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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 4, 2019	2018_768693_0016	030702-18	Resident Quality Inspection

Licensee/Titulaire de permis

Riverside Health Care Facilities Inc.
110 Victoria Avenue FORT FRANCES ON P9A 2B7

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

Rainycrest
550 Osborne Street FORT FRANCES ON P9A 3T2

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

MELISSA HAMILTON (693), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 3-7, and 10-14, 2018.

Inspector Sharon Goertzen (742) was also in attendance at this inspection.

The following additional intakes were inspected during this Resident Quality Inspection:
- One complaint related to nursing and personal support services;
- Three Critical Incident's (CI's) related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator (IA), Interim Director of Care (IDOC), Assistant Director of Care (ADOC), Unit Coordinators (UC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides (DAs), Registered Dietician (RD), Infection Control Practitioner, Nutrition and Food Services Manager (NFSM), Maintenance Lead (ML), Manager of Environmental Services (MES), Director of Environmental Services (DES), Activity Manager, Resident Assessment Instrument (RAI) Coordinator, Reception Clerk, Administrative Assistant, residents and family members.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **3 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	Légende 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident (CI) was submitted to the Director for am incident with injury of resident #008 on a specified date.

During a review of resident #005's health record, including incident documentation pertaining to an incident that occurred on a specific date, which resulted in an injury, as well as, a subsequent incident on another specific date, Inspector #621 found no corresponding post-falls assessments completed by the home.

During an interview with the IDOC, they reported to Inspector #621 that starting on a specified date, the home changed over from Gold Care to Point Click Care (PCC), with the licensee's direction to deactivate the incident reporting components of PCC, and instead utilize the licensee's approved risk management reporting system known as Adverse Events Management System (AEMS). The IDOC identified that as a consequence of this change in the home's reporting and documentation process, for a one month period in a specified year, the completion of post-fall assessments using a clinically appropriate assessment tool did not occur for residents who had an incident occur during this time frame. The IDOC further reported that the gap in documentation was discovered as of a specified date; thereafter, the home began utilizing the "Post Fall Screening Tool" in PCC as their clinically appropriate post falls assessment after each resident fall.

The IA confirmed with Inspector #621 that it was their expectation that a post-falls assessment using a clinically appropriate assessment tool designed for falls was completed after each incident. On review of documentation for the two specified dates of incidents of resident #005, the IA and IDOC confirmed that the resident did not have a post-falls assessment completed for either fall, and should have. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #196 reviewed a medication incident report which indicated that resident #017 had not been administered their prescribed medications on a specified date, at an identified time. The report identified that on a specified date, RPN #105 noted that the medications for resident #017 for an identified time had been removed from the blister pack and the medications from the previous evening had remained within the blister pack.

During an interview with the ADOC, they reported to the Inspector that the medication incident was that RPN #106 had administered the prescribed medications for an identified time, in error at another identified time, on a specified date.

Inspector #196 reviewed a specified policy from the pharmacy service provider, last updated on an identified date. The policy defined a medication incident as "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional or patient."

The Medication and Order Review, effective on the date of the medication incident, identified that an identified number of specific medications were to be administered to resident #017 at an identified time daily.

During a interview with the ADOC, they confirmed to the Inspector that the medications that were administered to resident #017, at a specified tome on an identified date, were not given as prescribed. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and documented results of this screening were available to the licensee.

During review of the Long-Term Care Home Licensee Confirmation Checklist Infection Prevention and Control (IPAC) completed by the home's Interim Administrator (IA), Inspector #693 identified that the home had responded that each resident admitted to the home had not been screened for tuberculosis (TB) within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee.

The IA provided a copy of all current residents in the home and their TB screening status to the Inspector. Inspector #693 identified that in the home's RQI of 2016, which took place on November 14 to 19, 2016 and November 21 to 25, 2016, the home had been subjected to a written notification (WN) under s. 229 (10) of the LTCHA, in this inspection.

Inspector #693 reviewed the TB screening status of all residents in the home who were admitted between November 26, 2016, and December 6, 2018. The Inspector identified that the following residents were not screened for TB:
- Resident #006
- Resident #013
- Resident #014

- Resident #016
- Resident #017
- Resident #018
- Resident #019
- Resident #020
- Resident #021
- Resident #022
- Resident #023
- Resident #024
- Resident #025
- Resident #026
- Resident #027
- Resident #028
- Resident #029
- Resident#030
- Resident #031
- Resident #032
- Resident #033
- Resident #034
- Resident #035
- Resident #036

In addition, Inspector #693 identified that resident #015 was screened a specified number of days after admission to the home. There were 25 residents who lived in the home at the time of inspection who had been admitted during a specific time period; 25 out of 35 or 71 per cent of residents who had not been screened for TB as per legislative requirements.

In an interview with the Infection Control Practitioner, they stated that the home's process for TB screening was for a chest x-ray (CXR) to be completed for all new admissions who were 65 years of age or older, 90 days prior to admission or within 14 days of admission and for a 2-Step TB skin test to be completed for all new admissions who were under the age of 65. The Infection Control Practitioner stated that they had sent an email to the Interim Director of Care (IDOC) on October 26, 2018, that identified there were 30 residents admitted to the home who were not screened for TB.

Inspector #693 obtained a copy of the email sent from the Infection Control Practitioner to the IDOC, composed on October 26, 2018. In this email, the Infection Control Practitioner identified that there were 30 admitted residents who had outstanding TB

screening and that Extendicare recommended for this screening to have been done and documented. In the email, the Infection Control Practitioner referenced s. 229 (10) of the LTCHA, which identified the legislative requirement for TB screening.

Inspector #693 obtained the home's policy entitled "Riverside Health Care - TB Screening in Long Term Care Procedure, ORG-II-NGE-20" , effective September 19, 2018, from the IA. The policy stated that the home's practice for residents who were under the age of 65 was to complete step 1 of the 2-step TB skin test within 14 days after admission. If the resident was 65 years or older, to have ensured a CXR was completed 90 days prior to admission or 14 days after admission.

In an interview with the IDOC, they stated that they were aware that there were approximately 20 residents living in the home who had not yet been screened for TB. They stated that they had not gone ahead with screening as they were waiting on a new policy. The IDOC reviewed the October 26th, 2018 email from the Infection Control Practitioner and stated that there were 30 residents identified who had not been screened for TB and the home would now begin this process as they had a policy in effect. Together with the Inspector, the IDOC reviewed the list of residents who had not been screened for TB, and confirmed that 25 residents had not been screened 90 days prior to admission or within 14 days of admission for TB and that there were a total of 30 residents living in the home who had not yet been screened. [s. 229. (10) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and documented results of this screening were available to the licensee, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the skin and wound care program was complied with.

The most recent Minimum Data Set (MDS) assessment identified Resident #007 as having developed a new area of altered skin integrity.

The licensee policy with a specific title, indicated that the registered staff were to "obtain physician order for treatment recommendations". The guidelines from an identified date, as located in the front of the treatment binders on the treatment carts indicated, "ensure you have "specific" orders for the wound treatment form the Physician/NP".

The physician orders from a three month period in a specified year, were reviewed and there was no reference to resident #007's altered skin integrity or treatment of altered skin integrity.

During an interview with the ADOC, they reported to the Inspector that a physician's or nurse practitioner's (NP) order for the treatment of the specified altered skin integrity was required. The ADOC confirmed, after a review of resident #007's chart, there was no order for wound treatment for the altered skin integrity that had been first discovered on a specified date,and there should have been an order.

During an interview with the IDOC, they reported to the Inspector that the registered staff were to follow the guidelines from a specified date, as located in the front of the treatment binders on the treatment carts and the licensee policy, "Skin and Wound Care Program".

CO #001 was issued during inspection #2018_703625_0014 pursuant to O.Reg 79/10, s. 8. (1) with a compliance due date January 15, 2019. As the compliance date was not yet due at the time of this inspection, this finding will be issued as a WN to further support the order. [s. 8. (1) (a),s. 8. (1) (b)]

WN #5: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Personal Assistance Services Device (PASD) described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

On four specified dates, during this inspection, resident #004 was observed seated in a specialized ambulation device in a specific position.

A review of the resident's health care records included an identified diagnosis. The progress notes in PCC, from a specified time frame, did not include reference to the use of the identified ambulation device in the specific position. The current care plan as in PCC did not include the intervention of the identified ambulation device in the specific position.

During an interview with RPN #105, they reported to the Inspector that resident #004 required the the identified ambulation device in the specific position for positioning purposes; it was not a restraint as they wouldn't be able to move themselves in the identified ambulation device anyway, and had two specific contributing diagnoses. They added that this identified ambulation device in the specific position would be considered a restraint only if the device was positioned to stop the resident from moving themselves in the device, otherwise it would not be a restraint.

During an interview with UC #107, they reported to the Inspector that this resident used the identified ambulation device in the specific position, for positioning and comfort and the only reason the device was in the specific position was for comfort and for their back. They further reported that the current care plan should have included the use of the identified ambulation device in the specific position, as a means of communication, so the staff knew how to provide care to this resident. UC #107 then confirmed to the Inspector that the use of the identified ambulation device in the specific position was not referenced in the care plan.

During an interview with the IDOC, they reported that a specific home policy, effective on an identified date, was old and the home would be changing to new policies soon. They confirmed to the Inspector that these identified ambulation devices in the specific positions were restraint devices and should have been included in this resident's plan of care. [s. 33. (3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

During a tour of the West side of the home, Inspector #577 observed used, unclean, unlabeled personal care items as follows:

-one tub room had one black brush with grey hair unlabelled and two black combs with hair debris unlabelled in the cupboard; an unlabelled plastic container with three used, unclean nail clippers; one used, unclean pair of nail clippers on window sill unlabelled;
-one shower room had one pink brush with grey hair and two black combs with hair debris, unlabeled.

Three days later, the Inspector made similar observations of the tub room which contained one black brush with grey hair and one beige brush with hair; and an unlabelled plastic container with three used, unclean nail clippers.

Inspector #577 reviewed the home's policy "Labeling of clothing and Personal items – DEP-LL-III-20" effective August 9, 2018, indicated that when a resident was admitted, all new items had to be labelled and placed into the residents personal cubicle.

During an interview with PSW #108, they reported that they were unaware of whom the brushes belonged to, and removed the items. They further reported that the nail clippers weren't being used and they would be removed for cleaning.

During an interview with RPN #109, they reported that unlabelled personal belongings should not be kept in the tub rooms and should be in the resident rooms.

During an interview with PSW #110, they reported that residents' personal belongings-brushes and combs should be labelled, brought to the tub room with the resident and returned to their room after their bath. They further reported that nail clippers were to be used once and then placed in a dirty bin for clippers to be sterilized.

Inspector #577 spoke with the IA who confirmed that unclean, unlabeled personal belongings should not be kept in tub and shower rooms. They further reported that each resident had a plastic basket that contained all of their personal items that would be brought with them to the tub room and returned back to their room after their care. [s. 37. (1) (a)]

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 has failed to ensure that a resident exhibiting altered skin integrity,

including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The most recent Minimum Data Set (MDS) assessment identified Resident #007 as having developed new altered skin integrity.

A review of the Gold Care progress notes from a specified date, indicated that the resident had developed new altered skin integrity. A document titled "Treatment Record - Long Term Care" from a specified date, identified an initial assessment by RN #111 which specified the new area of altered skin integrity.

During an interview with the IDOC, they reported to the Inspector that the registered staff were to follow the guidelines from a specified date, as located in the front of the treatment binders on the treatment carts.

A review of the guidelines from a specified date, indicated that when altered skin integrity was identified, the assessment tool titled “Wound Care Flow Sheet” was to be completed. This assessment tool allowed for the documentation of the wound type, the stage/grade, length, width, depth, drainage, type, odour, comment and staff signature.

During a further interview with the IDOC, they confirmed to the Inspector that the staff should have utilized the Wound Care Flow Sheet, as the assessment tool, for resident #007's new altered skin integrity and not the Treatment Record - Long Term Care. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who was 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.

Resident #007 was identified as having developed a new area of altered skin integrity on a specified date.

A review of the Gold Care progress notes from an identified date, indicated that the resident had developed a new area of altered skin integrity. A document titled "Treatment Record - Long Term Care" from an specified date, identified an initial assessment by RN #111 which specified a new area of altered skin integrity.

During an interview with the IDOC, they reported to the Inspector that the registered staff were to follow the guidelines from a specified date, as located in the front of the treatment binders on the treatment carts.

A review of the guidelines from a specified date, indicated that a referral to the dietitian was to be made when a resident was "first presented with impaired skin integrity"

The licensee policy with an identified title, indicated that the Registered Dietitian was to "complete nutritional and hydration risk assessment within 7 days".

During an interview with the RD, they reported that they had not received a referral to assess this resident in a specified month, in an identified year.

According to the IDOC, a referral should have been made to the RD. The IDOC confirmed to the Inspector that this had not been done. [s. 50. (2) (b) (iii)]

WN #8: 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements: 1. Communication of the seven-day and daily menus to residents.

During an observation of the dinner meal service on a specific day during this inspection, in an identified home area, Inspector #621 reviewed a copy of the home's day-at-a-glance menu, as posted on the home area's servery door. The Inspector however, was unable to locate a copy of the home's week-at-a-glance menu within the unit.

During an interview with DA #103, who was completing the supper meal services for the specified home area, they identified to Inspector #621 that the week-at-a-glance menu was typically posted on the bulletin board inside the servery and adjacent to the counter for staff and residents to preview if needed. DA #103 confirmed however, that the week-at-a-glance menu was not present at the time of inspection, and should have been.

During later observations of the menu postings for the home's Main Dining Hall, Inspector #621 observed the day-at-a-glance menu posted at the entrance of the dining room, however, the week-at-a-glance menu was not present.

During an interview with the NFSM, they reported that the home utilized both week-at-a-glance and day-at-a-glance menus to communicate the menu options to residents. NFSM further identified that both the weekly and daily menus were to be posted in proximity to each of the three dining areas in the home. During an observation of the menu postings each of the three dining areas, the NFSM confirmed to Inspector #621 that the weekly menu was not present at the entrance of the Main Dining Hall, as required. [s. 73. (1) 1.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)

(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements.

During a tour of the home, Inspector #577 noted postings of inspection reports on a bulletin board in the main hallway. On further inspection, the Inspector noted that there were two public inspection reports not posted; Critical Incident System (CIS) Inspection report #2017_435621_0012 with report date of May 17, 2017, and Follow Up (FU) Inspection report #2017_435621_0011 with report date of May 17, 2017, as identified on the home's Compliance History Report.

During an interview with the IA, together with Inspector #577, they reviewed the posted inspection reports. They confirmed that the public versions of the two inspection reports were not posted on the bulletin board during the time of the inspection and confirmed that the home was required to post the previous two years inspection reports. [s. 79. (3) (k)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results.

During an interview with the co-chairperson of the Residents' Council, they reported to Inspector #196 that the council had not been provided an opportunity to provide input into the development of the resident satisfaction survey.

During a review of the Residents' Council meeting minutes, for the past three months, the Activity Coordinator, together with the Inspector, noted a reference that read, "Residents' Council is to: Review existing survey, determining if there are areas for input capturing what residents feel is important".

During an interview with Activity Coordinator, they reported to the Inspector, after a review of the previous years' Residents' Council meeting minutes, that there was no record of the licensee having obtained advice from the council regarding the development of the satisfaction survey. [s. 85. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service; O. Reg. 79/10, s. 90 (2).
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and O. Reg. 79/10, s. 90 (2).
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services under clause 15(1)(c) of the Act, heating, ventilation and air conditioning systems were cleaned and in a good state of repair and inspected at least every six months by a certified individual, and that documentation was kept of the inspection.

During the inspection a complaint was expressed during a family interview that the temperatures in the home fluctuated, with some areas colder than others.

During an interview with the Maintenance Lead (ML) and the Manager of Environmental Services (MES), they reported to Inspector #621 that temperatures were monitored daily from thermostats throughout the three home areas to ensure temperature stability, and documented as part of morning reports with management. Additionally, ML reported that resident rooms had their own thermostats which could be regulated to support the resident's individual preference. Further, ML identified that the home's heating system was inspected annually by a certified inspector, with documentation kept of these inspections.

During an interview with the Director of Environmental Services (DES), they reported that the home's heating system was inspected annually by a certified inspector, but that the 2018 inspection had been missed in spite of a purchase order being sent to the company who performed the inspection. On review of the legislative requirements, the DES confirmed with Inspector #621 that the home's heating system was not inspected by a certified individual at least every six months. [s. 90. (2)]

WN #12: 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. (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:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

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:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented: The person who applied the device and the time of application.

Inspector #196 observed resident #002, on two dates during the inspection, in an identified ambulation device with a specific restraint in place on a specific area of the resident's body.

A review of the residents' health care records included a physician's order for an identified restraint to be applied at all times for safety and positioning. The current care plan identified the use of the identified restraint.

A review of the "Restraint Monitoring Record" for a specific month, in an identified year, was conducted. The following was not documented:
- on a specific date, the time that the identified restraint was applied and by whom;
- on a specific date, the time that the identified restraint was applied and by whom; and
- on a specific date, the time that the identified restraint was applied and by whom.

During an interview, PSW #112, reported to the Inspector that the PSWs were to

document the time the identified restraint was applied.

During an interview with the ADOC, they reported that resident #002 was in the home and in their specified ambulation device with the identified restraint in place, during an identified three-day time period. They confirmed that the initials of staff that had applied the restraint as well as the time of the application should have been documented on the monitoring record. [s. 110. (7) 5.]

2. Inspector #196 observed resident #003, on two identified dates during this inspection, in a specified ambulation device with an identified restraint in place.

A review of the resident's health care records included a physician's order for an identified restraint when up in ambulation device. The current care plan included the use of an identified restraint when up in a specified ambulation device.

A review of the "Restraint Monitoring Record" for a specific month, in an identified year, was conducted. The following was not documented:
- on a specific date, the time that the identified restraint was applied and by whom.

During an interview with the ADOC, they confirmed to the Inspector that there was no record of the time or the staff member that had applied the identified restraint on a specific date. [s. 110. (7) 5.]

3. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee was to ensure that the following were documented: The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Inspector #196 observed resident #002, on two dates during this inspection, in a specified ambulation device, with an identified restraint in place on a specific area of the resident's body.

A review of the residents' health care records included a physician's order for an identified restraint to be applied at all times for safety and positioning. The current care plan identified the use of the identified restraint.

A review of the "Restraint Monitoring Record" for a specific month, in an identified year,

was conducted. The following was not documented:
- on a specific date, the time that the identified restraint was applied and by whom;
- on a specific date, the time that the identified restraint was applied and by whom; and
- on a specific date, the time that the identified restraint was applied and by whom.

During an interview with PSW #112, they reported to the Inspector that after a review of the Restraint Monitoring Record for a specific month, in an identified year, that some of the documentation was not completed; and some days there was no record of when it was removed.

During an interview with the ADOC, they confirmed to the Inspector that the removal of the identified restraint and the time and initials of the staff that removed the restraint was to be documented on the monitoring record. [s. 110. (7) 8.]

Issued on this 16th day of January, 2019

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

Original report signed by the inspector.