff in 2014. [s. 51. (1) 5.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. On two evenings in August 2014, resident #42 did not receive the assistance of staff to ensure they were able to complete bedtime care.
i. Review of the plan of care indicated that the resident had a history of responsive behaviours, including but not limited to, resistance to care and environmental stress. The resident was also noted to be independent at times but required supervision with personal hygiene, and assistance with dressing.
ii. In July 2014, BSO outlined interventions for staff to minimize resistance to care included re-approaching the resident at different times of the shift.
iii, Interview with the PSW who cared for the resident on the two days identified above, stated that they did not feel like fighting with the resident and therefore, did not use interventions identified by BSO to respond to the needs of the resident. [s. 53. (4) (c)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that planned menu items were offered at each meal.

A) On April 20, 2015, during lunch meal service in the Elm dining room, the posted daily menu indicated ice cream sandwiches and pears were to be offered for dessert. A PSW offering and serving dessert reported that sorbet and pears were available. A FSM confirmed that ice cream sandwich should have been offered to residents.

B) On April 20, 2015, resident #010 was observed eating their main course and fluids in the Elm dining room. Following the completion of the main entree, the PSW escorted the resident out of the dining room. The PSW confirmed after the dining room was cleared that resident #010 was not offered dessert, then proceeded to offer it. (585) [s. 71. (4)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system provided for, at minimum, preparation of all menu items according to the planned menu.

On April 22, 2015, during lunch meal service in the Dogwood dining room, puree omelette was prepared and available for meal service. The omelette was sampled, and contained notable chunks of egg film. Two dietary aides confirmed the presence of the film, and stated that they did not serve the item as it did not appear safe. The FSM confirmed puree food should be smooth and not contain chunks or film (585) [s. 72. (2) (d)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that fluids served to residents were provided at a temperature that was palatable to residents.

In April 23, 2015, during a dining observation in the Dogwood home area, a resident asked the inspector to taste the tea being served, as it was cold. A fresh cup was poured from the carafe, and measured 115 degrees Fahrenheit (46 degrees Celcius), and did not taste hot. The FSM confirmed in an interview that the home's expectation for the temperature of tea was 160 degrees Fahrenheit (71 degrees Celcius) to be palatable. (585) [s. 73. (1) 6.]

WN #23: 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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures were implemented for cleaning and disinfection of resident care equipment, specifically tub lift seats.

According to the Director of Care and the home's policy 4-5 tilted "Bath tub lift cleaning procedure" dated 2013, staff were required to clean and disinfect the underside of the lift seat after each use. During the inspection on April 30, 2015, the underside of the lift seats in the tub rooms of Aspen, Birch, Cedar (minor residue), Dogwood and Fir Terrace home areas all had a heavy layer of film or scum under the seat, an indicator that staff did not clean the underside after use. [s. 87. (2) (b)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the PASD used under section 33 of the Act is applied by staff in accordance with the manufacturer's instructions, if any.

On April 22, 2015, resident #14 was observed in the dining room, tilted up to position the resident up for feeding. The resident's headrest was observed in contact with the crown of their head. Interview with the Occupational Therapist confirmed the headrest was part of the the tilt chair and the as per manufacturers instructions the headrest should only be in contact with the resident's head when reclined in a tilted position and was not applied in accordance of manufactures instructions. (585) [s. 111. (2) (b)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that skin and wound training was provided to all staff who provide direct care to residents.

Skin and Wound Care training for direct care staff was completed in August 2014. The CQI Coordinator confirmed that approximately 85% of staff had been provided with the training at that time. In an interview with the Coordinator of CQI and Education, it was identified that Skin and Wound Care was not included as part of new staff training and therefore staff hired after August 2014 were not provided training on Skin and Wound Care. (528) [s. 221. (1) 2.]

2. The licensee failed to ensure that all staff who provide direct care to residents are provided training for continence care and bowel management.

Continence Care and Bowel Management training was completed in December 2014. Discussion with the Coordinator of CQI and Education identified that only 85% of the direct care staff were provided training. THe CQI Lead confirmed that Continence Care and Bowel Management training is not included as part of new staff orientation, therefore, staff hired after December 2014, have not been provided training on continence care and bowel management. (528) [s. 221. (1) 3.]

3. The licensee failed to ensure that training was provided for all staff who apply physical devices or who monitor residents restrained by a physical device, which included the application of these physical devices.

Interview with DOC and Coordinator of CQI and Education confirmed that the home did not provide education to all staff who applied physical devices or who monitored residents restrained by physical devices on the application of these devices in 2014. It was identified that education was provided to staff on Restraints and PASD's; however; this education did not include the application of devices. (168) [s. 221. (1) 5.]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident’s written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that, a written record was maintained for each resident of the home.

Resident #90 had a history of responsive behaviours. Staff interviewed and progress notes identified that at times the resident was on every 15 minute checks. A review of the clinical record contained only three pages of Resident Observation Records (ROR) from July to November 2014. A request was made for the additional ROR's for review. The DOC indicated that a search was completed and that the home was unable to locate the records at this time. The DOC confirmed that as per staff on the floor the ROR's were completed; however, were not maintained in the clinical record and could not be located. (168) [s. 231. (a)]

2. The licensee filed to ensure that the resident’s written record is kept up to date at all times.

B. In September 2014, resident #45 displayed physical aggressive behaviours to a co-resident. As a result, new interventions included but were not limited to, monitoring the resident using behavioural observation charting, and referrals to both the Psychogeriatric Resource Consultant (PRC) and Behavioural Supports Ontario (BSO). Review of the plan of care did not include any behavioural charting following the incident in September 2014. Interview with the DOC on May 4, 2015, identified that the DOS charting would have been completed by staff for PRC and BSO assessment; however, the written record was not kept up to date to include the completed DOS charting. [s. 231. (b)]

Issued on this 19th day of June, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528), BERNADETTE SUSNIK (120), DIANNE BARSEVICH (581), LEAH CURLE (585), LISA VINK (168)
Inspection No. / No de l'inspection :	2015_267528_0012
Log No. / Registre no:	H-002312-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 25, 2015
Licensee / Titulaire de permis :	ST. PETER'S CARE CENTRES 125 Redfern Ave, HAMILTON, ON, L9C-7W9
LTC Home / Foyer de SLD :	ST. PETER'S RESIDENCE AT CHEDOKE 125 Redfern Avenue, HAMILTON, ON, L9C-7W9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Renee Guder

To ST. PETER'S CARE CENTRES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_240506_0022, CO #001; 2014_205129_0014, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit, and implement a plan for achieving compliance to ensure that the care set out in the plan of care is provided to all residents, including but not limited to, residents #14, #22, #98; within relation to personal assistance service device (PASD), type and level of assistance required, and Registered Dietitian (RD) assessment.

The plan shall be emailed to Cynthia.Ditomasso@ontario.ca by June 30, 2015. The plan shall be fully implemented by: July 15, 2015.

Grounds / Motifs :

1. Previously issued as a Compliance Order in August 2014 and September 2014.
The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

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

A. The plan of care for resident #22 indicated that they required the use of a table top and seat belt PASD to ensure proper positioning as a result poor trunk control. The plan of care directed staff to undo and reapply the PASD "at least hourly". On April 24, 2015, the resident was monitored for a period of four hours, during which both PASDs were not released and reapplied. A PSW caring for the resident for the first three hours of the observation indicated the PASDs were

not removed and reapplied during the observation. Interview with registered staff confirmed the plan stated staff were to check the PASDs hourly. (585)

B. The plan of care for resident #14's identified that the resident was a high nutritional risk and were followed by the RD for evaluation and recommendations quarterly and as needed. A review of the clinical health record revealed that the resident was last assessed by the RD in November 2014. At the time of the inspection, five and a half months passed since the resident was last assessed by the RD. The RD was interviewed and confirmed the resident was not assessed quarterly as outlined in their plan of care. (585)

C. The plan of care for resident #98 identified that staff were to allow the resident time to turn self from side to side using the bed rail, as this was less painful for the resident who was able to move themselves. In January 2015, the resident communicated that an identified staff member hurt them as they did not provide any verbal indication that they would be rolling them and just moved them while in bed, which aggravated a previous injury. Interview with staff confirmed that the bed rail was raised during the provision of care but that the positioning from side to side was completed by staff, not the resident and that the care on the identified date was quick as they were running late for breakfast. Care was not provided according to the plan of care related to allowing them to turn self from side to side, as confirmed during staff interviews. (168) [s. 6. (7)] (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 25th day of May, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Cynthia DiTomasso

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