Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 2, 2017	2016_449619_0035	034931-16	Resident Quality Inspection

Licensee/Titulaire de permis

SPECIALTY CARE / WOODHALL PARK INC
400 Applewood Crescent Suite 110 VAUGHAN ON L4K 0C3

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

Woodhall Park Care Community
10260 KENNEDY ROAD NORTH BRAMPTON ON L6Z 4N7

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

SAMANTHA DIPIERO (619), HEATHER PRESTON (640), KATHLEEN MILLAR (527)

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): December 28, 29, 30, 2016, and January 3, 4, 5, 6, 2016.

The following complaint inspections were done concurrently with this Resident Quality Inspection:
log #008144-16 - related to personal support services
log #012073-16 - related to falls prevention
log #018837-16 - related to falls prevention
log #008007-16 - related to responsive behaviours
log #025748-16 - related to infection prevention and control

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Behaviour Support Ontario (BSO), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Housekeeping Aide, Director of Resident Services, Resident Assessment Instrument (RAI) Coordinator, Administrative Assistant (AA), 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, medication storage room, meeting minutes, clinical health records, and log reports.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee failed to ensure that each resident who is incontinent received an assessment that included identification of causal factors, patterns, types of incontinence and potential to restore function with specific interventions, and that there the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment tool.

Resident #011 was admitted to the home on an identified date in June 2016, and on admission was assessed as being continent of bowel and bladder. An interview with PSW #123 indicated that the resident began experiencing functional urinary incontinence and began requiring the use of continent products a little after their admission to the home. Interview with RPN #122 indicated that when a resident experiences new onset incontinence, that a continence assessment with the use of the home's continence assessment tool should be completed. On review of the resident's health record, a continence assessment could not be located; however, a Tena portrait assessment, a tool used to identify the most appropriate incontinence product for a resident, was located. RPN #122 indicated that the continence program lead, BSO PSW #127, was responsible for the clinical incontinence assessment. RPN #122 confirmed that the Tena portrait assessment does not include the assessment or identification of causal factors, patterns, types of incontinence and potential to restore function with specific interventions for residents. Interview with BSO PSW #127 indicated that they were responsible for completing incontinence product assessments, but not the continence assessment itself, as this is a task that only a member of the registered staff is able to complete. Interview with DOC confirmed that the resident did not receive a continence assessment with the use of a clinically appropriate assessment tool.

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 with r. 51(2) where every licensee of a long-term care home shall ensure that, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 :

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Resident #034 was abused by PSW #118 on an identified date in September 2016. PSW #120 witnessed the abuse of resident #034 and did not report it to the home until twenty four (24) days later on an identified date in October 2016. The home's "Prevention of Abuse & Neglect of a Resident" policy, number VII-G-10.00, last revised January 2015, was reviewed and directed all employees to immediately report any suspected or known incident of abuse to the Director of MOHLTC and the Executive Director or designate in charge of the home. The resident's clinical record and the home's investigative notes were reviewed, which indicated that PSW #120 was orientated to the requirement by the home to report allegations of abuse immediately as outlined in their training materials and their zero tolerance policy; however, PSW #120 was intimidated by PSW #118 and was afraid to report the incident. The DOC confirmed that PSW #120 did not comply with the home's zero tolerance for abuse policy to immediately report the abuse of resident #034.

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 with s.20(1) where 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, to be implemented voluntarily.

WN #3: 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 :

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

Resident #031 received a falls risk assessment on an identified date in April 2016, that identified the resident as a risk for falls. The written plan of care, last updated in June 2016, indicated that the resident required the use of a mobility device, and required one staff to assist with transferring.

A) On an identified date in June 2016, resident #031 fell while attempting to self-transfer. A review of the resident's health record indicated a head to toe assessment, dated the same date of the fall in June 2016, that the resident had an injury and subsequent altered skin integrity. A review of the resident's health record indicated that no weekly skin and wound assessment was initiated.

B) Resident #031 fell a second time in June 2016, and required transfer to hospital for further treatment and assessment for a wound, and was admitted to the hospital in relation to a second health issue. The resident returned to the home on an identified date in June 2016, with medical intervention still in place. On review of the resident's chart, the medical intervention was removed 10 days post re-admission in July 2016, as per the

physician's orders. A review of the resident's health record did not indicate that a skin and wound assessment or a weekly skin and wound assessment was initiated by any member of the registered nursing staff for this resident's wound.

On review of the Emergency Department physicians' assessment, and the physical assessment notes from the attending paramedics who transferred the resident to hospital, it was noted that on the resident's admission to hospital on an identified date in June 2016, that the resident had skin alterations and moderate injury to an identified area. A review of the resident's health care record did not indicate that the resident had any alterations in their skin condition. Further review of the resident's health record indicated that upon the resident's re-admission to the home, no weekly skin and wound assessment was initiated in relation to the ongoing monitoring of the resident's wound; the resident's wound was not assessment until an identified date in June 2016, ten (10) days after the resident's re-admission to the home when the medical intervention was removed.

Interview with RPN #113 indicated that when there is a change in a resident's skin condition that the registered staff were responsible for initiating a weekly skin and wound assessment, and indicated that this was not completed for resident #031 on two occasions related to alterations in their skin condition on two separate areas of their body. Interview with DOC confirmed that resident #031's altered skin and new wound required monitoring and confirmed that it was not completed by the registered staff on a weekly basis.

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 with r. 50(2) where 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, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 :

The licensee failed to ensure that the resident was protected from abuse by a staff member.

Resident #034 was cognitively impaired and had responsive behaviours. Based on the home's investigative notes, PSW #118 was observed by PSW #120 abusing resident #034. PSW #120 further observed PSW #118 improperly transfer resident #034 to the bed on an identified date in September 2016. PSW #120, who witnessed the abuse of resident #034, did not report it to the home until an identified date in October 2016. RPN #119 was unable to assess the resident for any injuries on the date/time of the incident, as the home was not aware of the allegation of abuse. Upon review of the resident's clinical record, there was no indication of injury or pain immediately following the incident. The resident was assessed on an identified date in October 2016, once the home became aware of the allegation of abuse, which identified no injuries; however, the assessment was completed 24 days after the incident.

The home's "Prevention of Abuse & Neglect of a Resident" policy, number VII-G-10.00, last revised January 2015, was reviewed and directed all employees to immediately report any suspected or known incident of abuse to the Director of MOHLTC and the Executive Director or designate in charge of the home. The resident's clinical record and the home's internal investigation notes were reviewed, and indicated that PSW #120 was orientated to the requirement by the home to report allegations of abuse immediately as outlined in their training materials and the home's zero tolerance policy; however, PSW #120 was intimidated by PSW #118 and was afraid to report the incident. The LTCH Inspector was not able to contact PSW #120 for an interview. The DOC was interviewed and indicated that they had difficulty contacting PSW #120 as well. The home failed to protect resident #034 from abuse by PSW #118.

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 with s.19(1) where 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date in November 2016, resident #035 reported to registered staff that they lost their balance and nearly fell while being assisted to transfer by PSW #121. Interview with resident #035 indicated that they had requested assistance from PSW #121 to transfer to bed. A falls risk assessment completed in August 2016, indicated that the resident was a high risk for falls, further identified that the resident did not have a fall since admission on an identified date in June 2016, and that they required assistance from two (2) staff to complete transfers. Interview with PSW #121 confirmed that they transferred the resident on their own, and indicated that other staff completed transfers for this resident like this as well. A review of the home's policy titled, "Resident Transfer and Lift Procedures", policy # VII-G-20.20, last revised July 2015, indicated that for residents who have been assessed by a member of the registered staff as requiring a two person pivot transfer, two staff are required to be present, one to lead and the other to guide the resident. Interview with the DOC confirmed that PSW #121 did not use safe transferring and positioning techniques when transferring this resident.

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 with r. 36 where every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: 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).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

The licensee failed to ensure that the following requirements were 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.

Resident #008 and #013 were observed on an identified date in December 2016, and a subsequent identified date in January 2017, with a restraining device in place. Both residents were unable to unlock their respective restraining devices and both restraining devices were loose. The LTCH Inspector #527 was able to place seven fingers between the residents' pelvises and the restraining devices. The residents' clinical records were reviewed and both of the residents' families had requested specified restraining devices as a safety measure to assist in preventing falls.

The home's "Restraint Implementation Protocols" policy, number VII-E-10.00, last revised November 2015, directed staff to apply the restraint to a resident according to manufacturer's specifications. The manufacturer instructions for the retraining devices were reviewed and they identified that the retraining device should be approximately four centimetres, which was confirmed with the DOC as two finger widths between the device and the resident's body. This was also confirmed in the home's educational information.

Interviewed RPN #117 on an identified date in December 2016, and they identified that they did not have the manufacturer's instructions, but were trained every year on the proper application of restraining devices. RPN #117 indicated that two fingers between the restraining device and the resident's body was the proper application, which was their understanding of the manufacturer's instructions. Interview with PSW #125 and PSW #126 on two identified dates in January 2017, indicated that they were not aware of where to find the manufacturer's instructions for the correct application; however the PSWs indicated that they were trained that there should be enough space for two fingers to fit between the device and the resident's body. Both confirmed that the residents' restraining devices were loose and not applied according to what they were trained as the manufacturer's instructions. Interviewed the DOC who confirmed that the staff were trained annually on the proper application of restraining devise, and the restraining devices for resident #008 and#013 were not applied according to the manufacturer's instructions.

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 with r. 110(1) where 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 and (7) the licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 7. every release of the device and all repositioning, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, 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. (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. (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 failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

The following non-compliance is issued in relation to complaint #012073-16. A review of the written plan of care for resident #025, in effect during March 2016, under the falls prevention focus, directed staff to use two persons and a mechanical lift for lifts and transfers. Under the mobility focus, the same written plan of care directed staff that the resident required a two person pivot transfer. Interview with PSW #128 and SW #129 confirmed the use of a mechanical lift was required for resident #025 and not the pivot transfer, due to a request by the SDM. Interview with RAI co-ordinator and the DOC confirmed the written plan of care did not provide clear direction to the staff related to transfers for resident #025.

2. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

On an identified date in March 2016, resident #025's Substitute Decision Maker (SDM), observed staff transferring the resident using a mechanical lift. In an interview the SDM stated that the home did not notify them regarding the implementation of a mechanical lift for the resident. During inspection, the LTCH Inspector was unable to locate any documentation of notification or consent from the designated SDM, to the change in the resident's plan of care. In an interview, the DOC confirmed that consent for the implementation of the mechanical lift and the documentation of that consent was required to be completed by staff. The DOC confirmed there was no consent from the SDM and no documentation of consent received prior to the implementation of the use of a mechanical lift.

3. The licensee failed to ensure that the resident was re-assessed 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 or care set out in the plan was no longer necessary.

Resident #011 was admitted to the home on an identified date in June 2016, and was assessed as being continent of bladder. Interview with PSW #123 indicated that shortly after the resident's admission the resident became incontinent of urine. PSW #123

indicated that the resident had functional urinary incontinence, and stated that the resident required a specific continence product during the day because they were mobile and able to transfer themselves to the bathroom, and required a second specific continence product at night as they were unable to transfer themselves to the bathroom. A review of the written plan of care, last revised in June 2016, indicated that the resident was continent of urine, and did not indicate that the resident was incontinent, nor that they required the use of specified continence products during the day and night. Interview with RPN #122 indicated that when there had been a change in the resident's condition that the plan of care was to be updated to reflect accurate care information for the resident. Interview with DOC confirmed that the care plan was not revised when the resident's care needs changed.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to report to the Director the results of every investigation undertaken under clause (1)(a) and every action taken under clause (1)(b).

An allegation of abuse/neglect by a staff member to resident #034 occurred on an identified date in September 2016. The allegation of abuse was reported to the Ministry of Health & Long Term Care (MOHLTC) Director on an identified date in October 2016, when the home became aware of the allegation of abuse. The critical incident report was submitted to the MOHLTC Director on a second identified date in October 2016. The critical incident report stated that an investigation had been initiated, staff involved were on administrative leave pending investigation, and other actions will be based on the outcome of the investigation. No further updates were provided to the MOHLTC Director that indicated the outcome of the investigation or any further long term actions planned to correct the situation and prevent recurrence. The DOC was interviewed on an identified date in January 2017, and confirmed the results of the alleged abuse/neglect investigation had not been submitted to the MOHLTC Director once the investigation had been completed in October 2016.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

The licensee failed to ensure that the written policy to minimize the restraining of residents (b) was complied with.

The home's policy called "Restraint Implementation Protocols", number VII-E-10.00, last revised November 2015, directed registered staff to obtain a written consent for the initial restraint use, annually thereafter, and upon any change in the restraint order. The clinical record for resident #013 was reviewed and there was a consent from the resident's substitute decision maker (SDM) for a restraint signed on an identified date in November 2014. Interview with RPN #107 indicated that they had difficulty contacting the resident's SDM in order to obtain the annual written consent, and the SDM never came in to visit. The RPN indicated that their policy directed them to obtain a consent for restraints on an annual basis. Interview with the DOC confirmed that the registered staff were expected to obtain a written consent for restraints annually as identified in their policy and procedures. The DOC confirmed that the registered staff did not comply with the home's restraint policy.

WN #10: 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 :

The licensee failed to ensure that for each resident exhibiting responsive behaviours that strategies are developed and implement to respond to these behaviors where possible.

Resident #025 required extensive assistance from staff for personal hygiene and peri-care. Interview with PSW #136 indicated that the resident exhibited responsive behaviours after they experienced bowel incontinence while wearing a continence product, and indicated that this was an ongoing behaviour. A review of the written plan of care, last revised in March 2016, did not include any identified behaviours related to bowel incontinence. Interview with RN # 113 indicated that when a new responsive behaviour is identified, a referral is made by registered staff to the Behavioural Support Ontario (BSO) staff member who will then complete an assessment of the behaviour in order to develop and implement appropriate interventions. Interview with BSO #127 indicated that no referral was received in relation to the resident's behaviours surrounding bowel incontinence, and that no assessment of the behaviour was completed. Interview with DOC confirmed that strategies were not developed and implemented to respond to the ongoing responsive behaviour.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Resident #031 had a fall with injury on an identified date in June 2016. The resident had an injury that required transfer to hospital for treatment, for which the resident received medical intervention; the resident was admitted to the hospital. A review of Critical Incident Report indicated that the critical incident which caused a significant change in status to resident #031, occurred on an identified date in June 2016, and was reported to the Director on a second identified date in June 2016, upon the resident's re-admission to the home.

The Long Term Care Homes Act, 2007, defines a significant change in status as, "a major change in the resident's health condition that a) will not resolve itself without further intervention, b) impacts on more than one aspect of the resident's health condition, and c) requires assessment by the interdisciplinary team or a revision to the resident's plan of care". On review of the resident's health records, LTCH Inspectors determined that resident #031's injuries and subsequent treatment of said injuries fit this definition of significant change.

Interview with DOC confirmed that the critical incident report was not submitted in accordance with the regulated time lines, and that the home failed to submit the critical incident report to the Director within one business day.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

On an identified date in December 2016, LTCH Inspector observed RPN #113 complete the morning medication administration and observed that they did not perform hand hygiene between each resident. On an identified date in January 2016, during the noon time medication pass, RN #109 administered medication to five residents and did not perform hand hygiene between each resident. On a second identified date in January 2016, during the noon time medication pass, RPN #122 was observed administering medications to six residents and did not perform hand hygiene between each resident. During interview with RPN #113, RPN told the LTCH Inspector that hand hygiene was not performed between each resident during medication administration, but should have been. The home's policy "Hand Hygiene", #IX-G-10.10, revised January 2015, directed staff to complete hand hygiene before and after administering a medication by any route. In an interview, the DOC confirmed the expectation of the home was that hand hygiene was to be performed between each resident during medication administration.

Issued on this 8th day of February, 2017

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

Original report signed by the inspector.