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
Mar 8, 2016	2016_229213_0005	001309-16	Resident Quality Inspection

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET LONDON ON N5V 3R3

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

Earls Court Village
1390 Highbury Avenue North LONDON ON 000 000

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

RHONDA KUKOLY (213), AMIE GIBBS-WARD (630), DONNA TIERNEY (569), MELANIE NORTHEY (563), NUZHAT UDDIN (532)

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): January 20, 21, 22, 25, 26, 27, 28, 29, February 1, 2, 3, 4, 5, 2016

The following were completed concurrently within the RQI:
Follow up log #034027-15 (compliance date January 31, 2016) related to Continued Quality Improvement (CQI)
Follow up log #000992-16 (compliance date January 31, 2016) related to reporting

and complaints
Follow up log #000987-16 (January 4, 2016) related to reporting abuse
Complaint log #034793-15 (IL-42086-LO) related to multiple resident care concerns
Complaint log #034803-15 (IL-41998-LO) related to the handling of cytotoxic medications
Complaint log #034911-15 (IL-41985-LO) related to staffing, mechanical lifts and continence care
Complaint log #034946-15 (IL-41960-LO) related to the handling of cytotoxic medications and concerns regarding Methicillin-resistant Staphylococcus Aureus (MRSA)
Complaint log #035271-15 (IL-42164-LO) related to new staff orientation
Complaint log #035480-15 (IL-42144-LO) related to handling of cytotoxic medications
Complaint log #036198-15 (IL-41958-LO) related to continence care products and agency staff
Complaint log #036325-15 (letter from the public) related to wound care and communication
Complaint log #001311-16 (IL-001311-LO) related to drain care
Complaint log #001822-16 (IL-42650-LO) related to continence care products
Critical Incident log #036015-15 (CI #3047-000042-15) related to staff to resident abuse
Critical Incident log #003348-15 (CI #3047-000014-15) related to a fall and fracture
Critical Incident log #005572-15 (CI #3047-000002-14) related to a fall and fracture
Critical Incident log #029537-15 (CI #3047-000037-15) related to elopement
Critical Incident #3047-000001-16 related to a fall and fracture

During the course of the inspection, the inspector(s) spoke with the President and Chief Operating Officer, the Administrator, the acting Director of Care, the Geriatric Clinical Nursing Specialist, the Senior Equipment Consultant from Arjo, the Director of Dietary Services, the Physiotherapist, the Registered Dietitian, four Dietary Aides, the Director of Facility Services, three Housekeepers, 30 Personal Support Workers, three Recreation Aides, the Behavioural Supports Ontario Personal Support Worker, 12 Registered Practical Nurses, the Behavioural Supports Ontario Registered Practical Nurse, two Registered Nurses, the Office Manager, the Receptionist, the Family Council Co-Chair, the Resident Council President, over 40 residents and six family members.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry of Health and Long-Term Care information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation
Trust Accounts

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

37 WN(s)
22 VPC(s)
16 CO(s)
2 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. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A family interview with Inspector #532 on January 21, 2016 revealed the family member of resident #022 shared there is not enough staff available, that they found another resident in the dining room on the floor one day. The family shared that they do need some Personal Support Worker (PSW) staff, that the staff work really hard and they need more staff.

Resident #024 shared in an interview with Inspector #532 on January 21, 2016 that they have to wait to go to the bathroom because there is only three staff and that they have waited three quarters of an hour.

A resident interview with resident #071 on February 4, 2016 revealed the resident shared

the staff treat them with respect and dignity, but they have to rush because there is not enough staff, they do not have enough help and they need more help.

Interview with Personal Support Worker (PSW) #146 on January 29, 2016 with Inspector #630 revealed she is a PSW from an agency. The PSW reported that they work one to two times per week. The PSW reported that they does not have access to (Point of Care) POC, the Kardex or charting in POC or the Point Click Care (PCC) plan of care. The PSW reported that they are not able to chart in POC and will tell the regular staff what care they provided and she/he will chart. In order to identify a resident's care needs, the PSW reported they will look on the wall in the resident's room or look at the "log" at the desk or ask the staff.

Five of the complaints completed concurrently within this inspection were related to a high use of agency staff, both personal support workers and registered staff as well as staff shortages.

The Family Council shared a concern with Inspector #569 in an interview on February 3, 2016. The Family Council identified that all areas of operations are being adversely impacted by this constant fluctuation of staff. This ultimately impacts the level of care residents receive. Some of the staffing concerns family council have raised are as follows: high turnover of staff at all levels, high percentage of agency staff vs full time, rotation of staff between floors, frequency of shifts being short staffed.

Record review of the master staff schedule and interview with the Administrator #101 on January 29, 2016 revealed there are supposed to be three PSW's on each of the four floors on day shift with a float PSW working between third and fourth floor and a float PSW working between first and second floor.

Observations on February 1, 2016 revealed there was an agency PSW working in the float position between third and fourth floor on day shift and the float position on day shift between first and second floor was unfilled and the units worked short staffed.

Staff interview with PSW #166 and PSW #171 on February 5, 2016 at 1045 hours revealed the home was short staffed that day, there was no PSW float for third and fourth floor, there was a PSW float for first and second floor and that this PSW was trying to help all four floors that day.

Record review of the PSW schedule and the Time Transaction Report for the pay period

of January 4 to 17, 2016 revealed agency personal support workers were scheduled and worked eight shifts in a fourteen day period. The home was unable to provide documented evidence of the number of agency personal support workers that were scheduled and worked during the pay period of January 18 to 31, 2016. The Office Manager #143 confirmed in an interview on February 4, 2016, that the home was unable to determine if the home was fully staffed by looking at the staff schedule as agency staff scheduled were not documented on the staff schedule.

Record review of the Registered Practical Nurse (RPN) Schedules for December 2015 and January 2016 revealed that in December 2015, 22 out of 93 shifts were filled with agency RPNs. In January 2016, 18 out of 93 shifts were filled with agency RPNs.

In an interview with the President and Chief Operating Officer #163 on February 2, 2016, he confirmed that the staffing plan had not been evaluated since the home was opened in 2014.

The licensee failed to evaluate the staffing plan annually to ensure that the staffing plan provides continuity of care or provides a staffing mix that is consistent with residents' assessed care and safety needs. [s. 31. (3) (e)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Record review of the care plan in Point Click Care (PCC) for resident #062 revealed no

indication of use an assistive device and refuses another particular intervention regarding oral care. Record review of the Resident Care Card in the bathroom for resident #062 indicated interventions contrary to the care plan in PCC.

Observations on July 26 and 28, 2015 for a period of one hour on each date revealed the interventions identified in the plan of care were not provided or in place.

Staff interview with Personal Support Worker (PSW) #108 on January 26, 2016 revealed resident #062 used an assistive device and has never used the intervention regarding oral care. Staff interview with PSW #105 on January 28, 2016 also revealed the resident used an assistive device and has never used the intervention regarding oral care. Staff interview with Registered Practical Nurse (RPN) #107 on January 28, 2016 confirmed resident #062 is supposed to use the assistive device and there was no direction in the plan of care related to the use of this intervention and there should be. The RPN shared that the intervention related to oral care has not been in use for several months. RPN #107 confirmed that the Resident Care Guide in the bathroom for this resident was inaccurate and needed to be updated and she was unsure of who was responsible to update the Resident Care Cards.

Staff interview with the Administrator #101 and the Geriatric Clinical Nursing Specialist #103 on January 27, 2016 confirmed that the conflicting information in the plan of care and the Resident Care Card did not provide clear direction for the staff related to the two interventions for resident #062. The Administrator shared that the Resident Care Cards were no longer in use and should have been taken down months ago. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

In an interview on January 20, 2016, resident #064 shared that there is an intervention in place that helps to make them feel safe.

Record review of the current plan of care for resident #064 revealed no interventions or directions related to the use of this intervention.

Observations on January 20, 25, 27 and 28, 2016 revealed an intervention in place for resident #064; however, it was not functional.

Personal Support Worker (PSW) #142 confirmed in an interview on January 28, 2016 that resident #064 had this intervention in place which helped the resident to feel more secure. The PSW shared that they were unsure of what times this intervention was supposed to be in place. PSW #142 confirmed that the plan of care did not include any interventions or direction related to the use of the identified intervention. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Record review of the current plan of care for resident #024 revealed the resident was incontinent and required interventions.

Observations on January 25, 2016 revealed the Resident Care Card posted inside a cabinet in the resident's bathroom stated that the resident used an identified intervention.

On January 25, 2016, resident #024 confirmed in an interview that they required interventions contrary to that which was identified in the plan of care.

On January 25, 2016, Registered Practical Nurse (RPN) #137 confirmed that they were unsure of the interventions required for resident #137. The RPN also reported that the Resident Care Card posted inside the bathroom was not current as they had not been updated since the facility opened.

On January 25, 2016, Personal Support Worker (PSW) #135 was asked where they get directions in respect to incontinence interventions. They shared that there was a list posted in both of the clean utility rooms and the tub room. The PSW accompanied Inspector #532 to the clean utility rooms and the tub room and was not able to locate a list in any of the rooms.

In an interview on January 27, 2016, the Administrator #101 shared that the Resident Care Cards in the bathroom were intended to be taken down months ago as they were not being updated and the Administrator was not aware that the Resident Care Cards were still posted inside the bathroom.

January 29, 2016 at 1029 hours Inspector #630 interviewed an agency PSW #146, who reported that they worked one to two times per week on a specific floor and shared that they did not have access to the charting in Point of Care (POC) or Point Click Care

(PCC) and the plan of care. The staff member reported that in order to identify a resident's care needs they refer to the Resident Care Cards on the wall in the resident's room.

On January 29, 2016, the Administrator #101 was informed regarding the above information and she acknowledged that all staff were to have access to POC and PCC and confirmed that the plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Record review in Point Click Care for resident #003 revealed:
Current care plan and kardex provided conflicting directions related to two interventions regarding continence care.

POC documentation in PCC for a one month period revealed conflicting and inconsistent care was provided for resident #003.

Staff interview with Personal Support Worker (PSW) #150 and Registered Practical Nurse (RPN) #151 on January 29, 2016, confirmed one the interventions related to continence were required and one was not. RPN #151 confirmed that the plan of care provides conflicting direction to staff related to toileting and does not provide direction to staff. [s. 6. (1) (c)]

5. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Record review for resident #024 revealed that the Resident Assessment Protocol (RAP) completed in December 2015, indicated pain daily, moderate pain. Record review revealed a physician's order for pain medication two times a day.

On January 25, 2016 in an interview, resident #024 reported they had pain and took medication daily.

On January 25, 2016, in an interview, the Registered Practical Nurse (RPN) #125

reported that resident #024 did take analgesic for pain; however, there was no focus or goals in the plan of care for this resident related to pain. The RPN confirmed that the plan of care was not based on an assessment of the resident and the resident's needs and preferences. [s. 6. (2)]

6. The licensee has failed to ensure the eating plan of care was based on an assessment and the resident's needs and preferences.

Observations on January 22, 2016, found resident #049 eating a meal while positioned inappropriately and without monitoring. Resident #049 indicated that they had difficulty and required assistance.

Interviews with PSW #116, PSW #117, Registered Practical Nurse (RPN) #111, the Director of Dietary Services (DDS) #129 and Registered Dietitian (RD) #132 identified that resident #049 had responsive behaviours and was not monitored while eating.

Review of the clinical record for resident #049 found that the most recent assessment for eating assistance in 2015, indicated resident #049 required help from one staff for eating.

The plan of care included conflicting interventions and did not address all areas of the resident's preferences and needs.

Review of the plan of care for resident #049 with DDS #129 and RD #132 on January 26, 2016, confirmed that this resident did require monitoring during meals and the goals and interventions did not reflect the resident's assessments, needs and preferences for eating at meals. [s. 6. (2)]

7. The licensee has failed to ensure the nutrition plan of care was based on an assessment of the resident and the resident's needs and preferences.

Review of the clinical record for resident #049 identified that she had not been weighed for over eight months. At the time of this last measurement resident #049 had had a weight change of 11.5 per cent in two months.

Interviews with Personal Support Worker (PSW) #116, PSW #117, Registered Practical Nurse (RPN) #111 and RD #132 identified that resident #049 refused many nutritional

interventions including weight measurements. During these interviews staff were unclear whether resident #049 was being asked to be weighed each month or whether staff were just assuming they refused to be weighed. PSW #116 and PSW #117 confirmed they had not been in the practice of asking resident #049 to be weighed.

Observation of the weight list in the tub room with PSW #116 identified that resident #049 was not on the list to be weighed in January 2016.

The nutritional plan of care did not reflect the significant weight change as a concern. This plan of care did not include alternative goals for nutritional health apart from weight maintenance.

Review of the plan of care for resident #049 with Registered Dietitian (RD) #132 on January 26, 2016, confirmed this plan of care did not identify the significant weight change as a concern, the nutritional goal was for weight maintenance but resident #049 was not within the goal weight range and it did not provide direction for staff regarding individualized approaches for weight monitoring. RD #132 confirmed the goals and interventions did not reflect the resident's assessments, needs and preferences and that it was the expectation that the nutrition plan of care would meet these requirements. [s. 6. (2)]

8. The licensee has failed to ensure that the plan of care was based on the resident's needs and preferences regarding dressing.

Multiple observations on January 21, 25, 27, and 28, 2016, found resident #045 dressed inappropriately and positioned inappropriately with safety concerns.

On January 27, 2016, the Geriatric Clinical Nurse Specialist (GCNS) #102 was alerted of the situation by Inspector #630 and then assisted resident #045. The GCNS #102 confirmed that the resident was not dressed appropriately, not positioned properly, and was at risk for injury.

Interviews with Personal Support Worker (PSW) #114, Registered Practical Nurse (RPN) #119 and RPN #134 identified that resident #045 refused specific aspects of care and this had been a long-standing personal preference that started prior to admission.

Review of plan of care for resident #045 with RPN #119 confirmed it did not reflect the

resident's preference or identify the risk for injury related to refusal of specific interventions.

Interview with GCNS #102 confirmed it was the expectation that personal preferences and risk for injury would be assessed and included in the plan of care. [s. 6. (2)]

9. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences related to the use of bed rails.

Observation of resident #001's bed system on January 20, 2016 revealed specific bed rails in use. Record review of the current care plan and kardex for resident #001 revealed there were no goals or interventions related to these specific bed rails.

Interview with resident #001 on January 27, 2016 confirmed the specific side rails were needed and always in use.

Staff interview with Personal Support Worker (PSW) #118 on February 4, 2016 revealed resident #001 required the rails daily for bed mobility.

Observation of resident #004's bed system on January 20, 2016 revealed specific bed rails in use. Record review of the current care plan and kardex for resident #004 revealed there were no goals or interventions related to the use of these specific bed rails.

Staff interview with PSW #169 on February 4, 2016 revealed resident #004 needed the bed rails to assist with bed mobility.

Observation of resident #005's bed system on January 20, 2016 revealed specific bed rails in use. Record review of the current care plan and kardex for resident #005 revealed there were no goals or interventions related to the use of these specific bed rails.

Staff interview with PSW #118 on February 4, 2016 revealed resident #005 used the rails daily for bed mobility and shared that this resident's required bed rails as a fall strategy.

Observation of resident #009's bed system on January 20, 2016 revealed specific bed rails in use. Record review of the current care plan and kardex for resident #009 revealed there were no goals or interventions related to the use of these specific bed rails.

Staff interview with PSW #118 on February 4, 2016 revealed although resident #009 used specific bed rails at their request. Staff interview with resident #009 on February 4, 2016 confirmed they prefer to use bed rails.

Staff interview with PSW #110 on January 21, 2016 during stage 1 of the Resident Quality Inspection (RQI) confirmed resident #001, 004, 005 and 009 used bed rails daily and staff interview with RPN #111 confirmed resident #001, 004, 005 and 009 did not have goals and interventions related to the daily use of bed rails.

Staff interview with the acting Director of Care #140 on February 2, 2016 at 1240 hours confirmed the plan of care was not based on an assessment of the resident's needs and preferences related to the use of bed rails and confirmed for those residents who needed bed rails, should have had goals and interventions for their use. [s. 6. (2)]

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

Record review of the current plan of care in Point Click Care for resident #062 revealed two identified interventions related to mouth care and continence care.

Observations on January 26, 2016 for a 90 minute period revealed resident #062 did not have the interventions provided identified in the care plan.

Staff interview with Personal Support Worker (PSW) #108 on January 26, 2016 confirmed that resident #062 the two interventions were not provided identified in the care plan. Staff interview with Registered Practical Nurse (RPN) #107 on January 26, 2016 confirmed that the care plan for resident #062 identified these two interventions related to mouth care and continence care and that care should have be provided as per the plan of care.

Staff interview with the Administrator #101 and the Geriatric Clinical Nursing Specialist #103 on January 27, 2016 confirmed that the home's expectation is that care was provided as specified in the plan of care. [s. 6. (7)]

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

Record review of the current plan of care for resident #064 revealed the resident has specific interventions related to safety and a feeling of security.

Observations on January 20, 25, 27 and 28, 2016 revealed these interventions were not provided.

Personal Support Worker (PSW) #142 confirmed these specific interventions identified in the care plan,in an interview on January 28, 2016.

The Administrator #101 and the Geriatric Clinical Nursing Specialist #103 confirmed in an interview on January 27, 2016, that the home's expectation was that care was to be provided as specified in the plan of care. [s. 6. (7)]

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

Record review of the current care plan for resident #016 revealed a risk for falls and two interventions were identified in the plan of care.

Observation of resident #016 by inspector #213 on February 3, 2016 at an identified time revealed the interventions outlined in the plan of care were not in place.

Staff interview with Personal Support Worker (PSW) #166 and #153 on February 3, 2016 by Inspector #213, revealed resident #016 does not use one of the interventions. On February 3, 2016, Registered Practical Nurse (RPN) #137 shared in an interview with Inspector #213 that the one interventions was used temporarily and was no longer needed.

Staff interview on February 5, 2016 with PSW #142 revealed they are the restorative care PSW and they are responsible for maintaining the interventions identified in the care plan and that resident #016 still required the interventions identified in the plan of care related to a high risk for falls.

The care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

13. The licensee has failed to ensure that the continence care specified in the plan of care was provided to the resident.

On January 21, 2016, an interview with a family member for resident #043 identified the concern that the resident was not receiving adequate care regarding toileting and felt it was affecting the resident's quality of life. This family member reported they visited regularly and on different occasions found that resident #043 had not received adequate care.

Observations of resident #043 on an identified date revealed staff did not provide interventions outlined in the plan of care over a three hour period. Interview with Personal Support Worker (PSW) #123 that date, confirmed that resident #043 had not received the identified interventions for the identified three hour period as the staff did not have time to provide this care. PSW #123 reported that resident #043 no longer received this intervention on a regular basis.

Observations of resident #043 on an identified date found two PSWs did provide the interventions identified in the care plan. Interview with PSW #141 confirmed that some staff do provide that intervention for resident #043.

Review of the plan of care #043 with Registered Practical Nurse (RPN) #119 confirmed it stated that the interventions were to be provided and that this care was not being consistently provided to the resident.

Review of the documentation in Point of Care (POC) for toileting care provided to resident #043 over a twelve day period showed there were no days when this intervention was provided as per the care plan and on four of these days the resident was not provided the intervention at all on one particular shift shift.

Interview with the Geriatric Clinical Nursing Specialist (GCNS) #103 on February 3, 2016, confirmed it is the expectation of the home that the care for continence set out in the plan of care was provided to residents. [s. 6. (7)]

14. The licensee has failed to ensure that staff who provided direct care to a resident were kept aware of the contents of the plan of care for bed rails and had convenient and immediate access to it.

On January 25, 2016, resident #043 was observed to have specific bed rails in use. There was no care card or logo observed on the wall in the resident's room related to bed rail use.

Interview with Personal Support Worker (PSW) #144 on an identified date revealed they would know that a resident used side rails by looking on the kardex or Point of Care (POC) but the PSW did not have access to the plan of care in Point Click Care (PCC). In review of POC for resident #043 with PSW #144, the PSW confirmed it was not included in point of care.

Interview with PSW #146 on an identified date revealed they worked for an agency but did work regularly on that home care area with resident #043. The PSW reported that they did not have access to point of care, the kardex or the plan of care in PCC. The PSW reported to identify the care needs of a resident they would look at the care card on the wall in the resident's room.

Interview with Registered Practical Nurse (RPN) #119 on January 29, 2016 confirmed that resident #043 used bed rails to hold onto during personal care when in bed. Review of the kardex with RPN #119 confirmed bed rails were not listed for this resident.

Interview with the Administrator #101 on January 27, 2016, identified that resident care cards were no longer being consistently used in the home as part of the plan of care.

Interview with RPN #119 on January 29, 2016 confirmed that the PSW staff did not have access to the plan of care in PCC for any residents and therefore did not have access to the plan of care regarding bed rails for resident #043 or for any residents.

In an interview with the Administrator #101 on January 29, 2016, she confirmed that agency staff did not have access to Point Click Care, with this, they were not able to see the plans of care for any residents and were not able to document care provided for any residents. [s. 6. (8)]

15. The licensee has failed to ensure that the provision of care and the outcomes of care set out in the plan of care as well as the effectiveness of the plan of care were documented.

Record review of Point of Care documentation in Point Click Care for the period of January 3 to February 1, 2016 for random residents on all four floors revealed:

Resident #003 was scheduled for a tub bath twice per week and no bath was documented as completed on one date of a scheduled bath in January 2016.

Resident #024 was scheduled for a shower twice per week and no bath was documented as completed on three dates of scheduled showers in January 2016.

Resident #061 was scheduled for tub baths twice per week and no bath was documented as completed on four dates of scheduled baths in January 2016.

Resident #071 was scheduled for tub baths twice per week and no bath was documented as completed on two dates of scheduled baths in January 2016.

Resident #072 was scheduled for a shower twice per week and no bath was documented as completed on one date of a scheduled shower in January 2016.

Record review of the Personal Support Worker (PSW) Job Routines for 0700 to 1500 hours and 1500 to 2300 hours float and all assignments revealed that each PSW in every assignment is responsible to complete at least one bath during their shift including float assignments.

Interview with Personal Support Worker (PSW) #146 on an identified date with Inspector #630 revealed they were a PSW from an agency. The PSW reported that they worked one to two times per week on fourth floor. They reported that they did not have access to Point of Care (POC), the kardex or charting in POC or the Point Click Care (PCC) plan of care. The PSW reported that they were not able to chart in POC and would tell the regular staff what care was provided and the regular staff would chart the care provided by agency staff.

Staff interview with Registered Practical Nurse (RPN) #152 on February 1, 2016 revealed that PSWs were responsible to document all care provided including baths provided during their shift in PCC. She confirmed that the above baths scheduled were not documented as completed and could not confirm if the baths/showers not documented were provided because they were not documented. RPN #152 shared that she was aware that staff have not always documented care provided despite the expectation and reminders.

In an interview with the Administrator #101 on January 29, 2016, she confirmed that agency staff did not have access to Point Click Care, with this, they were not able to see the plans of care for any residents and were not able to document care provided for any residents. She confirmed the expectation that all staff documented care they provided to residents in PCC, but without access to PCC, agency staff were unable to document the care they provided. [s. 6. (9)]

16. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Record review of the Minimum Data Set (MDS) completed for resident #064 revealed the resident's continence has changed from continent to usually incontinent to frequently incontinent over a nine month period.

Record review of assessments in Point Click Care (PCC)for resident #064 revealed the only continence assessment was completed in 2014 at the time of admission to the home.

The Geriatric Clinical Nursing Specialist #103 confirmed in an interview on January 27, 2016, that the home's expectation was that a continence assessment should have been completed in PCC following a change in continence documented in MDS including a change from continent to usually continent and a change from usually continent to frequently incontinent. [s. 6. (10) (b)]

17. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Record review of the Minimum Data Set (MDS) for an identified month for resident #024, indicated that this resident was occasionally incontinent of bowel, once a week; and bladder, 2 or more times a week but not daily. MDS three months later indicated that the resident was incontinent and had inadequate control of bowel, all (or almost all) of the time and the bladder, multiple daily episodes.

Record review revealed that the a bladder continence assessment was completed on admission in 2014 for resident #024.

Record review of the "Continence Care and Bowel Management" Policy #CPM-B-20 effective date February 2012 revealed "whenever resident has a change of condition for bladder incontinence they will be re-assessed using the Admission Assessments for Bowel/Bladder, on PCC".

On January 25, 2016, resident #024 confirmed in an interview that they wore incontinence products and that the staff assisted with toileting.

On January 26, 2016, the Acting Director of Care (ADOC) #140 acknowledged that resident #024 had complained that they were dissatisfied with the quality and performance of the new Attends incontinence products.

The ADOC further shared that she had informed the resident that there was no change in the resident's incontinence with the Tena incontinence products. The ADOC confirmed that this information was not based on an assessment but related to feedback from a Personal Support Worker (PSW).

In an interview on January 27, 2016, the Geriatric Clinical Nursing Specialist #103 confirmed that whenever a resident has a change in condition for bladder/bowel incontinence the expectation was for the resident to be re-assessed using the continence assessment for bladder and or bowel and she confirmed that resident #024 should have been reassessed and the plan of care reviewed and revised when the resident's care needs had changed. [s. 6. (10) (b)]

18. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Record review of the Minimum Data Set (MDS) for resident #081's locomotion on the unit changed from requiring supervision on the quarterly review assessment in an identified month, to requiring extensive assistance on the significant change in status assessment two months later.

Further record review of the current plan of care in Point Click Care (PCC) revealed: Locomotion on unit independent. Additionally the profile page on PCC indicated: Ambulatory, requiring no assistance but needs guidance.

Interview on January 25, 2015 with Physiotherapist #131 confirmed that resident #081 had experienced a decline in physical function and mobility, and required extensive assistance with locomotion. She confirmed that resident #081's care needs had changed and the care plan should have been updated to reflect those changes. [s. 6. (10) (b)]

19. The licensee has failed to ensure that the resident was reassessed when the resident's care needs changed.

Record review of the Minimum Data Set (MDS) for resident #081's bowel continence changed from frequently incontinent in the quarterly review assessment in an identified month, to incontinent in the significant change in status assessment two months later.

A bowel continence assessment was completed for resident #081 on admission in 2014. Further record review did not reveal any additional bowel continence assessments for this resident since the initial admission assessment.

Review of the home's Continence Care and Bowel Management Policy index #CPM-B-20 with an effective date February 2012 stated "If there is a change in continence in the past 90 days when the MDS assessment is done then a continence assessment [CPM-B-20-10 or CPM-B-20-15] is to be done".

Interview with the Administrator #101 on January 27, 2015, confirmed that no other continence assessments for resident #081 were completed since the admission assessment and since there was a decline in bowel continence as identified by the last MDS assessment, the expectation was that there should have been. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002, 011, 012, 013, 014 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 that the provision of care and the outcomes of care set out in the plan of care as well as the effectiveness of the plan of care are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

Four of the complaints inspected concurrently within this inspection were related to a high use of agency registered staff as well as staff shortages.

Record review of the Registered Nurse (RN) staff schedules for December 2015 revealed agency RNs (RNs employed by a nursing agency, not employees of the home) worked 28 out of 31 days in December for at least one shift. Agency RNs worked all three shifts; days, evenings, and nights on six out of 31 days in December 2015.

Record review of the Registered Nurse (RN) staff schedules for January 2016 revealed agency RNs (RNs employed by a nursing agency, not employees of the home) worked 25 out of 31 days in January 2016 for at least one shift.

In an interview with the President and Chief Operating Officer #163 and the Geriatric Clinical Nursing Specialist #103 on January 28, 2016, confirmed that the home was regularly scheduling RNs employed by a nursing agency to fill RN shifts in the home. The President and Chief Operating Officer and the Geriatric Clinical Nursing Specialist shared that they were not aware that the RN working in the home was required to be an employee of the home. [s. 8. (3)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.

Record review of the Professional Advisory Committee (PAC) meeting minutes dated December 17, 2015 revealed and identified incident of suspected potential abuse. There was no documented follow up in response to the incident, as noted in the PAC meeting minutes. The Physiotherapist (PT) #131, the Registered Dietitian (RD) #132, the Director of Dietary Services (DDS) #129, Physician #159, the Administrator #101, the acting Director of Care #140 and the Geriatric Clinical Nursing Specialist #103 were in attendance in the PAC meeting on that date.

Staff interview with Personal Support Worker (PSW) #142 on February 2, 2016, revealed they and the Physiotherapist had discovered this potential alleged incident of abuse. The PSW shared that the Physiotherapist reported the incidents at the PAC meeting on December 17, 2015.

Staff interview with the Physiotherapist (PT) #131 on February 2, 2016 at 1500 hours confirmed their discovery and reporting of the incident.

Record review of the Ministry of Health and Long Term Care Portal for critical incident reporting on February 2, 2016 revealed there was no submitted critical incident related to the alleged abuse or neglect.

The Acting Director of Care (ADOC) #140 and the Geriatric Clinical Nursing Specialist #103 confirmed on February 2, 2016 at 1250 hours, that the home did not immediately investigate or report the alleged incident that was reported during the PAC meeting on December 17, 2015 as far as they know. The home failed to report the suspicion of abuse or neglect immediately to the Director. [s. 24. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of improper or incompetent treatment of a resident that resulted in risk of harm to a resident that was reported to the licensee, was immediately investigated and appropriate action taken.

Record review of critical incident #3047-000043-15, revealed the administrator was advised on December 28, 2015 of an incident of improper or incompetent treatment of a resident with no injury to the resident

In an interview with the Administrator #101 and the Geriatric Clinical Nursing Specialist (GCNS) #103 on January 27, 2016, they confirmed the home's expectation regarding the treatment reported. The GCNS also confirmed that the staff member involved in the incident had not been interviewed to date and had not provided a statement of the incident. The GCNS also confirmed that the resident involved has not been interviewed or provided a statement to date. The GCNS confirmed that an investigation had not been completed and no actions had been taken related to a report of incompetent or improper care of resident #061. [s. 23.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee has failed to develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of

the accommodation, care, services, programs and goods provided to residents of the long-term care home.

The Long-Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 84 has been the subject of a previous non-compliance whereby a compliance order was issued on June 12, 2015, with a compliance date of August 21, 2015, under Inspection #2015_416515_0013, Log #001936-15 and was reissued on September 29, 2015, with a compliance date of November 2, 2015, under inspection #2015_416515_0027, Log #012786-15. This compliance order was issued for the third time under inspection #2015_262523_0036, Log #012780-15 with a compliance date of January 31, 2016 where by the licensee was to take action to achieve compliance by:
a) The home will demonstrate completed audits for all areas in the quality program
b) The home will demonstrate communications made to staff regarding their quality improvement program and staff will be aware of and be able to speak to changes made.
c) The home will demonstrate the communications made to both Councils.

Interview with President and Chief Operating Officer #163 on February 2, 2016 at 1600 hours, with Inspector #213, revealed the Continuous Quality Improvement (CQI) meeting minutes and CQI plan as well as evaluation of the CQI plan and/or any other evaluation of any programs had to be retrieved from the Administrator's computer and shared he would print it out and leave it for the Inspector the next day.

On February 3, 2016, the Office Manager #143 provided inspector #213 the "CIS Reports (MOHLTC) Tracking" and the "Written and Verbal Complaints/Concerns Analysis." She shared that the President and Chief Operating Officer #163 asked her to provide this information for CQI to Inspector #213 that had been requested the day prior.

Record review of the reports noted above included numbers of written and verbal complaints and critical incidents for 2015. The reports did not document the analysis, goals, objectives, plan, actions, target dates or accountability. No minute meetings or evaluations of the CQI program or any other programs were provided or received.

Record review of the Residents' Council binder on January 26, 2016 revealed there were no documented meeting minutes between October 2015 and January 2016 related to communications made regarding the CQI program to both Councils.

Staff interviews with Registered Practical Nurse (RPN) #147, Personal Support Worker (PSW) #118 and Recreation Aide (RA) #128 on February 4, 2016, confirmed they did not

receive communications regarding the home's quality improvement program and they were unable to speak to the quality improvement initiatives implemented to improve care, goods and services provided to the residents.

Staff interview with the Acting Director of Care #140 and the Geriatric Clinical Nursing Specialist #103 on February 2, 2016 at 1120 hours, confirmed there were no completed audits for any of the areas in the quality program. They also confirmed that the home did not demonstrate communications made to staff regarding the CQI program and confirmed family and residents were not informed or made aware of the home's CQI program at the Family and Resident Council meetings held in December 2015 and/or January 2016. [s. 84.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (1) Every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home. 2007, c. 8, s. 86. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had an infection prevention and control program.

Clinical record review for resident #042 identified that on an identified date, this resident was assessed by a Registered Practical Nurse (RPN) to have an illness. There was then a physician's order written on that same day for particular tests, treatments, and monitoring.

Review of progress notes and vital signs for resident #042 for evening and night shifts on

that date, and day shift the following day, found no documentation regarding the residents symptoms or illness, or monitoring. Review of the nursing shift report with RPN #134 for the following date, identified nothing was documented for resident #042 to communicate between nursing staff at shift change. RPN #134 identified she was unaware of the need to monitor the illness or provide the treatments for resident #042 until the time of interview with the inspector.

On an identified date, a review of the progress notes and physician order for resident #042 with RPN #134 and Acting DOC #140 brought to their attention that the physician order had not been processed and that the treatments and monitoring had not been started.

A follow-up interview with resident #042, identified that six days later they had not had the ordered tests. Interview with RPN #119 that day identified that the test request had been faxed the day after the physician's order was written, but identified that the test had not been completed.

Interview with Acting Director of Care #140 confirmed it was the expectation of the home that any possible respiratory infection was monitored based on the physician’s orders and that these orders would be processed in the home on the same day they were written and immediate action taken.

Annual education related to hand hygiene and infection prevention and control was not inspected during this RQI as the home has an outstanding compliance order with a compliance date of March 31, 2016 related to the completion of all mandatory education as no mandatory education including hand hygiene and infection prevention and control was completed in 2015.

Observation during medication administration on a particular date by Inspector #532 revealed Registered Practical Nurse (RPN) #124 was observed not washing hands after each medication administration, between, before and after resident contact. This RPN was touching residents' wheelchairs, sitting down to chat with residents, touching residents' hands and would return to the medication cart to administer the next resident's medication.

The Administrator #101, the Geriatric Clinical Nursing Specialist #103, and the Acting Director of Care #140 confirmed in a meeting on January 29, 2016 the home's expectation that registered staff complete hand washing before and after resident

contact.

Record review of the home's Infection Prevention and Control Manual and policies revealed the manual including all policies were last reviewed January 7, 2014.

The home did not provide documented evidence of infection prevention and control program meeting minutes, statistics reviewed or analyzed or an evaluation of the program.

The Administrator #101, the Geriatric Clinical Nursing Specialist #103, and the Acting Director of Care #140 confirmed in a meeting on January 29, 2016 that the home completed hand hygiene audits last when the building was opened in October 2014 and that they haven't completed any audits since that time.

The Administrator #101 and the Geriatric Clinical Nursing Specialist #103 confirmed in a meeting on January 27, 2016 that they were not aware if any infection prevention and control meetings occurred, if minutes were taken, or if an evaluation was completed for an infection prevention and control program. They confirmed that there is no designated lead for infection prevention and control in the home. [s. 86. (1)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: 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 had been assessed to minimize risk to the resident.

Observation of the bed systems for resident #001, #003, #004, #005, and #009 on January 20, 2016 revealed specific bed rails in use.

Record review of the Bedrail Use Risk Assessment for these five residents in 2014 revealed a quarter rail used, the bedrail (in its' upright position) does not prevent the resident from freely exiting the bed and the resident/POA do not want the bedrails to remain on the bed. The question “Are bedrails to be used?” the assessment was answered, “No.”

Record review of the "Entrapment Inspection Sheet" revealed the entrapment inspection occurred November 23-28, 2015. Resident #001, 003, 004, 005 and 009’s room numbers were identified on the inspection sheet as bed rails used with no fails identified for room numbers listed.

Staff interview with the acting Director of Care #140 on February 2, 2016 at 1240 hours, confirmed a Bedrail Use Risk Assessment was not completed for resident #001, 003, 004, 005 and 009 and the assessment should have been completed when bed rail use was initiated. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following interdisciplinary programs were implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

Record review of the home's required programs and policies revealed:
Continence Care and Bowel Management" Policy CPM-B-20 dated February 2012
Pain Assessment and Symptom Management Implementation CPM-D-20 dated February 2012
Skin and Wound Care Implementation Program Implementation CPM-F-20 dated February 2012
Falls Intervention Risk Management (FIRM) – Implementation CPM-C-20 dated January 2014

Record review of the Falls Intervention Risk Management (FIRM) Implementation policy #CPM-C-20 revealed:
"Evaluation

1. The DOC/Designate is responsible for the monthly review of all MDS outcomes related to falls, as a component of the Interdisciplinary Teams' review.
2. The DOC/Designate will review PCC documentation on a daily basis (business days) to review the documented falls that have occurred in the home.
3. The DOC/Designate will review documented falls on a monthly basis to identify trends and patterns of residents who have fallen".

Record review of the Pain Assessment and Symptom Management Implementation policy #CPM-D-20 revealed:
"Audits will be implemented to provide ongoing evaluation of the Pain Assessment and Symptom Management Program, in keeping with the Continuous Quality Improvement (CQI) Program. The Director of Care or designate will review audit results and implement corrective actions to address the identified deficiencies".

Record review of the Skin and Wound Care Program Implementation policy #CPM-F-20 revealed:
"CQI Manual - Individual Resident Skin/Wound Audit and Multi Resident Skin/Wound Audit (CQI-F-20-20-04); and any other tools which may be developed through the CQI proocess.
Monthly Skin Integrity Report (CPM-F-20-45) will be completed by the home's Wound Care Champion/designate at the end of each month and shared with the interdisciplinary team.
Wound Care Indicators - will be obtained from MDS indicators"

In interviews with the Administrator #101, the Geriatric Clinical Nursing Specialist #103 and the Acting Director of Care #140 on January 27 and 29, 2016, and with the Geriatric Clinical Nursing Specialist and the Acting Director of Care on February 2, 2016, they shared that there were no designated leads/champions for a falls prevention and management program, a skin and wound care program, a continence care and bowel management program or a pain management program. They confirmed that they had not participated in and were not aware of any meetings related to the required programs and were unable to produce documented evidence of meeting minutes, audits completed, statistics analyzed, goals, actions taken, or an evaluation for any of the required programs. [s. 48. (1)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was provided a response to the person who made the complaint, indicating what the licensee had done to resolve the complaint. The licensee also failed to ensure that a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

Record review of the Licensee Order for a Complaint Inspection dated May 28, 2015 with log #008221-15 revealed the home was ordered to prepare, submit and implement a plan related to the handling of complaints. During the follow up inspection for log #033924-15 on December 7, 8, 9, 2015 the Licensee Order was re-issued where by the licensee was to ensure that:
1. The Monitoring System "Complaints Management Tracking" is completed in full, in a timely manner, for every verbal and written complaint received, effective immediately.
2. The Family and Residents' Councils will be presented with this information by the Administrator or Designate and the members of Council will be given an opportunity to give feedback on the plan at the next planned Council meeting after the issuance of this order.
3. Staff who have not yet been educated on this process will complete their education by January 31, 2016.

Interview with resident #015's family members on an identified date in 2016 revealed the family member left a voice message with the Administrator in December 2015 related to the overall lack of communication in the home and the lack of follow up for three weeks related to a resident issue.

Record review of the "Complaints Management Tracking" on February 3, 2016 revealed there were no documented verbal or written complaints since October 2015. Resident #015's verbal complaint by a family member was not logged. The home was not compliant with the order to implement the monitoring system "Complaints Management Tracking" to be completed in full, in a timely manner, for every verbal and written complaint received, effective immediately.

Record review of the Family and Residents' Council minutes for meetings held on January 12, 2016 revealed information was not presented by the Administrator or Designate and the members of Council were not given an opportunity to give feedback on the plan after the issuance of this order which took place on January 4, 2016.

Interview with the Acting Director of Care (ADOC) #140 and the Geriatric Clinical Nursing Specialist #103 on February 2, 2016 at 1120 hours, confirmed the handing of complaints was not raised at Family or Residents' Council meetings on January 12, 2016.

The ADOC #140 provided the inspector with confirmation of those staff who received education related to the "Handling of Complaints" process and "Client Services Response Form." This revealed 119 staff members received training in the handling of complaints. The following 12 staff did not receive this training:
Registered Nurses= one staff
Registered Practical Nurses= three staff
Dietary Department= four staff
Personal Support Workers= four staff

Staff interview with the ADOC #140 and the Geriatric Clinical Nursing Specialist #103 on February 2, 2016 at 1120 hours, confirmed those staff who have not yet been educated on this process did not complete their education by January 31, 2016 related to the handling of complaints.

The home was not compliant with the order to educate those staff who have not yet been educated on the handing of complaints process. Their education was not completed by

January 31, 2016. [s. 101.]

Additional Required Actions:

CO # - 010 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #11: 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:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Record review of the paper charts and Point Click Care revealed resident #014, #061, #064, #74, #075, #076 were all admitted in either 2014 or 2015, they had consent and physician's order for the administration of immunization against pneumococcus and tetanus and diphtheria. There was no documentation of administration of immunization against pneumococcus or tetanus and diphtheria.

In staff interviews with Registered Practical Nurses (RPN) #164 and #137 and Registered Nurse (RN) #167 on a particular date, all three registered staff confirmed that to their knowledge, they have never seen pneumococcus vaccination in the home. They confirmed that they have never administered immunization against pneumococcus or tetanus and diphtheria in the home. They confirmed that all immunizations provided for residents are documented in Point Click Care in the immunizations tab.

In a staff interview with the Geriatric Clinical Nursing Specialist #103, she confirmed the home's expectation that residents should have been offered immunization against pneumococcus, tetanus and diphtheria. [s. 229. (10) 3.]

Additional Required Actions:

CO # - 015 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #12: 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' right to be properly cared for in a

manner consistent with his or her needs was fully respected and promoted.

Interview with resident #015's family members during the Resident Quality Inspection revealed the resident had a fall on an identified date and suffered a subsequent injury.

Record review of the progress notes on the date of the reported fall revealed documentation of the fall and subsequent injury. Record review of the Fall Incident Initial Post-Fall Assessment completed on the date of the fall revealed the resident #015 was not transferred to hospital, was experiencing pain, sustained an injury, physician was not notified, and Power of Attorney (POA) was notified on that date.

Record review of the Fall Incident Note Overview progress note dated the day of the fall revealed the physician was notified of the fall via the "FLAG" sheet. Interview with the Administrator #101, the acting Director of Care #140 and the Geriatric Clinical Nursing Specialist #103 on January 29, 2016 at 1110 hours, revealed "FLAG" sheets were communication sheets between the registered nursing staff and the physicians and are located on in a binder on each floor.

Record review of the progress notes dated the day after the fall revealed complaints of pain, pain medication administered, and an inability to complete usual activities of daily living. A physiotherapy referral was submitted the day after the fall and a progress note revealed further complaints of pain and observation of injury.

Record review of the progress notes dated the following day revealed further complaints of pain, observation of injury, pain medication administered but not completely effective and suggested that the resident may have need further tests to assess the injury.

Record review of the progress notes dated three days following the fall revealed the resident was unable to perform usual activities of daily living (ADL), had limited range of motion, and noted concern regarding the resident's safety related to the injury. A progress note was also documented indicating the resident required assistance with ADLs and assistive devices. There was no documented MD Progress Note.

Record review of the MD Progress Note dated ten days following the fall and documented as a late entry revealed, patient had a fall and has pain, deformity and limited movement, tests ordered.

Record review of the progress notes dated 12 days following the fall revealed a second

physiotherapy referral had been submitted for resident #015; eleven days after the first referral was submitted and without follow up.

Record review of the progress notes dated 17 days following the fall, revealed call made regarding test ordered and was expected to be done 7 days later. Also revealed a third physiotherapy referral had been submitted for resident #015; 16 days after the first referral was submitted and that the resident was seen by a Physiotherapist (PT). The progress note detailed a possible significant injury and that the test still had not been completed.

Record review of the MD Progress Note dated 17 days following the fall revealed, that despite the physician calling the staff to ensure that the test had been completed; it still had not been completed.
Record review of the progress notes dated 18 days following the fall, the resident had the test completed. The test result reviewed in the chart revealed a significant injury. A further progress note indicated that the MD at the hospital stated that this was not acceptable as the resident had not had the test or treatment in an acceptable time frame. In addition, the test and treatment in a timely fashion would have facilitated efficient and timely care for this resident.

Staff interview with the Administrator #101, the acting Director of Care #140 and the Geriatric Clinical Nursing Specialist #103 on January 29, 2016 at 1110 hours confirmed the home was negligent in care. The Administrator #101 shared the expectation that the leadership team reads the 24 hour report each day and the Geriatric Clinical Nursing Specialist #103 revealed she was not aware of the injury for resident #015 until she received the email from the Administrator and that she had not read the 24 hour report and indicated it was her responsibility to read this report daily. The Administrator shared that the staff should have called right away to have the test completed and confirmed there was no coverage when physiotherapist was away. The physiotherapist, nursing staff and the leadership team involved in the different aspects of care for resident #015 related to the injuries sustained post fall did not provide care consistent with her needs. (#563) [s. 3. (1) 4.]

2. The licensee has failed to ensure that the resident's right to be properly cared for in a manner consistent with his or her needs was fully respected and promoted.

Clinical record review for resident #042 identified that on an identified date, this resident

was assessed by a Registered Practical Nurse (RPN) to have an illness. There was then a physician's order written on that same day for particular tests, treatments, and monitoring.

Review of progress notes and vital signs for resident #042 for evening and night shifts on that date, and day shift the following day, found no documentation regarding the residents symptoms or illness, or monitoring. Review of the nursing shift report with RPN #134 for the following date, identified nothing was documented for resident #042 to communicate between nursing staff at shift change. RPN #134 identified she was unaware of the need to monitor the illness or provide the treatments for resident #042 until the time of interview with the inspector.

On an identified date, a review of the progress notes and physician order for resident #042 with RPN #134 and Acting DOC #140 brought to their attention that the physician order had not been processed and that the treatments and monitoring had not been started.

A follow-up interview with resident #042, identified that six days later they had not had the ordered tests. Interview with RPN #119 that day identified that the test request had been faxed the day after the physician's order was written, but identified that the test had not been completed.

Interview with Acting Director of Care #140 confirmed it was the expectation of the home that this type of illness should have been monitored based on the physician's orders and that these orders would be processed in the home on the same day they were written and immediate action taken.

The licensee did not fully respect or promote the resident's right to be properly cared for in a manner consistent with his or her needs were fully respected and promoted when the test that was ordered was not completed and that her symptoms were not monitored as per the physician's orders. (#630) [s. 3. (1) 4.]

Additional Required Actions:

CO # - 016 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #13: 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 home's Resident Personal Care Supplies policy was complied with.

Record review of the home's policy "IC-D-60 Infection Control Manual, Standard Precautions, Resident Personal Care Supplies" revealed:
"1. Control Measures
- use separate personal care items for each resident
- do no share personal care supplies (eg. soap, shaving razors, etc)
- all resident care supplies must be individually labelled
2. Storage and Handling of Personal Care supplies:
- supplies should be stored in a manner that keeps them clean and dry
- items taken to a common resident area should never be returned to a clean supply room, with the exception of unopened items that can be disinfected".

Observations on an identified resident home area on January 20, 2016 by Inspector #563 revealed the tub room had: six used and unlabeled sticks of deodorant, one used, unlabeled nail clipper with nail clippings and one used, unlabeled black comb. Staff interview with Personal Support Worker (PSW) #102 on January 20, 2016 confirmed there were six used and unlabeled sticks of deodorant, one used nail clipper with nail clippings and one used black comb in the tub room on the identified home care area.

Observation of the shared bathroom for residents #002 and #004 on January 20, 2016 by Inspector #563 revealed two of the same colour toothbrushes used and unlabeled,

stored in the same plastic cup and one used bar of soap in an unlabeled soap dish. Staff interview with PSW #110 on January 20, 2016 confirmed the two yellow toothbrushes were used and unlabeled and one used bar of soap in an unlabeled container. The PSW confirmed all personal care items should be labeled with the residents' names.

Observations on January 20, 2016 at 1015 hours on an identified resident home care area by Inspector #532 revealed the tub room had an unlabeled hair brush with hair in it, and an unlabeled nail clipper sitting in the tub room shelf. The shower room had a dried up bar soap sitting by the sink and a used nail file sitting on top of the hand wash soap container. PSW #135 and PSW #136 both confirmed that these unlabeled items were not supposed to be sitting in the tub or shower room; all personal items were to be labeled and stored in the resident personal container that was labeled either in the tub room or in the resident's room.

In an interview with the Geriatric Clinical Nursing Specialist #103 and the Acting Director of Care #140 on January 27, 2016, they confirmed the home's expectation that resident personal care items were not to be shared between residents and that they should have been labeled with the residents' names. [s. 8. (1)]

2. The licensee failed to ensure that the home's missing laundry protocol and procedure was complied with.

Interview with resident #064 on January 21, 2016 by Inspector #213, revealed the resident has had several missing clothing items since admission. Two specific items were identified that they were a gift. Resident #064 confirmed these two clothing items remained missing and that they were reported missing to staff during a second interview with Inspector #569 on February 1, 2016.

Policy review of the Facility Services Manual "Missing Resident Laundry FSM-B-95" with a revision date of October 2013 revealed:
"The PSW will:
1. Ensure that the Missing Laundry FORM is made readily available to families in each home area;
2. Assist the resident/family in completion of this form when an item is reported missing;
3. Conduct a search of the resident room and area for lost clothing;
4. Report the lost item by forwarding the Missing Laundry Form to the laundry staff if the item is not found in the home area".

Record review of "Missing Laundry Form FSM-B-95-05" with an effective date of October 2013 stated the following at the bottom of the form: "Forward to laundry within 24 hours if item is not found on the Resident Home Area".

Staff interview with Laundry Aide #148 on an identified date revealed that they were not aware of the described missing clothing items for resident #064. The laundry aide confirmed this after looking into the lost and found sections of the laundry area where unlabelled and unclaimed resident items were kept. They also shared that often the "Missing Laundry Form" was not sent down to the laundry room or came down well beyond the 24 hours stated on the form. In addition, staff often verbally report missing resident items to laundry staff and no missing form is filled out.

Review of the binder containing the missing laundry forms on February 1, 2015 in the laundry room revealed:
- form completed on Nov 23/15 and received in laundry Jan 8/16 (46 days)
- form completed on Dec 20/15 and received in laundry Jan 8/16 (19 days)
- form completed on Dec 25/15 and received in laundry Jan 8/16 (14 days)
- form completed on Jan 24/16 and received in laundry Feb 1/16 (8 days)

Further review failed to reveal a missing laundry form for resident #064.

Interview with the Director of Facility Services on February 5, 2016, confirmed it is the home's expectation for staff to follow the process for missing resident clothing as stated in the policy. [s. 8. (1) (b)]

3. The licensee failed to ensure that the home's "Labelling of Clothing" protocol and procedure was complied with.

Policy review of the Facility Services Manual "Labelling of Clothing FSM-B-20" with an effective date of February 2012, and a revision date of October 2013 revealed:
"Clothing Receipt and Inventory:
1. When a Resident is admitted or the family member brings in clothing items, the unit supervisor or in-charge person will place the clothing in a clear plastic bag, label the bag with resident's name, room number and date and take the labelled bag to the laundry.
Clothing Labelling:
1. The Director of Facility Services or his/her designate must then label the clothing

received and return clothing to the nursing unit within forty-eight (48) hours of receipt of clothing".

Interview on January 21, 2016 with resident #021 by Inspector #532 revealed the resident had been missing a personally owned linen item for approximately one week.

During a second interview with Inspector #569 on February 1, 2016 at 1000 hours, resident #021 confirmed that the linen item remained missing. The resident shared that they had a matching linen item she was presently using, but did not have a clean one to replace it as the home’s linen items did not meet the resident's needs.

Observation on February 1, 2016 revealed a “Missing Laundry Form” filled out for resident #021 describing the linen item with a date of January 24, 2016. This form was attached by tape to the identified resident home area nursing station desk.

Staff interview with Laundry Aide #148 on an identified date revealed that they just learned that resident #021's linen item was missing as they had just received the “Missing Laundry Form” from a staff member. The linen item had been in the laundry room for a while but it wasn’t labelled, and therefore did not know who it belonged to. The laundry aide sent the linen item up to the resident with the unit floor staff.

Observation of resident #021’s room on February 1, 2016 revealed the found linen item. Upon further observation it was revealed that neither of the resident’s personal linen items were labelled with the resident’s name.

Interview with the Director of Facility services #139 at 1600 hours, in the laundry area, confirmed that the home did not provide this particular linen item and that this personal linen item would be treated as a personal clothing item. He confirmed the resident’s personal linen item was not labelled and should have been as per the home’s policy. [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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #14: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care related to pain was based on an assessment.

Clinical record review for resident #043 found daily moderate pain as identified in the recent Minimum Data Set (MDS) assessment completed in 2015. This assessment also identified that resident #043 had cognitive decline and. The pain management plan of

care for resident #043 stated that staff were to monitor pain management every shift and administer medications accordingly, but did not specify how the pain was to be monitored. The documented pain monitoring for resident #043 for the month of January 2016 rated pain with a number scale.

There was no documented pain assessment observed in Point Click Care (PCC) or the resident's paper chart since the time of admission for resident #043. On January 27, 2016, interview with Registered Practical Nurse (RPN) #119 confirmed there had been no pain assessments documented for resident #043.

On February 1, 2016, interview with RPN #155 identified that staff were using the same pain rating scale for resident #043 as they used for cognitively well residents. The RPN confirmed that this resident was not be able to understand the pain rating scale. The RPN reported that staff had not received clear direction regarding the tool to use for monitoring pain for residents who were not able to rate their own pain with a number scale.

On January 27, 2016 the Geriatric Clinical Nursing Specialist (GCNS) #103 confirmed that it was the expectation of the home that a special pain scale would be used for residents with cognitive decline but that this tool had not been fully implemented. She indicated it was the expectation of the home that pain would be included in the plan of care and this would be based on an assessment of the resident and the resident's pain. (630) [s. 26. (3) 10.]

2. The licensee has failed to ensure that the plan of care for dental pain was based on an interdisciplinary assessment of the resident's dental pain.

On January 21 and 29, 2016, resident #042 identified during interviews that they had ongoing dental pain.

On January 25, 2016, Inspector #630 observed resident #042 tell Registered Practical Nurse (RPN) #119 that they had dental pain and RPN #119 asked the resident to rate the pain. Review of the clinical record for that day revealed that resident #042 rated this tooth pain as six out of ten and was given pain medication. The effectiveness of the PRN medication was not documented.

Interview with RPN #147 on January 29, 2016, identified that resident #042 had chronic

pain issues but was unable to identify where the pain was located and was unaware of dental pain. Review of pain monitoring through the electronic medication administration record (eMAR) with RPN #147 confirmed resident #042 had reported pain which was rated as eight out of ten on six occasions during a 19 day period in 2016 but this did not identify where the pain was located. Review of pain assessments for resident #042 with RPN #147 confirmed the most recent pain assessment was done in October 2015.

Review of clinical record for resident #042 revealed:
- Resident concern with dental pain was first noted in progress notes on an identified date, but there was no regular documentation of monitoring or assessing this concern.
- No identification of dental pain or dental problems in the most recent MDS dental care assessment.
- No identification of dental pain or dental problems in the resident's plan of care.

Interview with the Geriatric Clinical Nursing Specialist (GCNS) #103 on January 27, 2016, revealed pain assessments and progress notes were to be done for all residents who indicated they had pain. The GCNS #103 confirmed the expectation that dental pain was to be included in resident #042's plan of care. [s. 26. (3) 10.]

3. The licensee has failed to ensure that the plan of care for mouth and dental care was based on an interdisciplinary assessment and was based on the resident's needs and preferences.

On February 1, 2016, resident #044 identified dental issues and dental pain which had been a long standing problem. The resident reported that their family provided mouth wash and assisted with mouth care on a regular basis.

Interview with Personal Support Worker (PSW) #141 on February 1, 2016, revealed the staff provided set-up assistance for mouth and dental care for resident #044 twice daily but she was unaware of issues with dental pain or family involvement with care.

Review of the clinical record for resident #044 revealed no assessments or progress notes regarding dental care or dental pain since admission. The most recent Minimum Data Set (MDS) did not identify the resident's dental concern or include an assessment of dental care or mouth pain.

Review of the current plan of care for resident #044 identified the following:

- The 24 hour admission plan of care left the teeth section blank.
- The plan of care indicated there was no identification of dental issues or dental pain and it did not include specific interventions regarding care for mouth care.
- The kardex and Point of Care did not include any direction regarding dental or mouth care.

Inspector #630 reviewed the assessments and current plan of care for resident #044 with the Geriatric Clinical Nursing Specialist (GCNS) #103 on February 4, 2016, and she confirmed that the plan of care in place for this resident was not based on an assessment of the resident's dental and oral status. [s. 26. (3) 12.]

4. The licensee has failed to ensure that the plan of care was based on an assessment of the resident's activity patterns and pursuits.

On January 21, 2016, an interview with a family member of resident #043 revealed the resident loved music but did not attend music programs on a regular basis.

Review of the current recreation plan of care for resident #043 revealed it did not include interventions related to music.

Clinical record review for resident #043 revealed the initial recreation assessment had several sections that were incomplete and did not include any mention that the resident enjoyed music. The multidisciplinary care conference notes from 2015 did not include any documentation or assessment regarding recreation. There were no observed recreation assessments documented by recreation staff in 2015.

On February 1, 2016, interview with Recreation Aide #127 identified that apart from admission assessments the recreation staff were not doing regular assessments for any residents. She indicated there had been no clear direction given to the recreation staff regarding when or how to complete assessments. Reviewed the admission recreation assessment for resident #043 with Recreation Aide #127 and she confirmed it was incomplete and reported the plan of care she had created for resident #043 was not based on a documented assessment.

Review of Recreation Services policy "Recreation Department Overview REC-A-10" dated May 2014, identified that residents were to be assessed by a "qualified recreation professional" at admission and the assessment needed to include input from the resident

or their representative. This policy did not include direction for ongoing assessment or plan of care updates based on assessments after the initial admission assessment.

At the time of inspection, there was no Director of Recreation or Administrator working in the home to confirm the home's expectations regarding recreation assessments and plans of care.

On January 27, 2016, the Geriatric Clinical Nursing Specialist (GCNS) #103 identified that she was the acting lead for the recreation program but due to the newness of this role was unaware of the expectations in the home regarding recreation assessments. [s. 26. (3) 16.]

5. The licensee failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the safety risks.

Observations of resident #049 on January 27, 2016 revealed the resident had impaired skin integrity.

Record review of a progress note in October 2015 for resident #049 revealed a substance was taken out by staff and put in medication room. Writer spoke with resident about the safety risk. Resident understood and was cooperative with the decision at the time. Review of the progress notes revealed there were 20 documented notes related to the resident's independent use of an identified substance as a self treatment despite staff discouragement and interventions.

Interview with resident #049 on January 27, 2016 revealed the resident only used this substance as a self treatment related to skin integrity. The resident shared that they would order this substance independently for personal use and would pay for it independently. Resident #049 shared that the substance was taken from their room.

Staff interview with the Registered Practical Nurse (RPN) #111 on January 27, 2016 revealed the Acting Director of Care and the Director of Dietary Services removed the substance from the resident's room previously.

Record review of the current care plan for resident #049 revealed there was no documented interventions related to the use of the substance for skin integrity or any other specific instructions related to the resident's behaviour in relation to the use of the

substance or unsafe storage of the substance.

Staff interview with the Acting Director of Care (ADOC) on February 1, 2016 at 1400 hours, confirmed there have been ongoing concerns for resident #049's safety with the use and storage of the substance. The ADOC confirmed the use of the substance and the safety risks associated should have been a part of the resident's plan of care. [s. 26. (3) 19.]

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 plan of care related to pain is based on an assessment, the resident's needs and preferences, the resident's activity patterns and pursuits, and the safety risks, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Resident #009 shared in an interview with Inspector #563 on January 21, 2016 that they missed their last bath. Resident #010 in an interview with Inspector #563 on January 21, 2016 reported that they missed a bath last week.

Record review of Point of Care documentation in Point Click Care for a one month period in 2016 revealed:
Resident #009 was scheduled for a shower twice per week. No bath or shower was documented as provided or refused on two scheduled dates.

Resident #010 was scheduled for a bath twice per week. No bath or shower was documented as provided or refused on three scheduled dates.

Staff interview with Registered Practical Nurse #152 on February 1, 2016 revealed that she could not confirm if the baths/showers not documented were provided.

The Acting Director of Care #140 shared in an interview on February 1, 2016 that she could not confirm if the baths/showers not documented as provided were provided and that if it was not documented, it was not done. [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #16: 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 the 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 is specifically designed for skin and wound assessment.

Record review of Assessments in Point Click Care (PCC) for resident #042 revealed there was a Head to Toe Skin Assessment completed on an identified date which indicated impaired skin integrity.

Record review of the Physician's Orders for resident #042 revealed a nursing measure related to skin integrity.

Record review of Assessments in Point Click Care (PCC) revealed there were no Wound Assessment - Initial and Ongoing completed for resident #042 for the identified impaired skin integrity as described in the Head to Toe Assessment.

Staff interview with the Acting Director of Care (ADOC) #140, on February 1, 2016 at 1350 hours, confirmed the Wound Assessment - Initial and Ongoing should have been completed for the impaired skin integrity identified in the Head to Toe Assessment. [s. 50. (2) (b) (i)]

2. The licensee has 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 (RD) who is a member of the staff of the home.

Record review of a Wound Assessment - Initial and Ongoing for resident #042 revealed an area of impaired skin integrity. The assessment documented that a referral was not sent to the RD.

Record review of physician's orders revealed an order for identified treatment for the area of impaired skin integrity.

Record review of Assessments in Point Click Care (PCC) for resident #042 revealed the Dietary Referral/Diet Order/Change Form was not completed.

Record review of the "Skin and Wound Care Program Implementation" policy # CPM-F-20 on February 1, 2016 revealed, "Wound Assessment Initial/Ongoing [on PCC] - Residents with altered skin integrity will be referred to the Dietary Services Department by the Registered staff member for assessment by the Registered Dietitian".

Interview with the Registered Dietitian (RD) #132 on January 26, 2016 at 1000 hours by Inspector #630 confirmed she does not get referrals from the nursing staff or when she does receive referrals the information is incomplete. The RD shared that she has been getting referrals for fluid intake but not for skin integrity or many other nutritional issues. She reported that she has recently started to get a list of residents with skin issues from a nurse on a monthly basis due to the fact that she had not been receiving referrals via the home's policy and Point Click Care (PCC) forms.

Staff interview with the Acting Director of Care (ADOC) #140, on February 1, 2016 at 1350 hours, confirmed the RD referral should have been completed for the area of impaired skin integrity for resident #042. The ADOC also confirmed it was the home's expectation that the registered nursing staff were to complete the dietary referral in the "Assessment" tab of Point Click Care and the RD would complete an assessment and follow up. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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 and by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #17: 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).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence care and bowel management program included an annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff, and taking into account the evaluation when making purchasing decisions, including when vendor contracts were negotiated or renegotiated.

On January 25, 2016, resident #024 shared that they had concerns related to the inferior quality of incontinent products. The resident reported that the home made a change from Tena to Attends approximately two months ago without informing the residents of the home. The resident further shared that they were dependent on staff for care and the new products were not meeting the needs of the resident.

The current plan of care was reviewed and revealed the resident was incontinent and required assistance for the physical process of toileting.

On January 26, 2015, Personal Support Worker (PSW) #135 acknowledged that the resident's needs were not being with the new products despite the same type and amount of care.

In a meeting on January 27, 2015, the Administrator #101 shared that the home had sent out a memo to residents and families to inform them of the change from Tena to Attends incontinence products.

The memo was reviewed and it was noted that there was no date on the memo to indicate when it was issued and there was no date concerning when the change from Tena to Attends was to take place. Furthermore, the memo was not issued from the licensee or the management team of Earls Court.

On January 27, 2015, the Administrator #101 confirmed that there was no annual resident satisfaction evaluation of continence care products completed in consultation with residents, substitute decision-makers and direct care staff since the home had opened a year and half ago. She further acknowledged the purchasing decisions and the vendor contract was not based on the feedback of the residents as no evaluation was ever completed when making purchasing decisions. [s. 51. (1) 5.]

2. The licensee has failed to ensure that each resident who was incontinent of bladder had an individualized plan of care to promote and manage continence based on the assessment and the plan was implemented.

Interview with resident #042 on January 27, 2016 revealed they were continent when they received assistance with toileting from staff. Interview with Registered Practical Nurse (RPN) #119 and Personal Support Worker (PSW) #144 on January 27, 2016 revealed resident #042 was continent at times and that the timing of toileting was based on when the resident rang the bell for assistance, not on a specific toileting routine. PSW #144 reported resident #042 used the regular toilet not a commode and there was not a commode available for this resident.

Review of the clinical record for resident #042 revealed:
- there was no continence assessment completed since admission that identified pattern

or type of incontinence or potential to restore function.
- the plan of care and point of care was either absent of direction or provided conflicting direction related to continence and toileting.

Interview with the Geriatric Clinical Nursing Specialist (GCNS) #103 on February 4, 2016, confirmed it was the expectation of the home that the plan of care for continence was based on an assessment, reflected the needs and preferences of the resident and was implemented. [s. 51. (2) (b)]

3. The licensee has failed to ensure that each resident who was unable to toilet independently received assistance from staff to manage and maintain continence.

On January 27, 2016, resident #042 identified they were usually continent during identified times of the day. The resident indicated when they rang for assistance, assistance was not provided.

On January 27, 2016, interview with RPN #119 and PSW #144 identified that resident #042 was continent at times and that toileting care was based on the resident asking for assistance, not based on a specific toileting routine.

Review of plan of care for resident #042 did not include direction for toileting and listed check for wetness before, after meals, bedtime and on rounds during the night.

Review of documentation for toileting care provided to resident #042 showed no toileting occurred during any of the night shifts for a ten day period.

Interview with RPN #119 on January 27, 2016 confirmed that resident #042 was not usually toileted by staff during the night shifts and therefore was not receiving the assistance needed from staff to maintain continence.

Interview with GCNS #102 on February 4, 2016, confirmed it was the expectation of the home that residents received assistance from staff during the night shift to maintain continence. [s. 51. (2) (c)]

4. The licensee has failed to ensure that each resident that required continence care products had sufficient changes to remain clean, dry and comfortable.

On January 27, 2016, resident #042 reported that she rang for assistance at an identified time and did not receive this assistance until several hours later when the next shift arrived. The resident stated they reported this to Registered Practical Nurse (RPN) #119.

On January 27, 2016, interview with PSW #123 indicated they had provided this assistance to resident #042 at the beginning of their shift (the following shift).

The point of care documentation of toileting care provided to resident #042 showed care occurred during the identified shift on an identified date.

On January 27, 2016, interview with RPN #119 confirmed that resident #042 had reported the complaint that they had not received care as requested until next shift provided care.

Interview with the Geriatric Clinical Nursing Specialist (GCNS) #103 on February 4, 2016, indicated it was the expectation of the home that all residents received sufficient changes of continence products during the night shift to remain clean, dry and comfortable. [s. 51. (2) (g)]

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 program includes an annual resident satisfaction evaluation of continence care products in consultation with residents, substitute decision-makers and direct care staff, and taking into account the evaluation when making purchasing decisions, including when vendor contracts are negotiated or renegotiated,

to ensure that each resident who is incontinent of bladder has an individualized plan of care to promote and manage continence based on the assessment and the plan is implemented,

to ensure that each resident who is unable to toilet independently receives assistance from staff to manage and maintain continence,

and, to ensure that each resident that requires continence care products has sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Record review of the Minimum Data Set (MDS) for resident #064 completed in Point Click Care (PCC) revealed:
December 2015 - Pain daily, times when pain is horrible or excruciating
September 2015 – Pain daily, moderate pain
July 2015 – Pain daily, moderate pain
April 2015 - no pain
January 2015 – pain daily, moderate pain

Record review of a Medication Administration Record (MAR) for one month for resident #064 revealed the resident took pain medication twice daily. The MAR directed pain assessment every shift, three times per day. That month's MAR also indicated pain medication as needed for breakthrough pain. Documented as given at least once every day that month with the exception of two days with pain severity documented in numerical form on the MAR.

Record review of assessments completed in Point Click Care (PCC) revealed the only pain assessment documented for resident #064 was completed on admission in 2014.

Record review of the Pain Assessment and Symptom Management Implementation CPM-D-29 revealed "Each resident will be assessed by the registered staff upon admission, quarterly, annually, and with any identified alteration of the resident's pain processes".

In an interview on January 29, 2016, the Geriatric Clinical Nursing Specialist and the Acting Director of Care #140 confirmed that the home's expectations were that resident #064 should have had pain assessments completed quarterly, when there was a change from no pain to pain daily, when there was a change from moderate pain to times when pain is horrible or excruciating and when pain was not resolved by initial interventions. [s. 52. (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 the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Interview with the Resident Council President #013 on January 21, 2016 at 1545 hours, revealed the Resident Council President shared they never hear back whether the home can or can not do anything about a problem. They shared that they had the feeling the home was hoping the council would forget. The resident felt there was no point of having a council if they never know what's going on or how their concerns were being addressed. They shared, there was a light blinking in the dining room and he complained over two months and no one got back to them and the only reason they knew it was addressed was because by the third month the light stopped blinking. The resident shared they definitely did not receive anything in writing from the home.

Record review of the "Residents' Council Standing Agenda" dated August 11, 2015 revealed, "residents are concerned that the courtyard door continually not working and/or broken," and "residents concerned that there are broken lights and blinds in their rooms".

There was no "Action Outcome" documented for either concern.

Record review of the "Residents' Council Standing Agenda" dated September 15, 2015, revealed the following new documented concerns:
1. "Residents concerned that there are broken lights and blinds in their rooms."
2. "Residents concerned that the cabinet in library is broken."
3. "Residents concerned that the second patio door is not accessible for residents in wheelchairs. There is a lip making it difficult."
4. "Residents concerned with the room temperatures in their rooms, some are very warm and other too cold."
5. "Residents concerned that food is going missing from the Harvest Kitchen fridge, even when labelled."
6. "Residents want to know if the first floor fireplace can be fixed, it hasn't worked in some time."
There was no "Action Outcome" documented for any of the six concerns.

Record review of the "Residents' Council Standing Agenda" dated October 13, 2015, revealed the same six documented concerns outlined in in the Residents' Council agenda for September 15, 2015 and there was no "Action Outcome" documented for any of the six concerns.

Record review of the "Residents' Council Standing Agenda" dated November 10, 2015 revealed, "Dining room lights flashing by the windows on 1st floor" and "Residents concerned that there is a lift battery storage in the home." There was no "Action Outcome" documented for either concern.

Record review of the "Residents' Council Standing Agenda" dated December 8, 2015 revealed, "Residents concerned that their blinds are easily seen through when the sun is directly on them." There was no "Action Outcome" documented in response to this issue.

Record review of the "Residents' Council Standing Agenda" dated January 12, 2016 revealed a dietary concern, "meals late, residents not being asked to come to dining room". There was no "Action Outcome" documented in response to this issue.

Staff interview with the Director of Dietary Services #129 on January 26, 2016 at 1100 hours shared that she was the interim assistant appointed to the Residents' Council in the absence of the Director of Recreation and has attended the most recent Residents' Council meeting in January 2016. The Director of Dietary Services confirmed the

"Residents' Council Concerns Forms REC-620-05" should be completed to outline concerns presented at Residents' Council and the action taken or response to those concerns in writing within 10 days.

Record review of "Residents' Council Concerns Forms REC-620-05" in the Residents' Council binder revealed there were no completed forms between May 2015 and January 2016.

Staff interview with the Administrator #101 on January 26, 2016 at 1140 hours confirmed she looked in the office of the Director of Recreation and could not find the "Residents' Council Concerns Forms" missing from the Residents' Council binder dated from May 2015 to January 2016. The Administrator confirmed it is the home's expectation that concerns that arose from a Residents' Council meeting were to be documented on this form and the action taken or response to those concerns completed in writing within 10 days. [s. 57. (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 respond in writing within ten days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

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

Record review of the Family Council meeting minutes revealed:
- May 28, 2015, July 28, 2015, and November 24, 2015, Family Council requesting to have more chairs for the courtyard. There was no documented evidence of a written response to the Family Council from the licensee.

- July 28, 2015, and November 24, 2015, Family Council requesting a 'slow down' sign for the parking area outside the front of the home. There was no documented evidence of a written response to the Family Council from the licensee.

- July 28, 2015, and November 24, 2015, Family Council requesting for a timely response when family members brought issues to the attention of the Director of Care. There was no documented evidence of a written response to the Family Council from the licensee.

Interview with a Family Council co-chair on February 2, 2016, confirmed that Council had not received any written responses from the licensee related to concerns or recommendations that arose during Family Council meetings. [s. 60. (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 respond in writing within ten days of receiving Family Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the recreation and social activities program included the assistance and support to permit residents to participate in activities that may be of interest to them if the resident was not able to do so independently.

On January 21, 2016, an interview with a family member for resident #043 identified that the family member felt there were not enough activities for their parent who had cognitive decline. This family member gave an example that their parent loved music but the staff did not take them down to the music programs as they do not have enough staff to assist during the programs.

Multiple observations on January 22 and 25, 2016, found resident #043 wandering the halls or sleeping and at no time was observed to be engaged in recreation programs.

Interview with Recreation Aide (RA) #127 on January 26, 2016, identified that resident #043 had only attended two recreation programs during the month of January 2016 which were both "roll and stroll" on the resident's home unit. RA #127 indicated that music programs were only held on another floor in the home and that resident #043 was not taken to these programs due to the tendency to wander and not having enough staff at the activities to meet their needs.

Review of activity monitoring calendar with RA #127 confirmed that there were no music related activities offered on the identified resident home area in January 2016 and no music programs were provided to resident #043.

Interview with the Geriatric Clinical Nursing Specialist (GCNS) #103 (the acting lead for recreation) confirmed there was a lack of activities on that resident home area for residents with cognitive decline. She indicated the home had been short staffed for recreation and therefore, they have not been able to provide the necessary assistance with programs. [s. 65. (2) (f)]

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 recreation and social activities program includes the assistance and support to permit residents to participate in activities that may be of interest to them if the resident is not able to do so independently, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the Nutrition Care and Hydration Program there was a weight monitoring system to measure body mass index and height upon admission and annually thereafter.

Record review of height measurements in the vital signs section of Point Click Care for all residents in the home on January 27, 2016, revealed 82 out of 128 residents (64 per cent) did not have heights taken annually. For example:

Record review revealed residents' #043, #049, #052, #053 last height taken was in 2014.

On January 26, 2016, interview with Registered Dietitian (RD) #132 identified that heights were to be done at admission and annually by nursing using "Ulna Length" method. RD #132 indicated she was not aware prior to the interview that heights were not being done annually. On January 27, 2016, Director of Dietary Services (DDS) #129 revealed that the home did not have a policy in the dietary or nursing manuals to provide direction to staff for the method or frequency for measuring heights.

On January 27, 2016, interview with Administrator #101 confirmed the expectation that all residents were to have heights measured and documented annually and that the Nutrition Care program would include a monitoring system to measure and record the height on admission and annually thereafter. [s. 68. (2) (e) (ii)]

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 as part of the Nutrition Care and Hydration Program there is a weight monitoring system to measure body mass index and height upon admission and annually thereafter, to be implemented voluntarily.

WN #23: 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).

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: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

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: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all foods and fluids were served at a temperature that was both safe and palatable to residents receiving tray service.

On an identified date, in an identified unit dining room, a meal was prepared for resident #049 by Dietary Aide (DA) #120 at 1225 hours. This meal was then observed sitting on the counter in front of the food service area with plastic wrap covering some but not all items. Resident #049 arrived in the dining room at approximately 1300 hours after lunch meal service was completed and was served the meal by Personal Support Worker (PSW) #117. Resident #049 started to eat the meal at 1310 hours, 45 minutes after the meal had been prepared. Resident #049 was not asked by any other staff member if they wanted the meal warmed up until Inspector #630 spoke with Registered Practical Nurse (RPN) #111 at 1315 hours. Interview with PSW #117 confirmed that the meal had been sitting on the counter for 45 minutes and identified that they did not offer to warm up the

meal.

On another identified date, in the same dining room, a meal was observed sitting on the counter in front of the food service area at 1244 hours with plastic wrap covering some but not all items. Resident #049 was observed starting to eat the meal at 1257 hours, at least 13 minutes after the meal had been prepared.

Interview with resident #049 identified that meals were only warmed up by staff occasionally when they arrived later for the meal and that this resident found the food was not warm enough at times.

Review of the plan of care for resident #049 with the Director of Dietary Services (DDS) #129 confirmed there was not direction for staff regarding preferences for temperatures of the foods or beverages at meals.

Review of the Nutrition Care Policy titled "Tray Service DTY-A-260" effective February 2012 with DDS #129 confirmed this policy did not include procedures for storage of trays between preparation and service or expectations regarding the temperature of the food or beverages served on trays.

The Director of Dietary Services #129 indicated it was the expectation of the home that trays would be served at a temperature safe and palatable for residents and that all items would be covered. [s. 73. (1) 6.]

2. The licensee has failed to ensure that all meals were served course by course.

Observations in an identified resident home area dining room at lunch meal service on an identified date, identified four residents were served dessert while they were still eating the main entrée.

Observations in another resident home area dining room at lunch meal service on a different identified date, identified three residents were served dessert while they were still eating the main entrée.

Observation in another resident home area dining room at lunch meal service on the following day identified 17 residents were served dessert while they were still eating the main entrée. Interview with Personal Support Worker (PSW) #108 confirmed that course

by course service was not provided to the residents at this meal.

Observation in another resident home area dining room at lunch meal service on an identified date, identified five residents were served dessert while they were still eating the main entrée. Interview with PSW #123 and PSW #114 confirmed that course by course service was not provided to the residents at this meal.

On January 25, 2016, the Director of Dietary Services #129 confirmed it was the expectation of the home that residents were served their meals course by course. [s. 73. (1) 8.]

3. The licensee has failed to ensure that residents were provided with the personal assistance and encouragement required to eat and drink during meal service.

On an identified date, observations in an identified resident home area dining room at lunch meal service, found that resident #051 wandered in and out of the dining room for approximately 45 minutes and then at 1245 hours, left the dining room and did not return. Inspector #537 and #630 observed that resident #051 received no encouragement or assistance with eating from staff and consumed no food during the meal. Registered Practical Nurse (RPN) #107 indicated to inspector #537 that resident #051 tended to wander at meals and did not have other interventions at meals apart from liquid nutritional supplements.

Review of the clinical record for resident #051 identified:
- The food intake record for a 13 day period in 2016, showed that this resident consumed less than 25 per cent of food for 21 out of 39 meals (54 per cent).
- The most recent nutritional assessment by RD #132 indicated resident #051 needs encouragement to go to meals and stay in the dining room, easily distracted and leaves the dining room.
- The eating plan of care indicated the resident required assistance for eating
- The Point of Care record for this 13 day period in 2016, for type of eating assistance provided indicated that at 17 out of 28 shifts (60 per cent) she only received set-up assistance.

Interview with Registered Dietitian (RD) #132 on January 26, 2016, confirmed that resident #051 was at high nutritional risk and due to cognitive decline and required assistance and encouragement at meals to support intake of food and fluids. [s. 73. (1)

9.]

4. The licensee has failed to ensure that residents were provided with the personal assistance and encouragement required to eat and drink during meal service.

On an identified date, observations in an identified resident home area dining room at breakfast meal service identified that resident #043 was served a food item at 0830 hours with a verbal cue. Between 0836 hours and 0848 hours, resident #043 received four more verbal cues from various Personal Support Workers (PSW) assisting other residents in the dining room but no PSW was sitting at the table with them to provide assistance. Resident #043 did not start eating the food item until 0848 hours, 18 minutes after it was served. This resident was served the next course at 0851 hours, while still eating the first. The resident was taken from the dining room at 0900 hours and had completed their meal.

Review of Point of Care documentation for January 25, 2016, indicated resident #043 consumed less than 25 per cent of their breakfast meal.

Interview with Personal Support Worker (PSW) #123 on an identified date, confirmed that resident #043 required extensive assistance at breakfast as they were tired at the time. The PSW indicated that there were not enough PSWs available in the dining room to provide assistance to all residents as they were working short staffed as the PSW float shift had been pulled.

Interview with Registered Practical Nurse (RPN) #119 on January 25, 2016, revealed that the level of eating assistance required by resident #043 varied from meal to meal and confirmed they required total assistance due to tiredness at breakfast but did not receive this required assistance.

On January 26, 2016, the Director of Dietary Services #129 indicated it was the expectation of the home that residents received encouragement and assistance with eating as required. [s. 73. (1) 9.]

5. The licensee has failed to ensure that proper techniques were used to assist residents with eating.

On an identified date, in an identified resident home area dining room, during the lunch meal service, resident #050 was observed being assisted by Recreation Aide (RA) #128. RA #128 was standing to the right of the resident positioned approximately 50 centimeters above the resident and using a fork while providing eating assistance.

Interview with Registered Practical Nurse (RPN) #125 identified that staff should be sitting at eye level while assisting resident #050 and then directed RA #128 to sit down while assisting the resident.

Review of the plan of care for resident #050 revealed they required total assistance with eating due to cognitive deficit and physical limitations and there was no direction included indicating staff could stand or use a fork when providing assistance.

Interview with RA #128 on an identified date, identified that they were not aware of the feeding techniques required by specific residents in the dining room and had not been assisting in the dining room on a regular basis. The RA indicated they had not received training regarding eating assistance recently and had not reviewed the eating plan of care for resident #050.

Interview with the Geriatric Clinical Nursing Specialist (GCNS) #103 and Administrator #101 on January 27, 2016, confirmed that recreation staff had recently been directed, through a memo on January 22, 2016, to assist in the dining rooms at meals. The GCNS #103 confirmed that the recreation staff did not receive recent training or direction on the care needs of residents in the dining room prior to this new initiative and them performing these duties.

On January 26, 2016, the Director of Dietary Services #129 indicated it was the expectation of the home that all staff were to sit at eye level and use a teaspoon when providing eating assistance to residents. [s. 73. (1) 10.]

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 foods and fluids are served at a temperature that is both safe and palatable to residents, that all meals are served course by course, that residents are provided with the personal assistance and encouragement required to eat and drink during meal service, and that proper techniques are used to assist residents with eating and drinking, to be implemented voluntarily.

WN #24: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff had received training in the following areas before performing their responsibilities:
1. The Residents' Bill of Rights
2. The home's mission statement
3. The home's policy to promote zero tolerance of abuse and neglect of residents
4. The duty to make mandatory reports under section 24
5. The whistle-blower protections under section 26
6. The home's policy to minimize the restraining of residents
7. Fire prevention and safety
8. Emergency and evacuation procedures
9. Infection prevention and control
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities
11. Any other areas provided for in the regulations

Record review of the employee files of employees hired in 2015 revealed there was no documentation of orientation or training related to the Residents' Bill of Rights, the home's mission statement, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, the whistle-blower protections under section 26, the home's policy to minimize the restraining of residents, fire prevention and safety, emergency and evacuation procedures, infection prevention and control, all Acts, regulations, policies of the Ministry of Health and Long Term Care and similar documents, including policies of the licensee that are relevant to the person's responsibilities for 11 out of 41 employees.

In an interview with the Office Manager #143 by Inspector #630 on February 3, 2016, she confirmed there was no documentation of orientation for 27 per cent of employees hired and having worked in 2015 before performing their duties.

In an interview with the Geriatric Clinical Nursing Specialist #103 on February 2, 2016, she confirmed the home's expectation that staff receive training and orientation before performing their duties related to the Residents' Bill of Rights, the home's mission statement, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, the whistle-blower protections under section 26, the home's policy to minimize the restraining of residents, fire prevention and safety, emergency and evacuation procedures, infection prevention and control, all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities. [s. 76. (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 licensee ensured that all staff receive training in the following areas before performing their responsibilities:
1. The Residents' Bill of Rights
2. The home's mission statement
3. The home's policy to promote zero tolerance of abuse and neglect of residents
4. The duty to make mandatory reports under section 24
5. The whistle-blower protections under section 26
6. The home's policy to minimize the restraining of residents
7. Fire prevention and safety
8. Emergency and evacuation procedures
9. Infection prevention and control
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities
11. Any other areas provided for in the regulations, to be implemented voluntarily.

WN #25: 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. (2) A licensee shall make every reasonable effort to act on the results of the survey and to improve the long-term care home and the care, services, programs and goods accordingly. 2007, c. 8, s. 85. (2).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to make every reasonable effort to act on the results of the survey and to improve the long-term care home and the care, services, programs and goods accordingly.

Record review of the “Family Satisfaction Survey” action plan on January 26, 2016 which was created in response to concerns identified in the survey revealed the home documented the problem, topic of the problem, the number of negative survey responses and the action plan to correct or address the problem. There was no documented evidence that this process was implemented in response to the Resident Satisfaction Survey results or that the homes made every reasonable effort to act on the results of the Resident Satisfaction Survey to improve care and services.

Staff interview with the Administrator #101 on January 26, 2016 at 1140 hours, confirmed the results of the Resident Satisfaction Survey were available at the beginning of November 2015 and confirmed an action plan was not created in response to the satisfaction survey results. [s. 85. (2)]

2. The licensee has failed to document and make available to the Residents' and Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

Record review of the Residents' Council binder on January 26, 2016 revealed there were no documented meeting minutes between October 2015 and January 2016 related to the results of the satisfaction survey available in October 2015.

Staff interview with the Administrator #101 on January 26, 2015 at 1025 hours, confirmed the results of the satisfaction survey were available at the beginning of November 2015 and confirmed resident and family survey results were not shared with Residents' or Family Council. [s. 85. (4) (a)]

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 make every reasonable effort to act on the results of the survey and to improve the long-term care home and the care, services, programs and goods accordingly, and to document and make available to the Residents' and Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey, to be implemented voluntarily.

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, there were schedules and procedures in place for routine, preventive and remedial maintenance.

Staff interview with the Director of Facility Services on January 29, 2016 at 1100 hours, revealed contractors had been in to look at the patio doors in November and December 2015 to complete work on these doors because the doors were not closing properly.

Record review of the "Residents' Council Standing Agenda" dated January 12, 2016 revealed concerns that, residents want to go walking around back courtyard with an action plan to contact contractors since there was a problem with the lock, which had been corrected and the courtyard should have been done soon.

Record review of the "Residents' Council Standing Agenda" dated October 13, 2015 revealed, residents were concerned that the second floor patio doors were not accessible

for residents in wheelchairs. There was a lip making it difficult.

Record review of the "Residents' Council Standing Agenda" dated September 15, 2015 revealed residents were concerned that the courtyard doors were continually not working and/or broken with an action plan whereby Thames Glass has been contacted to fix the doors. Residents were also concerned that the second floor patio doors were not accessible for residents in wheelchairs. There was a lip making it difficult.

Record review of the "Residents' Council Standing Agenda" dated August 11, 2015 revealed, residents were concerned that the courtyard doors were continually not working and/or broken.

Interview with the Family Council Co-chair by Inspector #569 on February 3, 2016 at 0910 hours, demonstrated how the large disabled button was not working for the doors leading out to the back courtyard on first floor. She shared once outside one could not open the door to enter back in and needed to activate the call bell alarm located outside the door on the wall.

Interview with the Resident Council President, resident #013, on January 21, 2016 revealed that the patio doors to the outside did not lock or alarm all the time and although workers were here to fix them, he was unsure if it was still a problem.

Staff interview with the Director of Facility Services #139 on February 4, 2016 at 1400 hours, confirmed the first floor patio doors were not functioning properly and were currently unlocked to give access to residents and visitors and confirmed it was an ongoing problem. He confirmed that as part of the organized program of maintenance services there were no schedules or procedures in place for routine, preventive and remedial maintenance to ensure the safe and reliable function of exterior doors. [s. 90. (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 as part of the organized program of maintenance services, the licensee ensures that, there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to ensure that no medical directive or order for the administration of a drug to a resident was used unless it was individualized to the resident's condition and needs.

On February 03, 2016, medical directives were reviewed for the following residents and it was noted that all of the unscheduled "other" orders and "scheduled" orders were signed by the physician.

Record review revealed that resident #001, #024 and #049 had orders for identified medications as medical directives with no corresponding or appropriate diagnosis or condition to support the need for these medications.

Record review revealed that most of the residents in the home had all of the unscheduled "other" orders and "scheduled" orders signed by the physician and they were not individualized to the resident's condition and needs. This was confirmed with the Acting Director of Care #140 on February 3, 2016. [s. 117. (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 no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs, to be implemented voluntarily.

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least annually, there was an evaluation done by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator, of the utilization of drugs kept in the emergency drug supply in order to determine the need for drugs.

On February 1, 2016, the acting Director of Care (ADOC) #140 shared that she was not aware of an annual evaluation of the emergency drug supply done by the Medical Director, pharmacy service provider, DOC and the Administrator to ensure that the drugs were kept in the emergency drug supply were based on the need for the drugs.

Record review of the Professional Advisory Committee (PAC) meeting minutes from May, August, and December 2015, were provided by the home and it was noted that the emergency drug supply for the home was not discussed at any of these meetings and there was no evaluation or record of evaluation provided by the home as requested by Inspector #532.

On February 1, 2016 the ADOC #140 confirmed that she was not aware if there was an evaluation of the utilization of drugs that were kept in the emergency drug supply. She shared that she was not sure where to find the information. [s. 123. (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least annually, there is an evaluation done by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator, of the utilization of drugs kept in the emergency drug supply in order to determine the need for drugs, to be implemented voluntarily.

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs or complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, and lighting).

On January 20, 2016, it was observed that resident #030 had a medication in their room with an expiry date of March 2015.

On January 25, 2016 resident #064 had medication in their room with an expiry date of April 2015

The Acting Director of Care (ADOC) #140 confirmed in a meeting on January 25, 2016, that the above medications were not stored in an area used exclusively for drugs. She confirmed the drugs were expired and the home failed to comply with the manufacturer's instructions.

On February 2, 2016 at 1230 hours, the Government stock medication room contained Nitrostat tabs 0.6mg expiry date December 2015, and Enafimil Poly vis sol supplements with expiry date of January 01, 2016. The above medications were removed and given to the ADOC #140.

The ADOC #140 confirmed in a meeting on February 2, 2016, that there was no one, at this time, who was responsible to check for the expiration dates as there were different

Registered Nurses(RN), agency RNs, working nights; however, she would have to assign the task to ensure that home complies with the manufacturer's instructions for the storage of the drugs. [s. 129. (1) (a)]

2. The licensee has failed to ensure that the controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On January 28, 2016, and February 02, 2016, observation of two home care areas, it was observed that there was a medication fridge where a locked bin with controlled substances were stored, and this was not double-locked.

Observation on February 02, 2016, further revealed that on one home area, there were a number of injectable controlled medications inside the stat box; however, both of the bins were portable, not stationary, and not double locked.

The Acting Director of Care #140 confirmed that the controlled substances were not stored in a double-locked stationary cupboard in the locked area. [s. 129. (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 the drugs are stored in an area or a medication cart that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, and lighting).

Also to ensure that the controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #30: 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 has failed to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies.

On February 1, 2016, in an interview the Acting Director of Care (ADOC) #140, she shared that since she assumed the ADOC position November 2015, she found the daily count sheets in her office; however, she confirmed that no monthly audits of narcotic count sheets were completed to her knowledge.

Record review revealed that there were no audits completed of the daily count sheets and this was confirmed with the ADOC #140. She acknowledged that she waited for registered staff to complete a medication incident report if there were any discrepancies, as there were no monthly audits being completed. [s. 130. 3.]

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 monthly audit is 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, to be implemented voluntarily.

WN #31: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administered a drug to himself or herself unless the administration was approved by the prescriber in consultation with the resident.

On January 20, 2016, identified medications were observed in the room of resident #26. Record review revealed there was no physicians order for the identified medications to be self administered. On January 28, 2016, resident #026 reported that they used the medications independently on an as needed basis.

On January 20, 2016, an identified medication was observed in the room of resident #28. Record review revealed there was no physicians order for the identified medication to be self administered. On January 28, 2016, resident #026 reported that they used the medications independently on an as needed basis.

Registered Practical Nurse (RPN) #158 confirmed that the residents were not to self-administer medications unless the administration was approved by the prescriber and there were no orders for the above medications in place. [s. 131. (5)]

2. The licensee has failed to ensure that no resident who was permitted to administer a drug to himself or herself kept the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attended the resident.

On January 20, 2016 identified medications were observed in the rooms of residents #26, #27, #28, and #29.

Physician’s orders were reviewed and it was noted that the above residents were not authorized by a physician to keep any drugs in their room.

On January 20, 2016, Registered Practical Nurse (RPN) #107 shared that the drugs were not supposed to be in a resident's room unless they had an order to keep the drugs in their room.

On January 28, 2016, at 1530 hours, another observation and round was made of the same rooms as above with the RPN #158 to confirm the medications were removed from the residents as they did not have an order to keep the drugs in their room. During the observation on January 28, 2016, it was revealed that all of the above drugs were still inside the residents' rooms, despite the fact that it had been discussed with registered staff on January 20, 2016. It was confirmed with RPN #158 that the drugs should have been removed from residents' rooms; however, they were not. RPN #158 removed the drugs and acknowledged that no resident was permitted to administer a drug to himself or herself or keep the drugs in their room unless authorized by a physician and this was not done. [s. 131. (7)]

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 no resident administers a drug to himself or herself unless the administration is approved by the prescriber in consultation with the resident.

Also, to ensure that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident, to be implemented voluntarily.

WN #32: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Record review of progress notes in Point Click Care revealed:
Resident #071: documentation of administration of an identified PRN medication at an identified time and date with effect pending.

Resident #061: documentation of administration of an identified PRN medication at an identified time and date with effect pending on three separate dates.

Resident #016: documentation of administration of an identified PRN medication at an identified time and date with effect pending on two separate dates.

Resident #062: documentation of administration of an identified PRN medication at an identified time and date with effect pending on two separate dates.

In an interview with the Geriatric Clinical Nursing Specialist #103 and the Acting Director of Care #140 on February 2, 2016, they confirmed the home's expectation that registered staff should have assessed and documented the effect of PRN medications given and if the medication was not effective, reassessed and taken appropriate actions. [s. 134. (a)]

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 is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #33: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's substitute decision maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

On February 1, 2016, medication incidents reports were reviewed with the Acting Director of Care #140, and it revealed that medication incidents were not documented with a record of the immediate actions taken to assess and maintain the resident's health, the medication incidents were not reported to the resident or the resident's Substitute Decision Maker (SDM) and the pharmacy service provider was not notified. There were individual drug pouches still attached to the medication incidents reports.

The ADOC #140 further reported that since she took over the role of the ADOC, she had received no medication incident reports in the month of November 2015, three medication incidents in December 2015 and nine in the month of January 2016.

On February 1, 2016, the ADOC #140 confirmed that she did not follow through on all of the medication incidents; only 66 per cent of the medication incidents were documented with immediate actions to asses and maintain the residents' health and only 66 per cent of the SDM were notified and the pharmacy service provider was not notified in respect to any of the above medication incidents. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #34: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and his or her Substitute Decision Maker (SDM), if any, within six weeks of the admission of the resident, and at least annually after that. To ensure the resident, their SDM, if any, and any other person that either of them direct was invited to participate in these care conferences and a record was kept of the date, the participants, and the results of the conferences.

On January 21, 2016, in a family interview, the family of resident #022 notified inspector #532 that they were not invited to the six week care conference.

On January 29, 2016, the Receptionist #149 shared that she notified the family by sending a letter, as that was the routine procedure, however, they was not certain if the care conference happened as they were the person responsible for booking the care conference only.

Record review and staff interview with Registered Nurse (RN) #115 revealed that there was no documentation or record of the care conference in Point Click Care or the resident's paper chart.

On February 1, 2016, the Acting Director of Care (ADOC) #140 during an interview, reported that a care conference for resident #022 was booked for June 2015, and again for September 2015 as that was written on the calender; however, she was not able to show that an invitation was sent to the family. The ADOC was not able to confirm if the care conference was held and confirmed that there was no record of the date, the participants, and the results of the conference as nothing was documented or kept on the chart. She shared that she could not confirm that the meeting did occur in the absence of documentation of the meeting. [s. 27. (1)]

WN #35: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received the assistance required to dress. The licensee has failed to ensure that the resident was dressed appropriately, suitable to the time of day and in accordance with his/her preferences, in his/her own clean clothing and appropriate clean footwear.

On January 21, 2016, during stage 1 of the Resident Quality Inspection (RQI) in a family interview, the Power of Attorney (POA) for Care for resident #022 complained that when they visited the resident, they noted that the resident's bed linens and clothing were often soiled and that they had to change the resident's clothes when they visited.

On January 28, 2016 at an identified time, resident #022 was observed wearing soiled clothing.

On January 29, 2016 at an identified time, this resident was observed wearing the same soiled clothing and it was noted that the hair was unkempt and nails on both hand were soiled.

Record review of the plan of care for resident #022 revealed under personal hygiene support provided: one person physical assist.

In an interview on January 29, 2016, Personal Support Worker (PSW) #108 shared that resident #022 was independent with their own care and would get upset when the care was provided by staff.

Record review revealed that the resident had moderate cognitive impairment.

In an interview on January 29, 2016, Registered Practical Nurse (RPN) #107 shared that if the resident was resistive to care, staff left the resident and re-approached later.

On January 29, 2016, PSW #108 shared that they were not aware of any other interventions for care for the resident and the staff did not provide care for them.

In an interview on January 29, 2016, the Acting Director of Care (ADOC) #140 confirmed that the resident did not receive the assistance required to dress. Staff failed to ensure that the resident was dressed appropriately, suitable to the time of day and in accordance with her preferences, in her own clean clothing. [s. 40.]

WN #36: 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 name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(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)
(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)
(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 the most recent minutes of the Family Council meetings were posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, with the consent of the Family Council.

On January 20, 2016, at 1040 hours during the initial tour of the home by Inspector #563, observations revealed no Family Council minutes posted in a conspicuous and easily accessible location.

On February 3, 2016, at 1015 hours during a tour with a member of the Family Council of the first floor common areas, revealed no posting of the Family Council minutes for the most recent meeting of January 12, 2016. The Family Council member indicated that a binder of the minutes were usually kept at the reception desk but could not find the binder when she arrived at the home that day.

Interview with the front desk Receptionist #149 confirmed that the Family Council binder containing the meeting minutes was not at the front desk and they did not know where it was located.

Staff interview with Inspector #563, the Administrator #101 and the Geriatric Clinical Nursing Specialist #103 on January 27, 2016 at 1100 hours confirmed that the Family Council was never asked to have the minutes posted and were not being posted in the home. [s. 79. (3) (o)]

WN #37: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of laundry services, procedures were developed and implemented to ensure that residents' linens were changed at least once a week and more often as needed.

Observation of resident #022's room by Inspectors #569 and #532 on January 28, 2016, at 1615 hours, revealed the bed linens were soiled.

A second observation of resident #022's room on January 29, 2016, at 1005 hours revealed the bed was made with soiled linens.

Staff interview with Personal Support Worker (PSW) #108 at on January 29, 2016 revealed that resident bedding should be changed once a week or sooner if it becomes stained or soiled. PSW #108 confirmed that the bed linens in resident #022's room were significantly soiled and should have been changed which she proceeded to do.

Record review of the "PSW Job Routines 0600-1400" revealed: "finish making any unmade beds. Ensure the linens have been changed for all beds in assignment".

Interview with the Geriatric Clinical Nursing Specialist #103 on February 1, 2016, confirmed the home's expectation that resident bed linens should have been changed once a week on the day of the resident's bath, and if they were soiled or stained, then more often as needed. [s. 89. (1) (a) (i)]

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

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Issued on this 21st day of March, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RHONDA KUKOLY (213), AMIE GIBBS-WARD (630), DONNA TIERNEY (569), MELANIE NORTHEY (563), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2016_229213_0005
Log No. / Registre no:	001309-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 8, 2016
Licensee / Titulaire de permis :	SHARON FARMS & ENTERPRISES LIMITED 1340 HURON STREET, LONDON, ON, N5V-3R3
LTC Home / Foyer de SLD :	Earls Court Village 1390 Highbury Avenue North, LONDON, ON, 000-000
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paula Thomson

To SHARON FARMS & ENTERPRISES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee will evaluate and update their staffing plan based on an evaluation of:
a) The staffing mix being consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation
b) The use of agency staff and how the home will promote continuity of care
c) The back up plan for nursing and personal care staff.

The evaluation must also include the date(s) of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date those changes are made.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A family interview with Inspector #532 on January 21, 2016 revealed the family

member of resident #022 shared there is not enough staff available, that they found another resident in the dining room on the floor one day. The family shared that they do need some Personal Support Worker (PSW) staff, that the staff work really hard and they need more staff.

Resident #024 shared in an interview with Inspector #532 on January 21, 2016 that they have to wait to go to the bathroom because there is only three staff and that they have waited three quarters of an hour.

A resident interview with resident #071 on February 4, 2016 revealed the resident shared the staff treat them with respect and dignity, but they have to rush because there is not enough staff, they do not have enough help and they need more help.

Interview with Personal Support Worker (PSW) #146 on January 29, 2016 with Inspector #630 revealed she is a PSW from an agency. The PSW reported that they work one to two times per week. The PSW reported that they does not have access to (Point of Care) POC, the Kardex or charting in POC or the Point Click Care (PCC) plan of care. The PSW reported that they are not able to chart in POC and will tell the regular staff what care they provided and she/he will chart. In order to identify a resident's care needs, the PSW reported they will look on the wall in the resident's room or look at the "log" at the desk or ask the staff.

Five of the complaints completed concurrently within this inspection were related to a high use of agency staff, both personal support workers and registered staff as well as staff shortages.

The Family Council shared a concern with Inspector #569 in an interview on February 3, 2016. The Family Council identified that all areas of operations are being adversely impacted by this constant fluctuation of staff. This ultimately impacts the level of care residents receive. Some of the staffing concerns family council have raised are as follows: high turnover of staff at all levels, high percentage of agency staff vs full time, rotation of staff between floors, frequency of shifts being short staffed.

Record review of the master staff schedule and interview with the Administrator #101 on January 29, 2016 revealed there are supposed to be three PSW's on each of the four floors on day shift with a float PSW working between third and fourth floor and a float PSW working between first and second floor.

Observations on February 1, 2016 revealed there was an agency PSW working in the float position between third and fourth floor on day shift and the float position on day shift between first and second floor was unfilled and the units worked short staffed.

Staff interview with PSW #166 and PSW #171 on February 5, 2016 at 1045 hours revealed the home was short staffed that day, there was no PSW float for third and fourth floor, there was a PSW float for first and second floor and that this PSW was trying to help all four floors that day.

Record review of the PSW schedule and the Time Transaction Report for the pay period of January 4 to 17, 2016 revealed agency personal support workers were scheduled and worked eight shifts in a fourteen day period. The home was unable to provide documented evidence of the number of agency personal support workers that were scheduled and worked during the pay period of January 18 to 31, 2016. The Office Manager #143 confirmed in an interview on February 4, 2016, that the home was unable to determine if the home was fully staffed by looking at the staff schedule as agency staff scheduled were not documented on the staff schedule.

Record review of the Registered Practical Nurse (RPN) Schedules for December 2015 and January 2016 revealed that in December 2015, 22 out of 93 shifts were filled with agency RPNs. In January 2016, 18 out of 93 shifts were filled with agency RPNs.

In an interview with the President and Chief Operating Officer #163 on February 2, 2016, he confirmed that the staffing plan had not been evaluated since the home was opened in 2014.

The licensee failed to evaluate the staffing plan annually to ensure that the staffing plan provides continuity of care or provides a staffing mix that is consistent with residents' assessed care and safety needs.

The scope of this issue was widespread. The severity of the issue was determined to be a level two with a potential for harm or risk to residents. The home did have a history of non-compliance with a similar sub-section of the

regulation. It was issued as a voluntary plan of correction on April 28, 2015 and on December 19, 2014 related to no back up plan for nursing and personal care staff. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 04, 2016

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee will ensure that plan of care sets out clear directions to staff and others who provide direct care to all residents and specifically:

a) That the plan of care sets out clear direction for resident #024 related to continence.
b) That the plan of care sets out clear direction for resident #062 related to the use of a walker and dentures.
c) That the plan of care sets out clear direction for resident #064 related to the use of a door alarm.
d) That the plan of care sets out clear direction for resident #003 related to continence and toileting.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Record review in Point Click Care for resident #003 revealed:
Current care plan and kardex provided conflicting directions related to two interventions.

POC documentation in PCC for a one month period revealed conflicting and inconsistent care was provided for resident #003.

Staff interview with Personal Support Worker (PSW) #150 and Registered

Practical Nurse (RPN) #151 on January 29, 2016, revealed resident #003 confirmed the interventions required. RPN #151 confirmed that the plan of care provides conflicting direction to staff related to toileting and does not provide direction to staff. (213)

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Record review of the current plan of care for resident #024 revealed the resident was incontinent and required interventions.

Observations on January 25, 2016 revealed the Resident Care Card posted inside a cabinet in the resident's bathroom stated that the resident used an identified intervention.

On January 25, 2016, resident #024 confirmed in an interview that they required interventions contrary to that which was identified in the plan of care.

On January 25, 2016, Registered Practical Nurse (RPN) #137 confirmed that they were unsure of the interventions required for resident #137. The RPN also reported that the Resident Care Card posted inside the bathroom was not current as they had not been updated since the facility opened.

On January 25, 2016, Personal Support Worker (PSW) #135 was asked where they get directions in respect to incontinence interventions. They shared that there was a list posted in both of the clean utility rooms and the tub room. The PSW accompanied Inspector #532 to the clean utility rooms and the tub room and was not able to locate a list in any of the rooms.

In an interview on January 27, 2016, the Administrator #101 shared that the Resident Care Cards in the bathroom were intended to be taken down months ago as they were not being updated and the Administrator was not aware that the Resident Care Cards were still posted inside the bathroom.

January 29, 2016 at 1029 hours Inspector #630 interviewed an agency PSW #146, who reported that they worked one to two times per week on a specific floor and shared that they did not have access to the charting in Point of Care (POC) or Point Click Care (PCC) and the plan of care. The staff member reported that in order to identify a resident's care needs they refer to the

Resident Care Cards on the wall in the resident's room.

On January 29, 2016, the Administrator #101 was informed regarding the above information and she acknowledged that all staff were to have access to POC and PCC and confirmed that the plan of care did not set out clear directions to staff and others who provide direct care to the resident. (532)

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

In an interview on January 20, 2016, resident #064 shared that there is an intervention in place that helps to make them feel safe.

Record review of the current plan of care for resident #064 revealed no interventions or directions related to the use of this intervention.

Observations on January 20, 25, 27 and 28, 2016 revealed an intervention in place for resident #064; however, it was not functional.

Personal Support Worker (PSW) #142 confirmed in an interview on January 28, 2016 that resident #064 had this intervention in place which helped the resident to feel more secure. The PSW shared that they were unsure of what times this intervention was supposed to be in place. PSW #142 confirmed that the plan of care did not include any interventions or direction related to the use of the identified intervention. (213)

4. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Record review of the care plan in Point Click Care (PCC) for resident #062 revealed no indication of use an assistive device and refuses another particular intervention regarding oral care. Record review of the Resident Care Card in the bathroom for resident #062 indicated interventions contrary to the care plan in PCC.

Observations on July 26 and 28, 2015 for a period of one hour on each date revealed the interventions identified in the plan of care were not provided or in place.

Staff interview with Personal Support Worker (PSW) #108 on January 26, 2016 revealed resident #062 used an assistive device and has never used the intervention regarding oral care. Staff interview with PSW #105 on January 28, 2016 also revealed the resident used an assistive device and has never used the intervention regarding oral care. Staff interview with Registered Practical Nurse (RPN) #107 on January 28, 2016 confirmed resident #062 is supposed to use the assistive device and there was no direction in the plan of care related to the use of this intervention and there should be. The RPN shared that the intervention related to oral care has not been in use for several months. RPN #107 confirmed that the Resident Care Guide in the bathroom for this resident was inaccurate and needed to be updated and she was unsure of who was responsible to update the Resident Care Cards.

Staff interview with the Administrator #101 and the Geriatric Clinical Nursing Specialist #103 on January 27, 2016 confirmed that the conflicting information in the plan of care and the Resident Care Card did not provide clear direction for the staff related to the two interventions for resident #062. The Administrator shared that the Resident Care Cards were no longer in use and should have been taken down months ago.

The scope of this issue was a pattern. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did have a history of non-compliance with this sub-section of the regulation. It was issued as a voluntary plan of correction on March 6, 2015 and again on April 28, 2015. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 04, 2016

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee will ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

Grounds / Motifs :

1. The licensee has failed to ensure that there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

Four of the complaints inspected concurrently within this inspection were related to a high use of agency registered staff as well as staff shortages.

Record review of the Registered Nurse (RN) staff schedules for December 2015 revealed agency RNs (RNs employed by a nursing agency, not employees of the home) worked 28 out of 31 days in December for at least one shift. Agency RNs worked all three shifts; days, evenings, and nights on six out of 31 days in December 2015.

Record review of the Registered Nurse (RN) staff schedules for January 2016 revealed agency RNs (RNs employed by a nursing agency, not employees of the home) worked 25 out of 31 days in January 2016 for at least one shift.

In an interview with the President and Chief Operating Officer #163 and the Geriatric Clinical Nursing Specialist #103 on January 28, 2016, confirmed that the home was regularly scheduling RNs employed by a nursing agency to fill RN shifts in the home. The President and Chief Operating Officer and the Geriatric Clinical Nursing Specialist shared that they were not aware that the RN working in the home was required to be an employee of the home.

The scope of this issue was widespread. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did not have a history of non-compliance with this sub-section of the regulation. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 06, 2016

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_303563_0054, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will ensure that the Administrator or Acting Administrator immediately reports the suspicion of abuse or neglect of a resident and the information upon which it is based to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.

Record review of the Professional Advisory Committee (PAC) meeting minutes dated December 17, 2015 revealed and identified incident of suspected potential abuse. There was no documented follow up in response to the incident, as noted in the PAC meeting minutes. The Physiotherapist (PT) #131, the Registered Dietitian (RD) #132, the Director of Dietary Services (DDS) #129, Physician #159, the Administrator #101, the acting Director of Care #140 and the Geriatric Clinical Nursing Specialist #103 were in attendance in the PAC meeting on that

date.

Staff interview with Personal Support Worker (PSW) #142 on February 2, 2016, revealed they and the Physiotherapist had discovered this potential alleged incident of abuse. The PSW shared that the Physiotherapist reported the incidents at the PAC meeting on December 17, 2015.

Staff interview with the Physiotherapist (PT) #131 on February 2, 2016 at 1500 hours confirmed their discovery and reporting of the incident.

Record review of the Ministry of Health and Long Term Care Portal for critical incident reporting on February 2, 2016 revealed there was no submitted critical incident related to the alleged abuse or neglect.

The Acting Director of Care (ADOC) #140 and the Geriatric Clinical Nursing Specialist #103 confirmed on February 2, 2016 at 1250 hours, that the home did not immediately investigate or report the alleged incident that was reported during the PAC meeting on December 17, 2015 as far as they know. The home failed to report the suspicion of abuse or neglect immediately to the Director.

The scope of this issue was isolated. The severity of the issue was determined to be a level 2 as there was a potential for harm to residents. The home did have a history of non-compliance with this sub-section of the legislation. It was issued as a written notification on January 27, 2015; issued as a voluntary plan of correction on April 28, 2015 and again on June 19, 2015. It was issued as a compliance order on December 7, 2015 with a compliance date of January 4, 2016. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 11, 2016

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Order / Ordre :

The licensee must ensure that every alleged, suspected or witnessed incident of improper or incompetent treatment of a resident that resulted in harm or a risk of harm to a resident that is reported to the licensee, is immediately investigated and appropriate action taken.

Specifically, the licensee will investigate the report of an alleged improper transfer of resident #061, including interviewing the staff members involved, as well as the resident. The licensee will take appropriate actions related to the findings of the investigation and notify the resident and/or the resident's substitute decision maker regarding the investigation, the findings of the investigation and the actions taken.

Further to this, the licensee will immediately investigate and take appropriate actions related to every alleged, suspected or witnessed incident of improper or incompetent treatment of a resident that results in harm or risk of harm to a resident that is reported to the licensee.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of improper or incompetent treatment of a resident that resulted in risk of harm to a resident that was reported to the licensee, was immediately investigated and appropriate action taken.

Record review of critical incident #3047-000043-15, revealed the administrator was advised on December 28, 2015 of an incident of improper or incompetent treatment of a resident with no injury to the resident

In an interview with the Administrator #101 and the Geriatric Clinical Nursing Specialist (GCNS) #103 on January 27, 2016, they confirmed the home's expectation regarding the treatment reported. The GCNS also confirmed that the staff member involved in the incident had not been interviewed to date and had not provided a statement of the incident. The GCNS also confirmed that the resident involved has not been interviewed or provided a statement to date. The GCNS confirmed that an investigation had not been completed and no actions had been taken related to a report of incompetent or improper care of resident #061.

The scope of this issue was isolated. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did have a history of non-compliance with this sub-section of the regulation. It was issued as a voluntary plan of correction on February 10, 2015, on April 28, 2015 and on December 7, 2015. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 06, 2016

Order # / Ordre no : 006

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_262523_0036, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, S.O. 2007, c. 8, s. 84.

1. The plan must ensure that there is a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents developed and implemented in the home.

Specifically, the licensee will ensure that the continuous quality improvement (CQI) plan includes:
a) A written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
b) The home will document the utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long term care home, dates of reviews and the names of the persons who participated.
c) The system must be ongoing and interdisciplinary.
d) The home will demonstrate completed audits for all areas in the quality program.
e) The home will ensure that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided in the home. The home will use the results of these surveys in the development and implementation of the CQI

program.
f) The home will ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated and appropriate actions taken. A documented record of all complaints, the date of the complaint, what was done, the final resolution, response to the complainant and the documented record is analyzed for trends at least quarterly. The results of the review and analysis are taken into account when determining what improvements are required in the home and as part of the CQI program, and a written record is kept of each review and of the improvements made in response.
g) The home will demonstrate communications made to staff regarding their quality improvement program and staff will be aware of and be able to speak to changes made.
h) The home will demonstrate the communications made to Residents' and Family Councils regarding the home's CQI program and initiatives and changes made.
i) All required programs including falls prevention, continence care and bowel management, skin and wound care, pain management, recreation and leisure and infection prevention and control; with all of the corresponding policies and procedures, assessment tools and statistics gathered and analyzed, will be reviewed and revised annually as part of the CQI program.
j) A record must be maintained of the annual evaluation of the CQI program, the names of the persons who participated in evaluations, and the dates of the reviews.

The plan must include timelines for completion of the actions required and identify who is accountable for the task. The plan must also include who is responsible to oversee the maintenance of the program how the programs will be sustained moving forward.

Please submit the plan in writing to Rhonda Kukoly, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Long Term Care Homes Inspection Division, 130 Dufferin Ave, 4th Floor, London, ON, N6A 5R2, by email, at rhonda.kukoly@ontario.ca, by March 25, 2016.

Grounds / Motifs :

1. The licensee has failed to develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to

residents of the long-term care home.

The Long-Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 84 has been the subject of a previous non-compliance whereby a compliance order was issued on June 12, 2015, with a compliance date of August 21, 2015, under Inspection #2015_416515_0013, Log #001936-15 and was reissued on September 29, 2015, with a compliance date of November 2, 2015, under inspection #2015_416515_0027, Log #012786-15. This compliance order was issued for the third time under inspection #2015_262523_0036, Log #012780-15 with a compliance date of January 31, 2016 where by the licensee was to take action to achieve compliance by:
a) The home will demonstrate completed audits for all areas in the quality program
b) The home will demonstrate communications made to staff regarding their quality improvement program and staff will be aware of and be able to speak to changes made.
c) The home will demonstrate the communications made to both Councils.

Interview with President and Chief Operating Officer #163 on February 2, 2016 at 1600 hours, with Inspector #213, revealed the Continuous Quality Improvement (CQI) meeting minutes and CQI plan as well as evaluation of the CQI plan and/or any other evaluation of any programs had to be retrieved from the Administrator's computer and shared he would print it out and leave it for the Inspector the next day.

On February 3, 2016, the Office Manager #143 provided inspector #213 the "CIS Reports (MOHLTC) Tracking" and the "Written and Verbal Complaints/Concerns Analysis." She shared that the President and Chief Operating Officer #163 asked her to provide this information for CQI to Inspector #213 that had been requested the day prior.

Record review of the reports noted above included numbers of written and verbal complaints and critical incidents for 2015. The reports did not document the analysis, goals, objectives, plan, actions, target dates or accountability. No minute meetings or evaluations of the CQI program or any other programs were provided or received.

Record review of the Residents' Council binder on January 26, 2016 revealed there were no documented meeting minutes between October 2015 and

January 2016 related to communications made regarding the CQI program to both Councils.

Staff interviews with Registered Practical Nurse (RPN) #147, Personal Support Worker (PSW) #118 and Recreation Aide (RA) #128 on February 4, 2016, confirmed they did not receive communications regarding the home's quality improvement program and they were unable to speak to the quality improvement initiatives implemented to improve care, goods and services provided to the residents.

Staff interview with the Acting Director of Care #140 and the Geriatric Clinical Nursing Specialist #103 on February 2, 2016 at 1120 hours, confirmed there were no completed audits for any of the areas in the quality program. They also confirmed that the home did not demonstrate communications made to staff regarding the CQI program and confirmed family and residents were not informed or made aware of the home's CQI program at the Family and Resident Council meetings held in December 2015 and/or January 2016.

The scope of this issue was widespread. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did have a history of non-compliance with this sub-section of the regulation. It was issued as a compliance order on May 15, 2015 during the Resident Quality Inspection with a compliance date of August 15, 2015, it was reissued as a compliance order on September 29, 2015 with a compliance date of November 2, 2015, it was reissued again on November 25, 2015 with a compliance date of January 31, 2016.
(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 06, 2016

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 007

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 86. (1) Every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home. 2007, c. 8, s. 86. (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA 2007, c. 8, s. 86. (1).

1. The plan must ensure that there is an infection prevention and control program in the home including all requirements listed in O. Reg s. 229. Specifically, the infection prevention and control program must include:
a) Daily monitoring to detect the presence of infection in the resident and measures to prevent the transmission of infection. Symptoms are recorded and immediate action is taken as required.
b) Information gathered related to symptoms monitored is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends.
c) There is an interdisciplinary team approach in the co-ordination and implementation of the program. The team meets at least quarterly and the medical officer of health is invited to the meetings.
d) The program is evaluated and updated at least annually in accordance with the evidence-based practices with a written record kept relating to each evaluation including the date of the evaluation, the names of the persons who participated and a summary of the changes made and the date those changes were implemented.
e) There is a designated staff member to co-ordinate the program who has education and experience in infection prevention and control practices and that staff participate in the infection control program.
g) There is a hand hygiene program in accordance with evidence-based practices including documentation of hand hygiene audits and actions taken related to the audits, staff education and access to point of care hand hygiene agents.

The plan must include timelines for completion of the actions required and identify who is accountable for the task. The plan must also include who is responsible oversee the maintenance of the program how the programs will be sustained moving forward.

Please submit the plan in writing to Rhonda Kukoly, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Long Term Care Homes Inspection Division, 130 Dufferin Ave, 4th Floor, London, ON, N6A 5R2, by email, at rhonda.kukoly@ontario.ca, by March 25, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the home had an infection prevention and control program.

Clinical record review for resident #042 identified that on an identified date, this resident was assessed by a Registered Practical Nurse (RPN) to have an illness. There was then a physician's order written on that same day for particular tests, treatments, and monitoring.

Review of progress notes and vital signs for resident #042 for evening and night shifts on that date, and day shift the following day, found no documentation regarding the residents symptoms or illness, or monitoring. Review of the nursing shift report with RPN #134 for the following date, identified nothing was documented for resident #042 to communicate between nursing staff at shift change. RPN #134 identified she was unaware of the need to monitor the illness or provide the treatments for resident #042 until the time of interview with the inspector.

On an identified date, a review of the progress notes and physician order for resident #042 with RPN #134 and Acting DOC #140 brought to their attention that the physician order had not been processed and that the treatments and monitoring had not been started.

A follow-up interview with resident #042, identified that six days later they had not had the ordered tests. Interview with RPN #119 that day identified that the test request had been faxed the day after the physician's order was written, but identified that the test had not been completed.

Interview with Acting Director of Care #140 confirmed it was the expectation of the home that any possible respiratory infection was monitored based on the physician's orders and that these orders would be processed in the home on the same day they were written and immediate action taken.

Annual education related to hand hygiene and infection prevention and control was not inspected during this RQI as the home has an outstanding compliance order with a compliance date of March 31, 2016 related to the completion of all mandatory education as no mandatory education including hand hygiene and infection prevention and control was completed in 2015.

Observation during medication administration on a particular date by Inspector

#532 revealed Registered Practical Nurse (RPN) #124 was observed not washing hands after each medication administration, between, before and after resident contact. This RPN was touching residents' wheelchairs, sitting down to chat with residents, touching residents' hands and would return to the medication cart to administer the next resident's medication.

The Administrator #101, the Geriatric Clinical Nursing Specialist #103, and the Acting Director of Care #140 confirmed in a meeting on January 29, 2016 the home's expectation that registered staff complete hand washing before and after resident contact.

Record review of the home's Infection Prevention and Control Manual and policies revealed the manual including all policies were last reviewed January 7, 2014.

The home did not provide documented evidence of infection prevention and control program meeting minutes, statistics reviewed or analyzed or an evaluation of the program.

The Administrator #101, the Geriatric Clinical Nursing Specialist #103, and the Acting Director of Care #140 confirmed in a meeting on January 29, 2016 that the home completed hand hygiene audits last when the building was opened in October 2014 and that they haven't completed any audits since that time.

The Administrator #101 and the Geriatric Clinical Nursing Specialist #103 confirmed in a meeting on January 27, 2016 that they were not aware if any infection prevention and control meetings occurred, if minutes were taken, or if an evaluation was completed for an infection prevention and control program. They confirmed that there is no designated lead for infection prevention and control in the home.

The scope of this issue was widespread. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did not have a history of non-compliance with this sub-section of the regulation. (213)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 04, 2016

Order # / Ordre no : 008

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(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).

Order / Ordre :

The Licensee will ensure, where bed rails are used, the resident is assessed using an appropriate assessment tool to minimize risk to the resident.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used the resident had been assessed to minimize risk to the resident.

Observation of the bed systems for resident #001, #003, #004, #005, and #009 on January 20, 2016 revealed specific bed rails in use.

Record review of the Bedrail Use Risk Assessment for these five residents in 2014 revealed a quarter rail used, the bedrail (in its' upright position) does not prevent the resident from freely exiting the bed and the resident/POA do not want the bedrails to remain on the bed. The question “Are bedrails to be used?” the assessment was answered, “No.”

Record review of the "Entrapment Inspection Sheet" revealed the entrapment inspection occurred November 23-28, 2015. Resident #001, 003, 004, 005 and 009’s room numbers were identified on the inspection sheet as bed rails used with no fails identified for room numbers listed.

Staff interview with the acting Director of Care #140 on February 2, 2016 at 1240 hours, confirmed a Bedrail Use Risk Assessment was not completed for resident #001, 003, 004, 005 and 009 and the assessment should have been completed when bed rail use was initiated.

The scope of this issue was widespread. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did have a history of non-compliance with this sub-section of the regulation. It was issued as a compliance order on October 21, 2014 and was complied January 28, 2015. It was issued again as a voluntary plan of correction during the Resident Quality Inspection on April 28, 2015. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 06, 2016

Order # / Ordre no : 009

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.
O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 30 (1).
1. The plan must ensure that the following interdisciplinary programs are implemented in the home:
a) A falls prevention and management program to reduce the incidence of falls and the risk of injury.
b) A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
c) A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
d) A pain management program to identify pain in residents and manage pain.
e) A recreation and social activities program that is organized to meet the interests of all residents in the home.

2. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for

methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

3. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

4. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

5. The licensee shall keep a written record relating to each evaluation that includes the date of the evaluation, the names of the persons who participate in the evaluation, a summary of the changes made and the date that those changes are implemented.

The plan must include timelines for completion of the actions required and identify who is accountable for the task. The plan must also include who is responsible to oversee the maintenance of each program how the programs will be sustained moving forward.

Please submit the plan in writing to Rhonda Kukoly, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Long Term Care Homes Inspection Division, 130 Dufferin Ave, 4th Floor, London, ON, N6A 5R2, by email, at rhonda.kukoly@ontario.ca, by March 25, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the following interdisciplinary programs were implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

Record review of the home's required programs and policies revealed:
Continence Care and Bowel Management" Policy CPM-B-20 dated February 2012
Pain Assessment and Symptom Management Implementation CPM-D-20 dated February 2012
Skin and Wound Care Implementation Program Implementation CPM-F-20 dated February 2012
Falls Intervention Risk Management (FIRM) – Implementation CPM-C-20 dated January 2014

Record review of the Falls Intervention Risk Management (FIRM) Implementation policy #CPM-C-20 revealed:
"Evaluation
1. The DOC/Designate is responsible for the monthly review of all MDS outcomes related to falls, as a component of the Interdisciplinary Teams' review.
2. The DOC/Designate will review PCC documentation on a daily basis (business days) to review the documented falls that have occurred in the home.
3. The DOC/Designate will review documented falls on a monthly basis to identify trends and patterns of residents who have fallen".

Record review of the Pain Assessment and Symptom Management Implementation policy #CPM-D-20 revealed:
"Audits will be implemented to provide ongoing evaluation of the Pain Assessment and Symptom Management Program, in keeping with the Continuous Quality Improvement (CQI) Program. The Director of Care or designate will review audit results and implement corrective actions to address the identified deficiencies".

Record review of the Skin and Wound Care Program Implementation policy #CPM-F-20 revealed:
"CQI Manual - Individual Resident Skin/Wound Audit and Multi Resident Skin/Wound Audit (CQI-F-20-20-04); and any other tools which may be developed through the CQI proocess.
Monthly Skin Integrity Report (CPM-F-20-45) will be completed by the home's Wound Care Champion/designate at the end of each month and shared with the interdisciplinary team.
Wound Care Indicators - will be obtained from MDS indicators"

In interviews with the Administrator #101, the Geriatric Clinical Nursing

Specialist #103 and the Acting Director of Care #140 on January 27 and 29, 2016, and with the Geriatric Clinical Nursing Specialist and the Acting Director of Care on February 2, 2016, they shared that there were no designated leads/champions for a falls prevention and management program, a skin and wound care program, a continence care and bowel management program or a pain management program. They confirmed that they had not participated in and were not aware of any meetings related to the required programs and were unable to produce documented evidence of meeting minutes, audits completed, statistics analyzed, goals, actions taken, or an evaluation for any of the required programs.

The scope of this issue was widespread. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did not have a history of non-compliance with this sub-section of the regulation. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 04, 2016

Order # / Ordre no : 010

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_303563_0052, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. Dealing with complaints

Order / Ordre :

The licensee shall ensure that:
1. The Monitoring System "Complaints Management Tracking" is completed in full, in a timely manner, for every verbal and written complaint received, effective immediately and will include:
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.
2. The Family and Residents' Councils will be presented with this information by the Administrator or Designate and the members of Council will be given an opportunity to give feedback on the plan at the next planned Council meeting after the issuance of this order.
3. Staff who have not yet been educated on this process will complete their education by March 31, 2016.

Grounds / Motifs :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was provided a response to the person who made the complaint, indicating what the licensee had done to resolve the complaint. The licensee also failed to ensure that a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint;

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

Record review of the Licensee Order for a Complaint Inspection dated May 28, 2015 with log #008221-15 revealed the home was ordered to prepare, submit and implement a plan related to the handling of complaints. During the follow up inspection for log #033924-15 on December 7, 8, 9, 2015 the Licensee Order was re-issued where by the licensee was to ensure that:
1. The Monitoring System "Complaints Management Tracking" is completed in full, in a timely manner, for every verbal and written complaint received, effective immediately.
2. The Family and Residents' Councils will be presented with this information by the Administrator or Designate and the members of Council will be given an opportunity to give feedback on the plan at the next planned Council meeting after the issuance of this order.
3. Staff who have not yet been educated on this process will complete their education by January 31, 2016.

Interview with resident #015's family members on an identified date in 2016 revealed the family member left a voice message with the Administrator in December 2015 related to the overall lack of communication in the home and the lack of follow up for three weeks related to a resident issue.

Record review of the "Complaints Management Tracking" on February 3, 2016 revealed there were no documented verbal or written complaints since October 2015. Resident #015's verbal complaint by a family member was not logged. The home was not compliant with the order to implement the monitoring system "Complaints Management Tracking" to be completed in full, in a timely manner, for every verbal and written complaint received, effective immediately.

Record review of the Family and Residents' Council minutes for meetings held on January 12, 2016 revealed information was not presented by the Administrator or Designate and the members of Council were not given an opportunity to give feedback on the plan after the issuance of this order which

took place on January 4, 2016.

Interview with the Acting Director of Care (ADOC) #140 and the Geriatric Clinical Nursing Specialist #103 on February 2, 2016 at 1120 hours, confirmed the handing of complaints was not raised at Family or Residents' Council meetings on January 12, 2016.

The ADOC #140 provided the inspector with confirmation of those staff who received education related to the "Handling of Complaints" process and "Client Services Response Form." This revealed 119 staff members received training in the handling of complaints. The following 12 staff did not receive this training:
Registered Nurses= one staff
Registered Practical Nurses= three staff
Dietary Department= four staff
Personal Support Workers= four staff

Staff interview with the ADOC #140 and the Geriatric Clinical Nursing Specialist #103 on February 2, 2016 at 1120 hours, confirmed those staff who have not yet been educated on this process did not complete their education by January 31, 2016 related to the handling of complaints.

The home was not compliant with the order to educate those staff who have not yet been educated on the handing of complaints process. Their education was not completed by January 31, 2016.

The scope of this issue was widespread. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did have a history of non-compliance with this sub-section of the regulation. It was issued as a voluntary plan of correction on March 6, 2015, issued again as a compliance order on April 30, 2015 and re-issued as a compliance order on January 4, 2016 with a compliance date of January 31, 2016. (563)

Ontario

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 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 04, 2016

Order # / Ordre no : 011

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee will ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences for all residents and specifically:

a) The plan of care for resident #024 includes goals and interventions related to pain that are based on an assessment of the resident's needs and preferences related to pain.
b) The plan of care for resident #045 includes goals and interventions related to footwear that are based on an assessment of the resident's needs and preferences related to the use of footwear.
c) The plan of care for resident #049 includes goals and interventions related to eating and meals that are based on an assessment of the resident's needs and preferences related to eating and meals.
d) The plan of care related to resident #049 includes goals and interventions related to weight monitoring and weight maintenance that are based on an assessment of the resident's needs and preferences related to weight monitoring and weight maintenance.
e) The plan of care for resident #005 includes goals and interventions related to the use of bed rails that are based on an assessment of the resident's needs and preferences related to bed rails.

Grounds / Motifs :

1. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences related to the use of bed rails.

Observation of resident #001's bed system on January 20, 2016 revealed

specific bed rails in use. Record review of the current care plan and kardex for resident #001 revealed there were no goals or interventions related to these specific bed rails.

Interview with resident #001 on January 27, 2016 confirmed the specific side rails were needed and always in use.

Staff interview with Personal Support Worker (PSW) #118 on February 4, 2016 revealed resident #001 required the rails daily for bed mobility.

Observation of resident #004's bed system on January 20, 2016 revealed specific bed rails in use. Record review of the current care plan and kardex for resident #004 revealed there were no goals or interventions related to the use of these specific bed rails.

Staff interview with PSW #169 on February 4, 2016 revealed resident #004 needed the bed rails to assist with bed mobility.

Observation of resident #005's bed system on January 20, 2016 revealed specific bed rails in use. Record review of the current care plan and kardex for resident #005 revealed there were no goals or interventions related to the use of these specific bed rails.

Staff interview with PSW #118 on February 4, 2016 revealed resident #005 used the rails daily for bed mobility and shared that this resident's required bed rails as a fall strategy.

Observation of resident #009's bed system on January 20, 2016 revealed specific bed rails in use. Record review of the current care plan and kardex for resident #009 revealed there were no goals or interventions related to the use of these specific bed rails.

Staff interview with PSW #118 on February 4, 2016 revealed although resident #009 used specific bed rails at their request. Staff interview with resident #009 on February 4, 2016 confirmed they prefer to use bed rails.

Staff interview with PSW #110 on January 21, 2016 during stage 1 of the Resident Quality Inspection (RQI) confirmed resident #001, 004, 005 and 009 used bed rails daily and staff interview with RPN #111 confirmed resident #001,

004, 005 and 009 did not have goals and interventions related to the daily use of bed rails.

Staff interview with the acting Director of Care #140 on February 2, 2016 at 1240 hours confirmed the plan of care was not based on an assessment of the resident's needs and preferences related to the use of bed rails and confirmed for those residents who needed bed rails, should have had goals and interventions for their use. (563)

2. The licensee has failed to ensure that the plan of care was based on the resident's needs and preferences regarding dressing.

Multiple observations on January 21, 25, 27, and 28, 2016, found resident #045 dressed inappropriately and positioned inappropriately with safety concerns.

On January 27, 2016, the Geriatric Clinical Nurse Specialist (GCNS) #102 was alerted of the situation by Inspector #630 and then assisted resident #045. The GCNS #102 confirmed that the resident was not dressed appropriately, not positioned properly, and was at risk for injury.

Interviews with Personal Support Worker (PSW) #114, Registered Practical Nurse (RPN) #119 and RPN #134 identified that resident #045 refused specific aspects of care and this had been a long-standing personal preference that started prior to admission.

Review of plan of care for resident #045 with RPN #119 confirmed it did not reflect the resident's preference or identify the risk for injury related to refusal of specific interventions.

Interview with GCNS #102 confirmed it was the expectation that personal preferences and risk for injury would be assessed and included in the plan of care. (630)

3. The licensee has failed to ensure the nutrition plan of care was based on an assessment of the resident and the resident's needs and preferences.

Review of the clinical record for resident #049 identified that she had not been weighed for over eight months. At the time of this last measurement resident #049 had had a weight change of 11.5 per cent in two months.

Interviews with Personal Support Worker (PSW) #116, PSW #117, Registered Practical Nurse (RPN) #111 and RD #132 identified that resident #049 refused many nutritional interventions including weight measurements. During these interviews staff were unclear whether resident #049 was being asked to be weighed each month or whether staff were just assuming they refused to be weighed. PSW #116 and PSW #117 confirmed they had not been in the practice of asking resident #049 to be weighed.

Observation of the weight list in the tub room with PSW #116 identified that resident #049 was not on the list to be weighed in January 2016.

The nutritional plan of care did not reflect the significant weight change as a concern. This plan of care did not include alternative goals for nutritional health apart from weight maintenance.

Review of the plan of care for resident #049 with Registered Dietitian (RD) #132 on January 26, 2016, confirmed this plan of care did not identify the significant weight change as a concern, the nutritional goal was for weight maintenance but resident #049 was not within the goal weight range and it did not provide direction for staff regarding individualized approaches for weight monitoring. RD #132 confirmed the goals and interventions did not reflect the resident's assessments, needs and preferences and that it was the expectation that the nutrition plan of care would meet these requirements. (630)

4. The licensee has failed to ensure the eating plan of care was based on an assessment and the resident's needs and preferences.

Observations on January 22, 2016, found resident #049 eating a meal while positioned inappropriately and without monitoring. Resident #049 indicated that they had difficulty and required assistance.

Interviews with PSW #116, PSW #117, Registered Practical Nurse (RPN) #111, the Director of Dietary Services (DDS) #129 and Registered Dietitian (RD) #132 identified that resident #049 had responsive behaviours and was not monitored while eating.

Review of the clinical record for resident #049 found that the most recent assessment for eating assistance in 2015, indicated resident #049 required help

from one staff for eating.

The plan of care included conflicting interventions and did not address all areas of the resident's preferences and needs.

Review of the plan of care for resident #049 with DDS #129 and RD #132 on January 26, 2016, confirmed that this resident did require monitoring during meals and the goals and interventions did not reflect the resident's assessments, needs and preferences for eating at meals. (630)

5. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Record review for resident #024 revealed that the Resident Assessment Protocol (RAP) completed in December 2015, indicated pain daily, moderate pain. Record review revealed a physician's order for pain medication two times a day.

On January 25, 2016 in an interview, resident #024 reported they had pain and took medication daily.

On January 25, 2016, in an interview, the Registered Practical Nurse (RPN) #125 reported that resident #024 did take analgesic for pain; however, there was no focus or goals in the plan of care for this resident related to pain. The RPN confirmed that the plan of care was not based on an assessment of the resident and the resident's needs and preferences.

The scope of this issue was a pattern. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did have a history of non-compliance with this sub-section of the regulation. It was issued as a voluntary plan of correction on April 28, 2015 and April 30, 2015. (532)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 04, 2016

Order # / Ordre no : 012

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

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 will ensure that the care set out in the plan of care is provided to the resident as specified in the plan for all residents and specifically:

a) The care set out in the plan of care for resident #062 related to toileting and mouth care will be provided as specified in the plan.
b) The care set out in the plan of care for resident #043 related to the resident's feelings of anxiety and fear, specifically the door and the yellow ribbon will be provided as specified in the plan.
c) The care set out in the plan of care for resident #064 related to toileting and continence care will be provided as specified in the plan.
d) The care set out in the plan of care for resident #016 related to bed alarms, chair alarms and falls prevention will be provided as specified in the plan.

Grounds / Motifs :

1. The licensee has failed to ensure that the continence care specified in the plan of care was provided to the resident.

On January 21, 2016, an interview with a family member for resident #043 identified the concern that the resident was not receiving adequate care regarding toileting and felt it was affecting the resident's quality of life. This family member reported they visited regularly and on different occasions found that resident #043 had not received adequate care.

Observations of resident #043 on an identified date revealed staff did not provide interventions outlined in the plan of care over a three hour period. Interview with Personal Support Worker (PSW) #123 that date, confirmed that resident #043 had not received the identified interventions for the identified three

hour period as the staff did not have time to provide this care. PSW #123 reported that resident #043 no longer received this intervention on a regular basis.

Observations of resident #043 on an identified date found two PSWs did provide the interventions identified in the care plan. Interview with PSW #141 confirmed that some staff do provide that intervention for resident #043.

Review of the plan of care #043 with Registered Practical Nurse (RPN) #119 confirmed it stated that the interventions were to be provided and that this care was not being consistently provided to the resident.

Review of the documentation in Point of Care (POC) for toileting care provided to resident #043 over a twelve day period showed there were no days when this intervention was provided as per the care plan and on four of these days the resident was not provided the intervention at all on one particular shift shift.

Interview with the Geriatric Clinical Nursing Specialist (GCNS) #103 on February 3, 2016, confirmed it is the expectation of the home that the care for continence set out in the plan of care was provided to residents. (630)

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

Record review of the current care plan for resident #016 revealed a risk for falls and two interventions were identified in the plan of care.

Observation of resident #016 by inspector #213 on February 3, 2016 at an identified time revealed the interventions outlined in the plan of care were not in place.

Staff interview with Personal Support Worker (PSW) #166 and #153 on February 3, 2016 by Inspector #213, revealed resident #016 does not use one of the interventions. On February 3, 2016, Registered Practical Nurse (RPN) #137 shared in an interview with Inspector #213 that the one interventions was used temporarily and was no longer needed.

Staff interview on February 5, 2016 with PSW #142 revealed they are the restorative care PSW and they are responsible for maintaining the interventions

identified in the care plan and that resident #016 still required the interventions identified in the plan of care related to a high risk for falls.

The care set out in the plan of care was not provided to the resident as specified in the plan. (563)

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

Record review of the current plan of care for resident #064 revealed the resident has specific interventions related to safety and a feeling of security.

Observations on January 20, 25, 27 and 28, 2016 revealed these interventions were not provided.

Personal Support Worker (PSW) #142 confirmed these specific interventions identified in the care plan,in an interview on January 28, 2016.

The Administrator #101 and the Geriatric Clinical Nursing Specialist #103 confirmed in an interview on January 27, 2016, that the home's expectation was that care was to be provided as specified in the plan of care. (213)

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

Record review of the current plan of care in Point Click Care for resident #062 revealed two identified interventions related to mouth care and continence care.

Observations on January 26, 2016 for a 90 minute period revealed resident #062 did not have the interventions provided identified in the care plan.

Staff interview with Personal Support Worker (PSW) #108 on January 26, 2016 confirmed that resident #062 the two interventions were not provided identified in the care plan. Staff interview with Registered Practical Nurse (RPN) #107 on January 26, 2016 confirmed that the care plan for resident #062 identified these two interventions related to mouth care and continence care and that care should have be provided as per the plan of care.

Staff interview with the Administrator #101 and the Geriatric Clinical Nursing

Specialist #103 on January 27, 2016 confirmed that the home's expectation is that care was provided as specified in the plan of care.

The scope of this issue was a pattern. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did have a history of non-compliance with this sub-section of the regulation. It was issued as a voluntary plan of correction on April 28, 2015 and on April 30, 2015, and again on June 19, 2015. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 04, 2016

Order # / Ordre no : 013

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will ensure that staff who provide direct care to a resident are kept aware of the contents of the plan of care for bed rails and have convenient and immediate access to it.

Specifically, the licensee will ensure that the Kardex for resident #043 includes direction to direct care staff related to the use of bed rails.

Further to this, the licensee will ensure that Kardexes for all residents include direction to direct care staff regarding the use of bed rails for all residents who use bed rails. The licensee will also ensure that all staff working in the home, both staff employed by the home and agency staff, have access to Point of Care Documentation and the Kardex for residents they provide care to.

Grounds / Motifs :

1. The licensee has failed to ensure that staff who provided direct care to a resident were kept aware of the contents of the plan of care for bed rails and had convenient and immediate access to it.

On January 25, 2016, resident #043 was observed to have specific bed rails in use. There was no care card or logo observed on the wall in the resident's room related to bed rail use.

Interview with Personal Support Worker (PSW) #144 on an identified date revealed they would know that a resident used side rails by looking on the kardex or Point of Care (POC) but the PSW did not have access to the plan of care in Point Click Care (PCC). In review of POC for resident #043 with PSW

#144, the PSW confirmed it was not included in point of care.

Interview with PSW #146 on an identified date revealed they worked for an agency but did work regularly on that home care area with resident #043. The PSW reported that they did not have access to point of care, the kardex or the plan of care in PCC. The PSW reported to identify the care needs of a resident they would look at the care card on the wall in the resident's room.

Interview with Registered Practical Nurse (RPN) #119 on January 29, 2016 confirmed that resident #043 used bed rails to hold onto during personal care when in bed. Review of the kardex with RPN #119 confirmed bed rails were not listed for this resident.

Interview with the Administrator #101 on January 27, 2016, identified that resident care cards were no longer being consistently used in the home as part of the plan of care.

Interview with RPN #119 on January 29, 2016 confirmed that the PSW staff did not have access to the plan of care in PCC for any residents and therefore did not have access to the plan of care regarding bed rails for resident #043 or for any residents.

In an interview with the Administrator #101 on January 29, 2016, she confirmed that agency staff did not have access to Point Click Care, with this, they were not able to see the plans of care for any residents and were not able to document care provided for any residents.

The scope of this issue was a widespread. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did not have a history of non-compliance with this sub-section of the regulation. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 04, 2016

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 014

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee will ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change for all residents and specifically:

a) Continence assessments are completed and the plan of care reviewed and revised as needed for resident #064.
b) Continence assessments are completed and the plan of care reviewed and revised as needed for resident #024.
c) Continence assessments are completed and the plan of care reviewed and revised as needed for resident #081.
d) Mobility and transfer assessments are completed and the plan of care reviewed and revised as needed for resident #081.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed when the resident's care needs changed.

Record review of the Minimum Data Set (MDS) for resident #081's bowel continence changed from frequently incontinent in the quarterly review assessment in an identified month, to incontinent in the significant change in status assessment two months later.

A bowel continence assessment was completed for resident #081 on admission in 2014. Further record review did not reveal any additional bowel continence assessments for this resident since the initial admission assessment.

Review of the home's Continence Care and Bowel Management Policy index #CPM-B-20 with an effective date February 2012 stated "If there is a change in continence in the past 90 days when the MDS assessment is done then a continence assessment [CPM-B-20-10 or CPM-B-20-15] is to be done".

Interview with the Administrator #101 on January 27, 2015, confirmed that no other continence assessments for resident #081 were completed since the admission assessment and since there was a decline in bowel continence as identified by the last MDS assessment, the expectation was that there should have been. (569)

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Record review of the Minimum Data Set (MDS) for resident #081's locomotion on the unit changed from requiring supervision on the quarterly review assessment in an identified month, to requiring extensive assistance on the significant change in status assessment two months later.

Further record review of the current plan of care in Point Click Care (PCC) revealed: Locomotion on unit independent. Additionally the profile page on PCC indicated: Ambulatory, requiring no assistance but needs guidance.

Interview on January 25, 2015 with Physiotherapist #131 confirmed that resident #081 had experienced a decline in physical function and mobility, and required extensive assistance with locomotion. She confirmed that resident #081's care needs had changed and the care plan should have been updated to reflect those changes. (569)

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Record review of the Minimum Data Set (MDS) for an identified month for resident #024, indicated that this resident was occasionally incontinent of bowel, once a week; and bladder, 2 or more times a week but not daily. MDS three

months later indicated that the resident was incontinent and had inadequate control of bowel, all (or almost all) of the time and the bladder, multiple daily episodes.

Record review revealed that the a bladder continence assessment was completed on admission in 2014 for resident #024.

Record review of the "Continence Care and Bowel Management" Policy #CPM-B-20 effective date February 2012 revealed "whenever resident has a change of condition for bladder incontinence they will be re-assessed using the Admission Assessments for Bowel/Bladder, on PCC".

On January 25, 2016, resident #024 confirmed in an interview that they used incontinence products and that the staff assisted with toileting

On January 26, 2016, the Acting Director of Care (ADOC) #140 acknowledged that resident #024 had complained that they were dissatisfied with the quality and performance of the new Attends incontinence products were introduced.

The ADOC further shared that she had informed the resident that there was no change in the resident's incontinence with the Tena incontinence products. The ADOC confirmed that this information was not based on an assessment but related to feedback from a Personal Support Worker (PSW).

In an interview on January 27, 2016, the Geriatric Clinical Nursing Specialist #103 confirmed that whenever a resident has a change in condition for bladder/bowel incontinence the expectation was for the resident to be re-assessed using the continence assessment for bladder and or bowel and she confirmed that resident #024 should have been reassessed and the plan of care reviewed and revised when the resident's care needs had changed. (532)

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Record review of the Minimum Data Set (MDS) completed for resident #064 revealed the resident's continence has changed from continent to usually incontinent to frequently incontinent over a nine month period.

Record review of assessments in Point Click Care (PCC)for resident #064

revealed the only continence assessment was completed in 2014 at the time of admission to the home.

The Geriatric Clinical Nursing Specialist #103 confirmed in an interview on January 27, 2016, that the home's expectation was that a continence assessment should have been completed in PCC following a change in continence documented in MDS including a change from continent to usually continent and a change from usually continent to frequently incontinent.

The scope of this issue was a pattern. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did have a history of non-compliance with this sub-section of the regulation. It was issued as a voluntary plan of correction on December 1, 2014, and again on January 21, 2015. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 04, 2016

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 015

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

O. Reg. 79/10, s. 229 (10).

Order / Ordre :

The licensee will ensure that residents are offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry of Health and Long-Term Care website.

Specifically, the licensee will:
a) Obtain a current consent for administration of immunization against pneumoccocus and tetanus and diptheria for all residents in the home and any new residents admitted to the home.
b) Obtain a current physician's order for administration of immunization against pneumoccocus and tetanus and diptheria for all residents in the home and any new residents admitted to the home.
c) Administer immunization against pneumoccocus and tetanus and diptheria for all residents in the home and any new residents admitted to the home with consent and a physician's order.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Record review of the paper charts and Point Click Care revealed resident #014, #061, #064, #74, #075, #076 were all admitted in either 2014 or 2015, they had consent and physician's order for the administration of immunization against pneumococcus and tetanus and diphtheria. There was no documentation of administration of immunization against pneumococcus or tetanus and diphtheria.

In staff interviews with Registered Practical Nurses (RPN) #164 and #137 and Registered Nurse (RN) #167 on a particular date, all three registered staff confirmed that to their knowledge, they have never seen pneumococcus vaccination in the home. They confirmed that they have never administered immunization against pneumococcus or tetanus and diphtheria in the home. They confirmed that all immunizations provided for residents are documented in Point Click Care in the immunizations tab.

In a staff interview with the Geriatric Clinical Nursing Specialist #103, she confirmed the home's expectation that residents should have been offered immunization against pneumococcus, tetanus and diphtheria.

The scope of this issue was widespread. The severity of the issue was determined to be a level two with a potential for risk or harm to residents. The home did not have a history of non-compliance with this sub-section of the regulation. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 06, 2016

Order # / Ordre no : 016

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee will ensure that physician's orders for all residents in the home are followed in a timely manner to ensure the resident's right to be properly cared for is respected and promoted.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident's right to be properly cared for in a manner consistent with his or her needs was fully respected and promoted.

Clinical record review for resident #042 identified that on an identified date, this resident was assessed by a Registered Practical Nurse (RPN) to have an illness. There was then a physician's order written on that same day for particular tests, treatments, and monitoring.

Review of progress notes and vital signs for resident #042 for evening and night shifts on that date, and day shift the following day, found no documentation regarding the residents symptoms or illness, or monitoring. Review of the nursing shift report with RPN #134 for the following date, identified nothing was documented for resident #042 to communicate between nursing staff at shift change. RPN #134 identified she was unaware of the need to monitor the illness or provide the treatments for resident #042 until the time of interview with the inspector.

On an identified date, a review of the progress notes and physician order for

resident #042 with RPN #134 and Acting DOC #140 brought to their attention that the physician order had not been processed and that the treatments and monitoring had not been started.

A follow-up interview with resident #042, identified that six days later they had not had the ordered tests. Interview with RPN #119 that day identified that the test request had been faxed the day after the physician's order was written, but identified that the test had not been completed.

Interview with Acting Director of Care #140 confirmed it was the expectation of the home that this type of illness should have been monitored based on the physician's orders and that these orders would be processed in the home on the same day they were written and immediate action taken.

The licensee did not fully respect or promote the resident's right to be properly cared for in a manner consistent with his or her needs were fully respected and promoted when the test that was ordered was not completed and that her symptoms were not monitored as per the physician's orders. (#630) (213)

2. The licensee has failed to ensure that residents' right to be properly cared for in a manner consistent with his or her needs was fully respected and promoted.

Interview with resident #015's family members during the Resident Quality Inspection revealed the resident had a fall on an identified date and suffered a subsequent injury.

Record review of the progress notes on the date of the reported fall revealed documentation of the fall and subsequent injury. Record review of the Fall Incident Initial Post-Fall Assessment completed on the date of the fall revealed the resident #015 was not transferred to hospital, was experiencing pain, sustained an injury, physician was not notified, and Power of Attorney (POA) was notified on that date.

Record review of the Fall Incident Note Overview progress note dated the day of the fall revealed the physician was notified of the fall via the "FLAG" sheet. Interview with the Administrator #101, the acting Director of Care #140 and the Geriatric Clinical Nursing Specialist #103 on January 29, 2016 at 1110 hours, revealed "FLAG" sheets were communication sheets between the registered nursing staff and the physicians and are located on in a binder on each floor.

Record review of the progress notes dated the day after the fall revealed complaints of pain, pain medication administered, and an inability to complete usual activities of daily living. A physiotherapy referral was submitted the day after the fall and a progress note revealed further complaints of pain and observation of injury.

Record review of the progress notes dated the following day revealed further complaints of pain, observation of injury, pain medication administered but not completely effective and suggested that the resident may have need further tests to assess the injury.

Record review of the progress notes dated three days following the fall revealed the resident was unable to perform usual activities of daily living (ADL), had limited range of motion, and noted concern regarding the resident's safety related to the injury. A progress note was also documented indicating the resident required assistance with ADLs and assistive devices. There was no documented MD Progress Note.

Record review of the MD Progress Note dated ten days following the fall and documented as a late entry revealed, patient had a fall and has pain, deformity and limited movement, tests ordered.

Record review of the progress notes dated 12 days following the fall revealed a second physiotherapy referral had been submitted for resident #015; eleven days after the first referral was submitted and without follow up.

Record review of the progress notes dated 17 days following the fall, revealed call made regarding test ordered and was expected to be done 7 days later. Also revealed a third physiotherapy referral had been submitted for resident #015; 16 days after the first referral was submitted and that the resident was seen by a Physiotherapist (PT). The progress note detailed a possible significant injury and that the test still had not been completed.

Record review of the MD Progress Note dated 17 days following the fall revealed, that despite the physician calling the staff to ensure that the test had been completed; it still had not been completed.
Record review of the progress notes dated 18 days following the fall, the resident had the test completed. The test result reviewed in the chart revealed a

significant injury. A further progress note indicated that the MD at the hospital stated that this was not acceptable as the resident had not had the test or treatment in an acceptable time frame. In addition, the test and treatment in a timely fashion would have facilitated efficient and timely care for this resident.

Staff interview with the Administrator #101, the acting Director of Care #140 and the Geriatric Clinical Nursing Specialist #103 on January 29, 2016 at 1110 hours confirmed the home was negligent in care. The Administrator #101 shared the expectation that the leadership team reads the 24 hour report each day and the Geriatric Clinical Nursing Specialist #103 revealed she was not aware of the injury for resident #015 until she received the email from the Administrator and that she had not read the 24 hour report and indicated it was her responsibility to read this report daily. The Administrator shared that the staff should have called right away to have the test completed and confirmed there was no coverage when physiotherapist was away. The physiotherapist, nursing staff and the leadership team involved in the different aspects of care for resident #015 related to the injuries sustained post fall did not provide care consistent with her needs. (#563)

The scope of this issue was isolated. The severity of the issue was determined to be actual harm and risk to two residents. The home did not have a history of non-compliance with this sub-section of the legislation. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 04, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de sions de longue durée
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.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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
Inspection de sions de longue durée
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 8th day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RHONDA KUKOLY

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