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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 9, 2017	2016_573581_0003	034171-16	Resident Quality Inspection

Licensee/Titulaire de permis

859530 Ontario Inc. (operating as Jarlette Health Services)
c/o Jarlette Health Services, 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Royal Rose Place
635 Prince Charles Drive North WELLAND ON 000 000

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

DIANNE BARSEVICH (581), CYNTHIA DITOMASSO (528), KERRY ABBOTT (631), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 14, 15, 16, 19, 20, 21 and 22, 2016.

During the course of this inspection the following inspections were conducted concurrently:
Critical Incident Inspections:
027750-16 related to staff to resident abuse
033786-16 related to resident to resident abuse
034607-16 related to staff to resident abuse

Complaint Inspections
027917-16 related to personal care, skin and wound and nutrition and hydration
029229-16 related to comfort care
030357-16 related to personal care and privacy
033680-16 related to personal care
034593-16 related to personal care

Inquiries
029060-16 related to staff to resident abuse

During the course of the inspection, the inspectors: toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to policies and procedures, meeting minutes, investigative notes and clinical records.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care, Co-Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Staff Educator #1 and Staff Educator #2, Physiotherapist (PT), Physiotherapist Assistant (PTA), Registered Dietitian (RD), Restorative Care Co-ordinator (RCC), Food Service Manager (FSM), Dietary staff, Life Enrichment Coach, Chaplain, Recreation staff, residents and families.

The following Inspection Protocols were used during this inspection:

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
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

A. Resident #030 was admitted to the home in July 2016, was assessed as weight bearing on both legs and required two person extensive assistance for transfers in and out of bed. Review of the written plan of care revealed the intervention for their transfers was not documented. Interview with registered nurse (RN) #116 confirmed the transfer was planned care for the resident and was not documented in the written plan of care.

B. On an identified day in August, 2016, resident #030 was assessed by registered staff to require specific oral care as an intervention due to a diagnosis. Interview with PSW #124 stated that PSW staff provided oral care in a specified manner in the morning, before going to bed and after any meals, snacks or as needed. Interview with RN #116 stated the resident's condition deteriorated and a specific intervention was required for oral care and confirmed the written plan of care did not set out the planned care related to oral care. [s. 6. (1) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

On an identified day in December 2016, a specified room was observed with the call bell cord missing. Resident #007 was interviewed and was unable to tell the inspector any information as to the whereabouts of the call bell cord. Interview with the Restorative Care Co-ordinator (RCC) stated the resident did not have a call bell cord in place and stated that front line staff were responsible to ensure the call bell was in place and report missing call bell cords to registered staff. Interview with PSW #101 indicated they were aware a specified resident would often remove the call bell cord and this issue was brought to the attention of the registered staff. Interview with registered practical nurse (RPN) #102 stated that they were aware that the resident removed the call bell cord from the wall.

Review of the resident's plan of care indicated they had responsive behaviours and also identified that the staff were to ensure that the call bell cord was in place when the resident was in bed for safety. Review of the progress notes identified that after the incident, front line staff located several call bell cords in the resident's room. The PSW staff conducted a room audit and observed that call bells were also missing from four adjacent resident rooms. The plan of care did not indicate the resident was prone to removing their call bell cord. Further review of the resident's plan of care indicated that

no measures were in place to monitor all residents to ensure the call bell cord was in place. [s. 6. (2)]

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

Review of the Minimum Data Set (MDS) assessment on an identified day in September 2016, identified that resident #030 had one area of altered skin integrity. Review of the Wound and Treatment assessment on an identified day in September 2016, indicated they had three areas of altered skin integrity. Interview with Co-DOC stated that the resident only had one area of altered skin integrity at the time of the MDS assessment in September 2016 and confirmed that the MDS assessment and the Wound and Treatment assessments were not consistent with each other. (581) [s. 6. (4) (a)]

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

On an identified day in October 2016, a case conference was held for resident #010. The family of resident #010 expressed they would like to avoid specific medications. Several days later, the resident had a change in condition and new orders included but were not limited to, specific medications. When the family became aware of the medications the following day they expressed frustration and disappointment that the medications were ordered despite their opinion. Interview with Staff Educator #1 confirmed that the home was aware the family clearly did not want specific medications given to the resident; however, were ordered as part of a new diagnosis anyway. Interview with Staff Educator #1 confirmed that they had spoken to the substitute decision maker (SDM) at the time and they had refused to send the resident to the hospital for assessment deciding to keep the resident comfortable in the home; however, specific medication orders were not discussed with the SDM. Staff Educator #1 confirmed RPN #105 had called and notified the physician of the resident's change in condition, at which time, new orders were put in place. Staff educator #1 also stated they did not review the orders until the following day, when they realized they were not approved by the resident's SDM. Interview with RPN #105 confirmed that they did not speak with the family, it was Staff Educator #1 who spoke with the family. [s. 6. (5)]

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

A. Resident #091's plan of care stated they were at high nutrition risk due to a specific diagnoses and had an intervention for staff to follow an individualized menu plan. On an identified day in December 2016, the resident's individualized menu stated they were to be offered all items as specified on their individualized menu. During an observation of lunch on an identified day in December 2016, the resident was not offered one specific item, as confirmed by PSW #112. The Food Services Manager (FSM) confirmed the resident should have been offered the item, as per their individualized menu. (585)

B. The plan of care for resident #053 identified the resident was at a high risk for falls and required two specified interventions. On an identified day in July and December 2016, the resident sustained a fall. On an identified day in July 2016 and December 2016, the identified interventions were not in place. Interview with Staff Educator #1 confirmed that falls interventions were not in place for both falls. Interview with RCC confirmed that after review into the fall incidents in July and December 2016, it was determined that the falls interventions were not in place and the staff had to be re-educated in relation to one of the specific interventions.

C. On an identified day in August 2016, the physician ordered resident #030 to have a specific intervention applied to their altered skin area and to be reapplied every four days or as needed. Review of the eTAR revealed that the treatment was not started until three days after the order was prescribed and that the intervention was not reapplied every four days.

Interview with Co-DOC stated the physician made a change to the resident's specific intervention and confirmed it was not implemented until three days after the order was received and also confirmed that the intervention was not changed every four days as specified in the plan. (581) [s. 6. (7)]

6. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A. On an identified day in August 2016, the home's previous physiotherapist assessed resident #090 and developed a plan of care for the resident to receive treatment three times a week. Review of the resident's physiotherapy treatment record included

documentation that the resident's substitute decision maker (SDM) requested different treatment. Interview with Physiotherapist Assistant (PTA)#119 stated the resident's treatment changed in September 2016, to include the SDM's request; however, they did not recall the physiotherapist reassessing the resident at that time; nor did the paper record show the physiotherapist assessed the resident for the change in treatment. Further review of the clinical record revealed that on an identified day in October 2016, the resident's SDM expressed to PTA #119 that they had been asking for the resident to walk and the resident was still sitting. One day later, the resident was reassessed by the home's previous physiotherapist who implemented a plan to continue a specific treatment. Between an identified day in September to an identified day in October 2016, the clinical record did not include a reassessment of the resident by the physiotherapist regarding the changed interventions, as confirmed by the home's current physiotherapist.

B. On an identified day in August 2016, the physiotherapist assessed resident # 030's transfers and determined they required a specified lift for all transfers. Interview with PSW #124 stated the resident was a lift for all transfers. Review of the written plan of care under toileting focus indicated they required two person assistance for the entire process and under transferring focus revealed the resident was to receive assistance for transferring from one position to another related to unsteady gait; however, there was no intervention documented. Interview with registered staff #116 stated when the resident was admitted to the home they were transferred with extensive assistance and two staff and confirmed they were reassessed to require a specified lift; however, confirmed the plan of care was not revised to include their new transfer needs. (581)

C. On an identified day in August 2016, an area of altered skin area was noted on a specific area on resident #030. Review of the Wound and Treatment assessment two days later in August 2016, indicated the altered skin area had increased. Review of the written plan of care identified they had an area of altered skin integrity related to impaired mobility and incontinence but was not reviewed and revised until approximately three weeks later after the initial altered skin area was noted. Interview with Co-DOC confirmed the resident did have an area of altered skin integrity in August 2016 and that the written plan of care was not revised to include goals and interventions for that area. (581)

D. Review of the written plan of care identified that resident #030 required assistance of one staff for bed mobility. Interview with PSW #124 stated the resident required two person staff assistance for bed mobility and was repositioned every two hours. Interview

with registered staff #116 stated the resident had an area of altered skin integrity and required two staff for turning and positioning and confirmed the plan of care was not reviewed and revised when their care needs changed related to repositioning. (581) [s. 6. (10) (b)]

7. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the care set out in the plan had not been effective.

Resident #030's plan of care identified they were high nutrition risk, had poor fluid intake, required assistance with feeding, encouragement and cueing to consume food and fluids. On admission, the Registered Dietitian (RD) documented the resident's fluid requirement was a specific amount per day.
Review of resident #030's fluid intake record revealed they did not meet their fluid requirement on any day between an identified day in August to an identified day in September 2016. Review of progress notes revealed:
i. On an identified day in August 2016, the RD documented the resident was not consuming their required fluid amount and implemented an intervention twice per day.
ii. On an identified day in August 2016, the RD received a referral for poor food and fluid intake and documented to reduce the intervention to once a day and add another intervention for extra calories and nutrition. Staff were to keep assisting and encouraging the resident to eat and drink fluids.
iii. On an identified day in August 2016, registered staff documented the initiation of specific intervention for oral care due to a specific diagnosis.
iv. On an identified day in August 2016, RD documented the resident was not meeting their fluid requirement, and no new hydration interventions were implemented.
v. On an identified day in September 2016, the physician documented the resident was eating little and a plan to continue to encourage oral intake.
vi. On an identified day in September 2016, the RD documented the resident was not meeting their required fluid intake and did not implement change to hydration interventions.
vii. On an identified day in September 2016, the resident did not meet at least 50 percent of their fluid requirement for seven days and no referral was made to the RD, as confirmed by the RD.
viii. On an identified day in September 2016, the FSM documented the resident was consuming 100-300 ml of fluid per day and no new hydration interventions were implemented.
ix. On an identified day in September 2016, the RD assessed the resident for a

significant change in condition, noted the resident's average fluid intake continued to decrease and no changes were made to hydration interventions.

Interview with the RD stated they did not always receive a referral for poor fluid intake; however, they were aware of the resident's poor food and fluid intake. The RD confirmed they did not implement new interventions when the resident's daily fluid intake continued to decrease when the care set out in the plan of care was not effective. [s. 6. (10) (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 the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, that the resident, the SDM, if any, and the designate of the resident / SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care, that the care set out in the plan is provided to the resident as specified in the plan, that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan is no longer necessary and when the care set out in the plan is not effective, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with O. Reg. 79/10, r. 68 (2)(e)(i) requires every licensee of a long-term care home to have a weight monitoring system to measure and record with respect to each resident weight on admission and monthly thereafter.

The home's policy, "Resident's Rights, Care and Services – Nutrition Care and Hydration Programs – Monthly Weights and Weight Variance Report", revised November 4, 2016, stated PSW staff would measure the resident's weight on the resident's first bath day of each month. Registered staff would ensure that monthly weights were completed and documented by the tenth day of each month and recorded in electronic documentation when completed.

Resident #030 was admitted to the home in 2016, at which time their weight was taken and recorded at a specific weight. In August 2016, no weight was recorded until August 23, 2016, at which time their weight had decreased 22.1 percent. Interview with the RD who reported monthly weights were reviewed at weight management meetings held between the 10th and the 20th of each month to assess significant weight changes. The RD reported they were unaware of the resident's significant weight change as it was not recorded until August 23, 2016, and confirmed they did not assess the resident's weight again until an identified day in early September 2016. (581) [s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

On an identified day in November 2016, the plan of care for resident #053 identified they had a fall while being transferred by PSW #126. Review of the plan of care for the resident indicated they required the assistance of two staff with a sit to stand lift for morning transfers due to decreased mobility in the morning. Interview with PSW #126 confirmed the resident was being assisted to a wheelchair after morning care with one staff and no lift, when the PSW lost their balance and the resident fell. Interview with RCC confirmed that the resident required two staff assistance with morning transfers due to morning weakness and the resident was not provided safe transferring techniques when only one staff member assisted them. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident had fallen, the resident was assessed and if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home's policy, "Falls Prevention and Management Program", last revised May 2016, directed staff that when a resident had fallen the following had been completed including but not limited to:
i. The resident received a post falls assessment prior to moving which included assessments for range of motion of extremities, neck, lacerations bruises, vital signs and head injury routine as indicated.
ii. Is the subject of an immediate post falls huddle for completion using post fall assessment tool.
iii. Post fall follow up progress notes were to be completed for at least three shifts following the incident.

A. The plan of care for resident #013 identified the resident was at risk for falls and required a specific device in place when in their wheelchair and a different device when in bed for self transferring. On an identified day in September 2016, the resident was found out of bed on the floor. Interview with PSW #107 confirmed that the resident was found on the floor but the PSW could not recall if the specific device was in place at the time of the incident. Review of the plan of care identified that the post fall assessment was initiated; however, was not completed. Documentation did not include whether the interventions in the resident's care plan were or were not in place at the time of the fall. Furthermore, the post fall follow up progress note was not completed for one out of three shifts following the fall. Interview with RCC confirmed that the post fall assessment did not include information as to whether interventions were in place at the time of the fall, as required to complete the post fall assessment. Interview with Staff Educator #1 confirmed the post fall follow up progress note was not completed for one out of three shifts following the fall, as required in their policy.

B. The plan of care for resident #053 identified the resident was at a high risk for falls related to specific diagnoses. The resident had one fall in July 2016 and was being followed by physiotherapy until October 2016, at which time, the resident was discharged from treatment.
i. On an identified day in November 2016, the resident had a fall during a transfer with no injury. Post fall follow up notes were not completed on two out three shifts following the fall.
ii. On an identified day in December 2016, the resident had an unwitnessed fall out of

bed with no injury. Post fall follow up notes were not completed on one out of three shifts following the fall.

Interview with Staff Educator #1 confirmed that the post fall assessments were to include post fall follow up progress notes as required in the homes policy; however, were not completed for resident #053. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident has fallen, the resident is assessed and if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a resident that exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On an identified day in October 2016, registered staff #103 documented a progress note in resident #091's clinical record that the resident's substitute decision maker (SDM) had concerns regarding an altered area of skin integrity. Staff Educator #1 documented the area was reddened, applied a moisture barrier cream and initiated a nursing measure order; however, no skin assessment using a clinically appropriate assessment instrument specifically designed for skin and wound was completed. In addition, no prior notation in the resident's clinical record revealed concerns regarding the altered skin integrity. Interview with PSW #112 confirmed that during the inspection, the resident still experienced redness to the specific area. Interview with Staff Educator #1 confirmed a skin assessment was not completed as they were only conducted when a resident had open area.

B. On an identified day in August 2016, the progress notes for resident #030 identified they had a small open wound on a specific area and the physician ordered wound care to assess and treat the area. Review of the plan of care revealed that the Wound and Treatment assessment was not completed in point click care (PCC) until an identified day in August 2016 and this was confirmed by the Co-DOC. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. 50(2)(b)(iv)

A. Resident #030 had an ulceration or interference with the structural integrity of layers of skin caused by prolonged pressure related to impaired mobility and incontinence. Review of the plan of care identified weekly wound assessments were not completed as follows:
i. On an identified day in August 2016, an area of altered skin integrity was noted to a specific area. Review of the plan of care identified that a weekly wound assessment was initiated but not fully completed on two specific days in August 2016 and there was no weekly assessment initiated during the last week in August and the first week of September 2016. Interview with the Co-DOC confirmed that the weekly assessments were to be completed in PCC using the weekly wound assessment template and had not been completed for the weeks listed above, although clinically indicated.

B. On an identified day in November 2016, resident #014 was assessed to have an area of altered skin integrity. Review of their plan of care did not include a weekly skin and wound assessment. Interview with the Co-DOC and with registered staff #114 confirmed that after an identified day in November 2016, registered staff did not perform weekly assessments on resident #014's area of altered skin integrity. (631)

C. A review of resident #010's plan of care indicated that on an identified day in September 2016, the resident was assessed to have an area of altered skin integrity. A review of the resident's progress notes indicated that the registered staff had completed a wound note on two specific days in September and October, one specific day in November and December 2016, which was not consistent with registered staff performing weekly assessments on the area of altered skin integrity. Interview with the Co-DOC and registered staff #114 confirmed that registered staff did not perform weekly assessments. (631) [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(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).

Findings/Faits saillants :

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

The plan of care for resident #053 identified that the resident was frequently incontinent of bladder and occasionally incontinent of bowels, required assistance with toileting from two staff members. The plan of care directed staff to toilet the resident at specific times during the day and night and when toileting the resident not to ask if they needed to use the washroom but staff were to inform the resident they would be assisted to the toilet. On an identified day in December 2016, the resident had a fall with no injury while trying to transfer themselves to the toilet. Interview with PSW #125 confirmed that two staff provided continence care, "shortly before the resident fell" and the resident was not assisted to the toilet as required in the plan of care. PSW #125 stated the resident was toileted after the fall and voided at that time. Interview with resident #053 confirmed that they did not call for assistance when they had to use the washroom and attempted to toilet by themself. On an identified day in December 2016, the resident was observed from 0730 hours to 1130 hours. During that time the resident pressed the call bell to request assistance to use the bathroom after the scheduled toileting times. Interview with RPN #102 confirmed that the resident was on a toileting plan with specific times. The resident's individualized plan of care to promote and manage bowel and bladder continence was not implemented on two specific mornings in December 2016. [s. 51. (2) (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 resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #7: 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 failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The home's policy, "Pain Management Program", revised March 2016, directed staff that every resident was to receive a comprehensive pain assessment on admission (under assessments in Point Click Care) and when a resident, with worsening pain or unrelieved pain, as identified by a pain score of 2 or 3 on Resident Assessment Instrument (RAI), Minimum Data Set (MDS), or a score of four out of ten on verbal report of pain - numerical or descriptive, or when caregiver reported behavioural symptoms of pain.

In September 2016, the MDS assessment for resident #053 identified that the resident had a pain score of "2. Moderate Pain". Review of the plan of care did not include a comprehensive pain assessment completed in PCC. On an identified day in September 2016, resident #053 was started on specific pain medication as needed. The medication was increased on an identified day in October 2016. From an identified day in September to an identified day in October 2016, the electronic medication administration records (eMAR) revealed the resident scored on the pain scale a four or greater fourteen times when regularly scheduled medications were administered; however, comprehensive pain assessments were not completed in PCC. Interview with Acting DOC confirmed comprehensive pain assessments were not completed in PCC as required in the home's policy. [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 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, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

The plan of care for resident #052 identified that the resident demonstrated responsive behaviours towards co-residents. The home identified that specific interventions had been effective in preventing altercations. Review of the progress notes identified that on a specific day in December 2016, resident #052 had an altercation with resident #054's and no injury was documented. Interview with resident #054 and staff #120 confirmed that the specific intervention was not in place at the time of the incident. Interview with Staff Educator #1 and regular staff #121 confirmed that the specific intervention for the resident had been effective for a short period of time until the resident fell asleep. The specific intervention for resident #052 to minimize the risk of altercations was not implemented during the incident on an identified day in December 2016. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. The licensee failed to ensure that therapy services for residents of the home were arranged or provided under section 9 of the Act that included, on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs.

On an identified day in August 2016, resident #090 was assessed by the home's previous physiotherapist who at that time developed a plan of care for the resident to receive specific treatment three times a week. Review of resident's Physiotherapy Resident Log from August and September 2016, revealed they did not receive physiotherapy three times a week and only received therapy twice in the review period; which was confirmed by PTA #119.

On an identified day in October 2016, the home's previous physiotherapist reassessed resident #090 to receive physiotherapy twice a week, which would include specific

treatment. Review of the Physiotherapy Resident Log from an identified day in December 2016 until two weeks later revealed the resident only received physiotherapy twice in the month. The home's current physiotherapist confirmed the resident was not receiving physiotherapy services based on the residents' assessed care needs. (585)

B. In 2016, resident #013 was admitted to the home. Admission orders included but were not limited to, physiotherapy assessment and treatment. Review of the plan of care did not include a physiotherapy assessment until an identified day in September 2016, after the resident had a fall. Interview with Staff Educator #1 confirmed that resident #013 was not assessed by physiotherapy on admission, as required in the plan of care. Furthermore, on an identified day in September 2016, the physiotherapist identified that the resident was at risk for falls due to decreased lower extremity endurance and required three physiotherapy treatments per week. Physiotherapy attendance sheets from September to November 2016, revealed physiotherapy treatments occurred twice a week. Interview with PTA staff #104 confirmed that resident #013 did not receive three physiotherapy treatments a week in September, October and November 2016, as required in the plan of care. (528)

C. The home's policy, "Falls Prevention and Management Program", last revised May 2016, directed staff that when a resident had fallen the resident was referred to physiotherapy using the "Physiotherapy Falls Referral Guide", which directed physiotherapy referrals post first fall, frequent fallers who's frequency or pattern of falls had worsened, injury related to fall and change in functional status post fall.

In October 2016, resident #053 was discharged from physiotherapy. The resident had multiple falls from an identified day in November to an identified day in December 2016. Following the fall on an identified day in November 2016, registered staff documented that the resident required two person assistance with transfer to their wheelchair; and both falls in December 2016, were related to the resident's self transferring. The resident was not referred to physiotherapy post fall related to a change in transfer requirements, that the resident had frequent falls, or change in resident's pattern of self transferring. Interview with the physiotherapist confirmed the resident had not been referred by the nursing team for assessment and treatment. Interview with Acting DOC, confirmed registered staff were to follow the physiotherapy referral guide when deciding when to refer a resident to physiotherapy post fall. (528) [s. 59. (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 therapy services for residents of the home are arranged or provided under section 9 of the Act that include, on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs, to be implemented voluntarily.

WN #10: 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 failed to ensure that the nutrition care and hydration programs included the development and implementation, in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

Interview with the home's Registered Dietitian (RD), who was a member of the staff confirmed that they were not involved or consulted in the development and implementation of the home's policies and procedures relating to nutrition care and dietary services and hydration. [s. 68. (2) (a)]

2. The licensee failed to ensure that the nutrition care and dietary services program included the identification of any risks related to nutrition care, dietary services, and hydration with the implementation of interventions to mitigate and manage those risks.

The home's policy, "Resident Rights, Care and Services - Nutrition Care and Hydration Programs - Hydration", reviewed March 16, 2015, was not clear on how to identify poor hydration and when to initiate strategies to correct poor hydration. The policy, as it was being applied by staff did not ensure that risks related to hydration were identified and interventions to mitigate and manage those risks were implemented in a timely manner.

The policy directed staff to initiate a "Stop and Watch" program when residents were noted to have low fluid intake (did not specify what level) and to complete an assessment of those residents triggered with a "Stop and Watch" alert on their shift. The policy directed staff to complete a dehydration assessment and document their findings in "dehydration assessment" progress note and to complete a referral to the RD when residents were consuming less than 50 percent of their assessed fluid goal over a three day period. The policy also directed staff to complete a referral to the RD when the resident was consuming less than their fluid goal over three days.

The RD confirmed that staff were not to refer to them for poor hydration until residents were identified as consuming less than 50 percent of their fluid goal over a three day period. The RD confirmed that not all residents at risk for poor hydration would be identified with action taken to address the poor hydration in a timely manner. The RD confirmed that residents could be consuming less than their assessed hydration requirement for a period of three months until the next quarterly review prior to strategies being implemented. The home's policy did not address changes in hydration/fluid consumption until residents reached the high nutrition and hydration risk category and was not preventative with strategies being initiated early to prevent the high risk concerns.

The "Best Practices for Nutrition, Food Service and Dining in Long Term Care Homes" document, written by the Ontario Long Term Care Action Group Dietitians of Canada,

June 2007, revised April 2013, identified that homes should establish procedures for corrective actions, and documentation of same, when fluid intake did not meet residents' requirements or when there was a change in the residents' hydration status.

The presentation at the Dietitians of Canada conference, June 11, 2016, "Proactive Management of Dehydration in LTC", presented by Twinkle Patel RD, Seasons Care Inc. and Stacey Scaman RD, Seasons Care Inc. identified the need for a proactive versus a reactive approach to hydration in Long Term Care Homes.

The home's hydration policy was not clear in relation to when staff were to intervene (three consecutive days of poor hydration below the resident's assessed hydration target or three consecutive days of less than 50 percent of the resident's hydration target). The home's implementation of the program using less than 50 percent of the resident's hydration target over a three day period was not based on evidence based practices and did not ensure that action was taken in a timely manner when risks related to hydration were identified. [s. 68. (2) (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 nutrition care and hydration programs include 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 that the nutrition care and dietary services program include the identification of any risks related to nutrition care, dietary services, and hydration with the implementation of interventions to mitigate and manage those risks, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated when there was a change of five percent of body weight, or more, over one month.

Review of resident #030's weight identified that approximately one month after their admission they had a significant weight change. Review of the plan of care indicated the resident was not assessed by the RD. Interview with the RD confirmed that they did not assess the resident when the resident lost over 22 percent of their body weight. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated when there was a change of five percent of body weight, or more, over one month, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

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

A. On December 14, 2016, during a tour of the home, the following used unlabeled personal items were observed in the Robinson tub spa room: one comb and one toothpaste and in the Colborne shower spa room: one comb and one men's deodorant stick.

Two days later on December 16, 2016, the same unlabeled items were still observed and in addition one used roll on women's deodorant was observed in the Colborne shower spa room.

A review of the home's policy, "Infection Prevention and Control Program", dated September 16, 2013, under "Procedure" directed. "All staff will participate in the implementation of the infection prevention and control program to prevent and manage infections within the home; including but not limited to, for example; following routine precautions.

Review of the Provincial Infectious Disease Advisory Committee, (PIDAC) document titled, "Routine Practices and Additional Precautions, Third addition, PIDAC Routine Practices and Precautions, published August 2009 and revised November 2012. The

document stated, "Administrative controls are measures that the health care setting puts into place to protect staff", including, "not sharing personal items".

An interview with the Co-Director of Care confirmed that all resident's personal items were to be labeled in order to decrease the likelihood of cross-contamination.

B. On December 14 and 15, 2016, during initial observations of resident rooms, the residents' personal items were found unlabeled, unclean and/or stored in an improper manner:

Shared washroom 344: white used hairbrush unlabeled and two black combs.
Shared washroom 345: two unlabeled urinals and one unlabeled white toothbrush.
Shared washroom 347: one unlabeled blue and white electric toothbrush, one red and white toothbrush, one unlabeled urinal and one bedpan on the floor.

On December 20, 2016, PSW #133 confirmed the following observations and improper storage/labeling of personal items:
Shared washroom 345: two unlabeled urinals, one unlabeled white toothbrush
Shared washroom 347: a labeled visibly soiled bedpan sitting on the floor, two unlabeled electric razors, two unlabeled toothbrushes, two unlabeled basins. (585) [s. 229. (4)]

2. The licensee failed to ensure that on every shift:
(a) symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and
(b) the symptoms were recorded and that immediate action was taken as required.

The home's policy "Infection Prevention and Control Surveillance", effective September 2013, identified that on every shift for those residents with infection or suspected infection, staff were to document in the progress note, using infection note label, regarding the presence or absence of symptoms. Staff were to continue to document for 48 hours after the symptoms of infection have subsided, or until 48 hours after antimicrobial completion.

i. On an identified day in October 2016, resident #053 was transferred to the hospital due to a change in condition and returned the following day with diagnosis of a specific infection and required antibiotics. Review of the progress notes did not include any infection notes after the resident returned to the home and while the resident remained

on antibiotics.
ii. On an identified day in October 2016, family of resident #053 identified that the resident had a strong odour. Review of the progress notes did not include any infection notes or follow up related to the presence of infection symptoms.
iii. On an identified day in November 2016, resident #053 was ordered antibiotic for a specific diagnosis. Review of the progress notes did not include infection notes identifying the presence or absence of symptoms when the antibiotics were ordered.
iv. Following a specific test, on an identified day in November 2016, resident #053 was prescribed antibiotics for an ongoing infection. Review of the progress notes did not include any infection notes related to follow up on the presence or absence of symptoms until seven days later when the antibiotic therapy was completed.
v. On an identified day in December 2016, resident #053 was transferred to the hospital for assessment related to a change in condition. The resident returned the following day with a specific diagnosis and required antibiotics. Review of the progress notes did not include any infection notes until two days after the resident returned from the hospital and then was not consistently completed on every shift.

Interview with Staff Educator #1 confirmed that the resident was not monitored and symptoms were not recorded following a specific infection or suspected infection for resident #053. Furthermore, confirmed registered staff were not completing infection notes as required each shift following a resident infection or suspected infection. [s. 229. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

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

The homes policy "Resident Rights, Care and Services - Abuse", last revised March 2015, defined the physical force by a resident that causes physical injury to another resident as physical abuse and therefore to be immediately reported the the Ministry of Health and Long Term Care (MOHLTC).
The policy also directed the charge nurse to ensure immediate support or assistance was provided to the resident who had been abused and assess the resident's condition, evaluating safety, emotional and physical well being.

On an identified day in November 2016, resident #052 had an altercation with another co-resident resulting in a superficial injury. The charge nurse was notified but on call managers were not notified and the incident was not reported to the MOHLTC until four days later. Interview with staff educator #103 confirmed that the resident to resident altercation causing injury was not immediately reported to the MOHLTC, as required in the home's policy.

On an identified day in December 2016, resident #052 had an altercation with resident #054 which required a third person to intervene. Registered staff documented the incident in both residents' plan of care but did not include an assessment of resident #054's condition, safety, and emotional and physical well being. Interview with Staff Educator #1 confirmed that the registered staff did not complete an assessment including whether or not resident #054 was injured as a result of the altercation. [s. 20. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified day in December 2016, resident #093 was observed eating their lunch meal which was regular texture and thin fluid. The resident had an emesis basin in front of them which contained fluid and food debris and they reported they had difficulty swallowing. The resident's spouse reported swallowing issues started in September 2016 and staff were aware. Interview with PSW #115 confirmed the resident reported difficulty with swallowing. Review of the progress notes confirmed the resident had ongoing issues with phlegm and swallowing, including medications and the RD had assessed the resident. Interview with the Co-DOC who reported if a resident had ongoing issues swallowing, the home's expectation would be to refer to a Speech-Language Pathologist (SLP). The Co-DOC reported the resident was assessed by staff and a SLP assessment was suggested as an intervention; however, the spouse refused. The Co-DOC confirmed the home's assessment should have been documented. [s. 30. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening and/or cleaning of dentures.

Review of resident #030's written plan of care indicated that they had upper and lower dentures, they were to be removed every evening, soaked in water with a denture tablet and cleaned after meals. Review of the progress notes identified that on two identified days in September 2016, registered staff documented at approximately 0700 hours the resident still had their dentures in their mouth which were dirty and they were removed and washed and mouth care was provided. Review of POC revealed that oral care was provided on the evening shift on the two identified dates in September 2016. Interview with registered staff #116 confirmed that oral care was not provided on those nights as the resident's dentures were still in their mouth the next morning. [s. 34. (1) (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids. O. Reg. 79/10, s. 37 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident received assistance, if required, to use personal aids.

Resident #090's plan of care identified that they had a specific diagnosis, used a specific device, registered staff were to apply the device each morning and they were to be handed in by PSWs to registered staff nightly. Interview with resident #090's substitute decision maker (SDM) reported that the resident had a specific device and they were to be applied in the morning and removed in the evening by staff; however, at times found the device was applied, was not with registered staff or reported as missing. Review of progress notes and the resident's eTAR from an identified day in November to an identified day in December 2016, revealed documentation by registered staff on seven occasions when the resident's device was not in place; either still being in the medication cart at bed time or missing from the home as they were taken by PSW staff and not returned to registered staff and 45 required scheduled documentation times that did not indicate whether the device was either applied or removed. Staff Educator #1 confirmed they were aware of two occasions when the device was not in place as they were missing; therefore, the resident did not receive assistance to use their specific device. (585) [s. 37. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #052 was admitted to the home in July 2016, had unpredictable responsive behaviours towards co-residents and displayed responsive behaviours throughout the home. Since July 2016, dementia observation system (DOS) charting was initiated. In October 2016, Senior Mental Health Outreach consultation recommended the continuation of DOS charting to determine trends in the resident's behaviours. DOS charting from July to December 2016, was not completed as follows:

i. On three identified days in July 2016, on two identified days in August and September 2016, one identified day in October, November and December 2016, from 0730 to 2130 hours.
ii. On five identified days in July and August 2016, on four identified days in September 2016, two identified days in November and December 2016, from 0730 to 1330 hours.
iii. On one identified day in July 2016, from 1100 to 1830 hours.
iv. On one identified day in July 2016, two identified days in August 2016 and on identified day in September 2016, all hours.
v. On two identified days in August 2016, from 1100 to 2130 hours.
vi. On one identified day in August 2016, and two identified days in December 2016, from 1430 to 2130 hours.
vii. From an identified day in August 2016, 1400 hours to the following day at 1330 hours.
viii. From an identified day in August 2016, 1400 hours to the following day at 0700 hours.
ix. From an identified day in November 2016, 2230 hours to the following day at 0700 hours.

Interview with Staff Educator #1 confirmed that DOS charting was not consistently documented every thirty minutes, as required for resident #052 to determine if there was a pattern with the resident's behaviours. [s. 53. (4) (c)]

WN #18: 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 failed to ensure that assistance and support was offered to permit residents to participate in activities that may be of interest to them if they were not able to do so independently.

Resident #090's plan of care identified they had impacted ability to participate in recreational activities related to cognitive impairment, impaired communication, impaired mobility and responsive behaviours, with a goal to engage or receive encouragement to participate in one program per day. Interview with the resident's SDM who reported concerns that staff did not take the resident to recreation activities. Review of POC documentation, as well as paper forms used by recreation staff to track resident involvement in recreation and social activity programs between an identified day in November to an identified day in December 2016, revealed 15 out of 45 days when staff did not document whether the resident received encouragement to participate and/or participated in a recreation program. Interview with the recreation staff #122 who confirmed an occasion when they did not approach the resident to invite and provide support to attend an activity. [s. 65. (2) (f)]

Issued on this 17th day of February, 2017

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

Original report signed by the inspector.