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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Nov 24, 26, 2014	2014_202165_0029	L-001399-14	Resident Quality Inspection

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE FERGUS NURSING HOME
450 QUEEN STREET EAST FERGUS ON N1M 2Y7

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

TAMMY SZYMANOWSKI (165), DEBORA SAVILLE (192), 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): October 16, 17, 21, 22, 23, 24, 27, 28 and 29, 2014

CIS Inspections 000456-14; 003257-14; 005961-14; 006808-14 were completed during the RQI inspection

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Care Coordinator, Resident Assessment Instrument (RAI) Coordiantor, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aides, Nutrition Manager, Acting Activity Director, Maintenance Supervisor, Registered Dietitian, Administrative Assistant, Activation Aides, Restorative staff, family members, and residents

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

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

23 WN(s)
11 VPC(s)
8 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

The home's Head Injury Routine (HIR) Policy indicated that when a resident sustained any trauma to the head or had an unwitnessed fall, Registered staff were to complete a HIR using the Glasgow Coma Scale as a documentation tool including vital signs, for at least 72 hours with the following frequency:
Every half hour for the first 2 hours following the injury
Every hour for the next 4 hours
Every 4 hour for the next 8 hours
Every shift for the remainder of the 72 hours.

A) Record review indicated that resident #005 had a fall in 2014 and sustained an injury.

Record review indicated that the HIR was initiated on the day of the fall and vital signs were assessed for the first hour and a half. However, the HIR was not completed and the resident was not monitored for the 72 hours as indicated in the policy.

On October 22, 2014 a Registered Practical Nurse reported that staff monitor residents and initiate HIR, however, once a resident was observed as doing well, the HIR would be stopped and not completed.

The Director of Care confirmed that the expectation was that the HIR was completed for the 72 hours as indicated in the policy and that the homes policy and procedure in place was not complied with. (532)

B) In 2014, resident #012 was found to have an injury and the resident reported that they had a fall the previous night. The Registered Nurse on duty at the time of the fall confirmed that the fall had been unwitnessed by staff.

A review of the resident's clinical health record and the Registered Nurse confirmed on October 22, 2014, that there was no HIR completed post fall. The Director of Care verified that the expectation was for a HIR to be completed as indicated in the home's HIR Policy.

C) In 2014, resident #030 sustained an unwitnessed fall. The resident was sent to the hospital for assessment and returned to the home with injury.

The RAI Co-ordinator reported that a HIR would be expected to be completed as outlined in the home's policy.

A review of the resident's clinical health record indicated there was no HIR initiated for the resident, this was confirmed by the RAI Co-oridnator. [s. 8. (1) (a),s. 8. (1) (b)]

2. The home's policy titled Pain Assessment dated April 2010 indicated that the Caressant Care Pain Assessment Tool on Point Click Care would be utilized when a resident exhibits behaviour that may herald the onset of pain or a resident exhibits distress related behaviours.

Resident #013 was admitted to the home in 2014 and was identified at that time to be calm, quiet and polite. The resident sustained a fall one month later that resulted in a transfer to hospital with injury. The resident returned to the home, documentation review and interview confirmed that no pain assessment was completed post injury.

Documentation indicated that the resident began demonstrating behaviours ten days later. Documentation review and interview confirmed that no pain assessment was completed with escalating behaviours.

The licensee failed to comply with their Pain Policy when resident #013 sustained an

injury that could have resulted in pain and demonstrated an exacerbation in behaviours.

B) Resident #015 had a new pain medication initiated in 2014. Interview with the RAI Coordinator confirmed that no pain assessment was completed at the time this pain medication was initiated.

Resident #015 was observed to be exhibiting pain symptoms especially with a change in position.

The licensee failed to ensure that a Pain Assessment was completed when a new pain medication was initiated. [s. 8. (1) (b)]

3. The home's policy Narcotic and Benzodiazepine Shift Count effective May 2012 indicated that two registered staff, together are to count the actual quantity of narcotic and benzodiapine medication remaining, to confirm that the actual quantity is the same as the amount recorded on the Narcotic Medication Record and record the date, time, quantity of medication and sign in the appropriate spaces on the Shift Change Narcotic Count form.

Interview with the Director of Care and review of investigation notes taken by the home confirm that when dilaudid went missing from the home in 2014 registered staff failed to complete a narcotic and benzodiazepine shift count together. The home's investigation revealed that several of the registered staff of the home signed the Shift Change Narcotic Count form without confirming the actual quantity of narcotic available in the home.

The licensee failed to ensure that the Narcotic and Benzodiazepine Shift Count policy was complied with. [s. 8. (1) (b)]

4. The home's policy Storage, Handling and Administration of Vaccine effective June 2005 indicated that vaccines were to be kept in a refrigerator when temperatures were monitored and must always be between two degrees Celsius and eight degrees Celsius and when using multidose vials of vaccine nursing staff must write the date of the first dose taken out of the vial.

On October 24, 2014 an open vial of Tubersol was found in the fridge on Central care area. The vial had not been dated when opened and staff were unable to confirm how long the vial had been in the fridge. A review of the temperature monitoring for the fridge identified that the fridge temperature had exceeded eight degrees Celsius and staff

interviewed confirmed that vaccines were to be kept in the monitored refrigerator in the Resident Care Coordinators office.

The licensee failed to ensure that the Storage, Handling and Administration of Vaccine policy was complied with. [s. 8. (1) (b)]

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 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 was specifically designed for skin and wound assessment.

Resident #006 was admitted to the home in 2014 with impaired skin integrity.

Record review and interview with the RAI Coordinator confirmed that no assessment of the altered skin integrity using a clinically appropriate assessment instrument was documented until 26 days later and the expectation was the assessment would have been completed on the day of admission. [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, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Resident #013 was identified to have altered skin integrity. Record review and interview with the wound care nurse confirmed that no weekly wound assessment was completed for four identified weeks over a two month period.

B) Resident #006 was admitted to the home in 2014 with impaired skin integrity. The first recorded assessment of the wound was completed 26 days later. Interview with the Director of Care confirmed that wounds were to be assessed weekly on Wednesday and that weekly assessments were not consistently completed for resident #006.

Record review identified that weekly wound assessments were not completed for 11 identified weeks over the past five months.

The wound care nurse indicated that they were the only person completing wound assessments and that they were often pulled from wound care to cover staffing on the care area. When this occurs or if she was absent, weekly wound assessments were not completed.

The licensee failed to ensure that resident #013 and #006 who were exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 has failed to ensure that behavioural triggers were identified for the resident demonstrating responsive behaviours.

Resident #015 was identified to demonstrate behaviours at all times while awake.

Record review and interview with the RAI Coordinator confirmed that triggers for the identified behaviours have not been identified for this resident. The RAI Coordinator identified that there was currently no registered staff member assigned to the Behaviour Supports Ontario (BSO) program and assessments related to behaviours were not being completed. [s. 53. (4) (a)]

2. The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours.

Resident #012 was observed to have uncombed hair.

Interview with a Personal Support Worker (PSW) confirmed that the resident had not

received personal hygiene and grooming care in the morning as the resident refused. The PSW reported that the resident refuses personal hygiene and grooming care all the time and this was the residents usual behaviour.

The Minimum Data Set (MDS) assessment indicated the resident resists care and this behaviour was not easily altered. The Resident Assessment Protocol indicated that the behaviour symptoms would be care planned.

A review of the resident's clinical health record indicated there was no plan of care related to the resident's behaviour and there were no strategies developed and implemented to respond to these behaviours. [s. 53. (4) (b)]

3. The licensee has 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.

In 2014, resident #030 sustained a fall with an injury.

Six weeks prior to the fall, the Registered Nurse indicated in the progress notes that the residents behaviour changed, and requested that staff provide a specific intervention. Twenty two days after the Registered Nurses request, the Physician also indicated that the specific intervention was to be done. The RAI Coordinator confirmed that the specific intervention was not completed and there was no action taken to respond to the needs of the resident.

A review of the residents clinical health record indicated that the resident was experiencing increasing behaviour for six weeks. There was no reassessment and interventions developed to respond to the needs of the resident until after the resident sustained a fall with injury. [s. 53. (4) (c)]

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 O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a minimum of three meals daily.

On October 16, 2014, during lunch meal service at least seven identified residents were not offered the lunch meal. Six residents were identified to be in their bedrooms in the Central wing and one resident was in the hallway outside the dining room.

It was observed that two trays were prepared for residents in the North wing however, no other trays were prepared and offered to residents in the Central wing. The Dietary Aide confirmed that only two trays were prepared for residents that were not in the dining room during lunch service.

The RPN was unaware of all the residents that were not present in the dining room for the lunch meal and confirmed that resident #031 was placed in the hallway prior to meal service commencing and was left in the hallway during the entire lunch meal. The resident was identified as high nutritional risk by the home's Registered Dietitian and weight records indicated the resident has lost 2.6 kilograms over the past week.

On October 16, 2014, resident #032 reported that staff did not enter their bedroom to remind them of lunch meal service or offer a lunch meal. The resident was deemed high nutritional risk by the home's Registered Dietitian and the resident's plan of care indicated that the resident commonly remains in their room rather than going to the dining room and staff were to offer a tray.

On October 16, 2014, resident #033 did not have a lunch meal offered. The resident experienced a significant weight loss in October 2014 and was deemed high nutritional risk by the home's Registered Dietitian. The resident's plan of care indicated for staff to encourage food and fluids and provide alternatives for the resident.

Four of four residents interviewed reported that staff did not remind them of lunch meal service or offer the lunch meal October 16, 2014. [s. 71. (3) (a)]

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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

During observation of the medication pass on the North wing of the home on October 23, 2014 at 1045 hours and October 24, 2014 at 1130 hours it was observed that the medication cart was heavily soiled with spilled liquids on the right side of the cart (above the garbage can) and on the rubber bumper around the perimeter of the cart. Staff interviewed identified that they were each responsible for cleaning of the medication cart. One Registered Nurse confirmed that the cart was heavily soiled and identified that not everyone takes responsibility to clean the cart when a spill occurs.

During observation of the medication room on Central wing of the home on October 23, 2014 it was observed that the medication cart in the medication room was unclean with spilled items evident on the rubber bumper around the perimeter of the cart. The Registered Practical Nurse interviewed confirmed that the cart was dirty at the time of the observation.

The licensee failed to ensure that the medication carts used in the home are kept clean

and sanitary.

B) During a tour with the Administrator October 29, 2014, the following observations were confirmed:
The floors in at least 25 resident bathrooms/bedrooms and the hallways were observed to have black debris build up notably around the edges. Fans located in the hallways were observed to have a build up of dust hanging from the fans.

The large dining room was observed to have a thick build up of black debris around the edges of the servery, the kick plate under the cupboards was soiled and the dining room tables were soiled with food debris. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On October 21, 2014, it was observed that room 240 had a missing connector strip from the bedroom floor to the bathroom floor.

On October 16, 2014, it was observed that the laminate counter in room 202's bathroom, had a large chip on the edge of the counter which left it exposed.

On October 17, 2014, it was observed that the bathroom tiles in room 208 were cracked and lifting, there was no caulking around the base of the toilet and the front plate of the bathroom register was coming off.

On October 16, 17, and 28, 2014 it was identified that rooms 240, 226, 239 and 241 had missing base boards near the rooms entry way.

On October 28, 2014, the small dining room was observed to have a hole in the ceiling tile above the servery.

During a tour of the home with the Maintenance Supervisor October 28, 2014, observations were confirmed. The Maintenance Supervisor confirmed that the home had significant drywall damage, numerous paint chips on walls and door frames leaving the metal exposed and cracked tiling on the North wing and the large dining room floor. The Maintenance Supervisor confirmed that the current flooring in the North wing and the large dining room were not level and the tiles were cracked.

During a tour of the home with the Administrator October 29, 2014 the Administrator confirmed that the identified flooring in North wing and the large dining room were not level and tiles were cracked and splitting resulting in a trip hazard for residents. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 005 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 home, furnishings and equipment is kept clean and sanitary, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a resident-staff communication response system that was easily seen, accessed, and used by residents, staff and

visitors at all times.

A) On October 17, 2014 at 1345 hours call bell for resident #005 was observed lying on the floor away from the bed. A PSW confirmed that the call bell was on the floor and confirmed that it should be attached to the resident and came in the room and attached the call bell to the resident.

B) On October 16, 2014 at 1223 hours the call bell for resident #002 was observed behind the bed. The call bell cord was short and reached the head of the bed on the right side; however, the resident was sitting in the wheelchair on the left side of the bed and was not easily accessed by the resident.

On October 22, 2014 at 1108 hours the call bell was observed as attached to the privacy curtain on the right side of the bed and the resident was observed lying at the foot of the bed on the left side. A PSW reported that they attached the call bell to the privacy curtain as the call bell would not reach the resident. On October 22, 2014 a Registered Practical Nurse confirmed that the call bell needed a longer cord in order for the call be to be easily seen, accessed, and used by the resident at all times.

C) On October 16, 2014 at 1408 hours resident #017 was observed in bed and the call bell was hanging over the dresser on the one side.

On October 23, 2014 at 1327 hours call bell was observed inside the garbage can and resident was observed resting in bed.

On October 23, 2014 a Registered Practical Nurse confirmed that the resident's call bell was not accessible to the resident because the resident was not able to use the call bell. However, she was observed attaching the call bell to the resident's gown. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

During observation on October 17, 2014 it was identified that the resident-staff communication and response system in room 226 was not functioning and could not be activated by residents in beds three and four.

Interview with the Administrator confirmed that the home was aware that some call bells

were not functioning and the home was awaiting the arrival of Georgian Bay, the contractor responsible for repair of the system. The Administrator identified that call bells in rooms 211, 219 and 230 were known to be non-functioning however, was not aware of concerns with call bells in room 226. Bed alarms were provided to the resident's with non-functioning call bells and repairs were anticipated in the next few days.

On October 24, 2014 the call bells in room 226 beds three and four were again checked and found to be non-functioning. A bed alarm system was provided to the resident in bed three as an interim means of communication, however, no alternative was provided for the resident in bed four.

On October 28, 2014 the call bells in room 226 beds three and four were checked and found to be non-functioning. Interview with the Maintenance Supervisor confirmed that repair to the resident-staff communication and response system had not been completed and the home continued to await the return of Georgian Bay with the necessary parts to repair the system. The Maintenance Supervisor also identified that the system in room 219, 222 and 230 had been non-functioning for some time prior to the start of this inspection on October 16, 2014.

The licensee failed to ensure that the resident-staff communication and response system could be easily seen, accessed and used by residents, staff and visitors at all times in rooms 219, 222, 226 and 230 for a minimum of twelve days between October 17, 2014 and October 28, 2014. [s. 17. (1) (a)]

3. The licensee has failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

During observation on October 28, 2014 it was observed and confirmed by staff of the home that a resident-staff communication and response system was not available in the large lounge on the North wing, the small dining room on the North wing and the small lounge at the end of the Central wing. Interview with staff confirmed that no alternative communication system was available in these areas and someone requiring assistance would have to call out.

The licensee failed to ensure that every area accessible by residents has a resident-staff communication and response system available. [s. 17. (1) (e)]

4. The licensee has failed to ensure that the resident-staff communication and response

system clearly indicated when activated where the signal was coming from.

During stage one observation on October 17, 2014 it was identified that the resident-staff communication system in rooms 219, 222, 230 and 226 was not functioning. The system initiated by the home at an unknown date prior to October 17, 2014 was the use of bed alarms by residents with non-functioning call bells. The bed alarms provide an audible sound when activated but do not provide any indicator where the signal is coming from.

Over the course of this inspection it was observed that several residents utilize bed and chair alarms as a safety device related to fall prevention. When these alarms are activated there was no distinguishing sound or light to identify where the activated alarm was coming from.

PSWs interviewed identified that they have difficulty identifying which alarm was ringing, which could delay response time for the resident.

The resident-staff communication and response system put in place between October 17, 2014 and October 28, 2014 in rooms 219, 222, 226 and 230 did not indicate when activated where the signal was coming from. [s. 17. (1) (f)]

Additional Required Actions:

CO # - 006, 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that was reported to the licensee, was immediately investigated.

Resident #015 was admitted to the home in 2014. A head to toe assessment was completed at the time of admission that did not identify any injuries. Minimum Data Set (MDS) Assessment completed ten days later related to physical functioning and structural problems identified that resident #015 required total assistance for bed mobility, and all activities of daily living.

Documentation one month later identified that the resident had a specified injury. An internal incident report was completed at the time the specified injury was reported, was signed off by the Director of Care and by the Administrator.

Interview with the Director of Care identified that the specified injury would be an indicator of potential abuse of the resident and confirmed that the incident was not investigated.

Interview with the Administrator confirmed that she had not investigated the incident of reported injury.

Review of the home's policy Abuse and Neglect last reviewed August 2014 identified the specified injury as a potential sign of physical abuse that should be reported and investigated.

The licensee failed to investigate a reported injury of resident #015. [s. 23. (1) (a)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to 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.

Resident #015 was observed to be sitting in the corridor outside their room.

Two staff were observed to approach the resident without speaking to the resident, and pushed the resident into the bedroom.

Staff were observed to take the resident into the bathroom and without speaking to the resident transferred the resident to the toilet. The resident was heard to moan loudly with the transfer.

One staff member stayed with the resident, and three minutes later, the second staff member returned and without speaking to the resident, the resident was transferred back into the wheelchair. The resident was heard to moan loudly with the transfer. Staff spoke to each other, however the only comment made to the resident during the

provision of care was to tell the resident to "let go".

Staff involved in the transfer of resident #015 were interviewed and confirmed that they had not spoken to the resident prior to providing care.

The licensee failed to ensure that resident #015 was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [s. 3. (1) 1.]

2. The licensee failed to ensure that every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

A) Resident #017 was observed with dried food around their mouth and eyes were matted with yellow discharge on more than one occasion.

A Registered Practical Nurse confirmed that the resident's face was dirty with dried food around the mouth. The Registered Practical Nurse reported that she had instructed PSW staff to clean the resident's face earlier however, she would clean the resident immediately. (532)

B) Resident #005 was observed with dried food debris around the mouth on more than one occasion.

A Registered Practical Nurse confirmed that the resident's face had dried food around the mouth and reported that care should have been provided for the resident by staff as the resident required assistance and was not able to do it themselves. (532)

C) Resident #013 was admitted to the home in 2014. The Minimum Data Set (MDS) assessment completed for the resident on admission identified that the resident was exhibiting specific indicators and a Resident Assessment Protocol and care planning were completed. Interview with the Director of Care and the Resident Assessment Instrument (RAI) Coordinator confirmed that a referral to the physician would be expected at this time.

The following month resident #013 sustained a fall with injury and was sent to hospital. Interview with the RAI Coordinator and review of the Pain Policy confirmed that pain assessment would be expected at this time. No pain assessment was completed on

return from hospital with injury.

Ten days after sustaining the fall, resident #013 demonstrated behaviours that were unusual from behaviour demonstrated at the time of admission. The resident's demonstrated behaviours increased over the next few months.

The next scheduled MDS assessment indicated that the resident had a change in condition. Interview with the Director of Care and RAI Coordinator confirmed that the change in the resident's condition should have been referred to the physician. Medication was ordered for resident #013 four months after the onset of behaviours.

Staff interviewed confirmed that resident #013 was not treated with courtesy and respect.

Review of the medical record demonstrated an exacerbation in behaviours and interview with the RAI Coordinator confirmed that there was no Behaviour Support Ontario registered staff currently and that the resident's behaviours had not been reassessed.

Staff were observed yelling at the resident.

On October 17 and 23, 2014 resident #013 was observed ungroomed. Record review identified that the resident and family preferred resident #013 to be groomed at all times as it was very important to them. Interview and record review confirmed that the plan of care was not updated to include this requested assistance.

Interview with the resident confirmed that the resident prefers to be groomed daily but they do not receive assistance with the provision of care and that they "struggle through" on their own.

The licensee failed to ensure that resident #013 was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs. In addition, the licensee failed to ensure that the resident was reassessed with a positive change in their condition and that personal hygiene assistance was provided the resident.

D) Resident #015 was identified in Minimum Data Set (MDS) assessment to have had a change in condition which was observed during the inspection.

The Resident Assessment Instrument (RAI) Coordinator confirmed that no investigation in to the change in status was completed.

The licensee failed to ensure that resident #015 was assessed following identification of a change in condition and that staff failed to identify a change in residents condition during routine care on each shift. [s. 3. (1) 4.]

3. The licensee failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

During observation the privacy curtains around bed one in room 226, did not provide full coverage of the bed space. A gap of four feet was noted at the foot of bed when the curtain was fully extended.

Interview with the Administrator October 29, 2014, confirmed that the privacy curtain did not provide full coverage and that curtain hooks were required to ensure the privacy curtains provided full coverage. [s. 3. (1) 8.]

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 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;right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs and to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #9: 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. (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) Record review and interview on October 24, 2014 confirmed that the plan of care for resident #015 did not include interventions related to pain.

Resident #015 was observed to be in pain.

Review of the progress notes for resident #015 identified that the physician documented a potential diagnosis and prescribed routine analgesic for the discomfort.

The licensee failed to ensure that there was a written plan of care for resident #015 that sets out the planned care for the resident related to pain management.

B) Resident Assessment Protocol indicated that resident #005 was exhibiting a number of indicators which were not easily altered.

The RAI Coordinator stated that the resident was being monitored and was receiving medication.

The RAI Coordinator confirmed that there was no plan of care developed for the resident. (532) [s. 6. (1) (a)]

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

A) The plan of care for resident #015 related to Personal Hygiene, indicated that the resident was dependent for care and staff were to perform total care of activities every day.

Resident #015 was observed to be ungroomed and observations were Observations were confirmed by the Resident Assessment Instrument (RAI) Coordinator.

Staff interviewed identified that the resident required total assistance with hygiene and grooming and the PSW interviewed indicated the resident had no other special care requirements.

The RAI Coordinator confirmed that the plan of care did not provide clear direction to staff with regard to the needs of the resident for hygiene and grooming and that the plan of care goal was not met in that the resident was not neat, clean and odor free.

B) The toileting plan of care for resident #015 indicated that the resident used a brief and required full staff performance every day. A review of the Point of Care documentation required staff to document once each shift related to continence of bowel and bladder.

Interview with PSWs responsible for the care of resident #015 indicated that the resident required toileting every two hours, that the resident was positioned on the toilet and that they cannot be left unattended in the bathroom. Interview confirmed that efforts to maintain continence were at times successful.

The licensee failed to ensure that the plan of care for resident #015 set out clear

directions to staff and others who provide direct care to the resident.

C) The plan of care for resident #006 identified under Personal Hygiene that the resident required assistance with hygiene related to physical limitations and weakness. The identified intervention in the plan of care indicated to provide weight bearing support three or more times per week or complete performance of task most days but not everyday.

Interview with the Director of Care confirmed that the plan of care would not provide clear direction to staff as the resident's required assistance related to hygiene including daily maintenance of appearance, mouth care, shaving, and makeup application was not identified. [s. 6. (1) (c)]

3. 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.

A) Resident #013 was observed to be ungroomed.

Record review identified that the resident and family requested that the resident be groomed at all times as it was very important to them.

Interview with the resident confirmed that the resident preferred to be groomed daily but they do not receive assistance.

The plan of care related to personal hygiene, identified a goal of good oral hygiene but does not address all the resident's grooming needs. Interventions documented on the plan of care indicate the resident was independent and required little or no help or oversight two times or less in seven days.

The plan of care for resident #013 failed to include the needs and wishes of the resident related to daily grooming.

B) Resident #013 was assessed using the MDS assessment to have behavioural symptoms.

Resident #013 was observed exhibiting behaviours.

A PSW confirmed that interventions related to behavioural symptoms were not included

in the plan of care/kardex.

The licensee failed to ensure that the plan of care for resident #013 was based on the MDS assessment of the resident's needs and preferences.

C) Resident #009's admission assessment indicated the resident preferred to have a shower.

The resident reported that they currently prefer to have a tub bath as they were no longer capable of standing to have a shower.

A review of the bath schedule and Point of Care records indicated that when the resident was bathed they received baths.

The resident's plan of care was not based on their needs or preferences. [s. 6. (2)]

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

Plan of care for resident #002 indicated that the resident used a bed alarm and the staff were to ensure that the alarm was in place and responded promptly.

Record review indicated that resident #002 was found sitting on the floor by a PSW and was not alerted by a bed alarm.

On observation there was no bed alarm in place for this resident. A Registered Practical Nurse confirmed that there was no bed alarm in place for the resident, however, the alarm was to be in place as the resident was at high risk for falls. [s. 6. (7)]

5. The licensee has 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 change or care set out in the plan was no longer necessary.

A) Resident #009's plan of care related to therapeutic recreation indicated that recreation staff would visit with the resident as part of the one on one program.

A review of the resident's activity attendance records and the Acting Activity Director confirmed that the resident's attendance in programs has increased. The Acting Activity

Director reported that the resident previously received one on one visits however, the resident was not currently receiving one to one visits for the past five months, when attendance at programs began increasing.

The Acting Activity Director reported that the resident's plan of care should have been revised to reflect that the one on one program was no longer necessary when their assessment was completed quarterly. The resident had two quarterly assessment completed during this time, however, the plan of care was not revised.

B) The plan of care for resident #013 indicated that the resident was to be encouraged to attend group activities.

Review of attendance at planned activities for a two month period for resident #013 with the Acting Activity Director identified that resident #013 participated in only one to one programs and walking outdoors in very small groups.

Interview with the Acting Activity Director identified that resident #013 did not attend group programing as their condition had changed. The plan of care was not revised with this change in the resident's care needs.(192) [s. 6. (10) (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 there is a written plan of care for each resident that sets out the planned care for the resident, that the plan of care sets out clear directions to staff and others who provide direct care to the resident, the plan of care is based on an assessment of the resident and the resident's needs and preferences, the care set out in the plan of care is provided to the resident as specified in the plan and residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #10: 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 has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #015 was observed to have two full bed rails in place during stage one of this inspection. The plan of care indicated that the resident required two side rails up at all times when in bed for safety.

Resident #015 was observed two days later to be restless in their bed and attempting to put their legs over the bed rail.

It is noted the following day that the bed resident #015 was observed in earlier was exchanged for a high low bed and the bed rails were removed.

The Director of Care identified that the bed resident #015 was originally using had not been assessed for entrapment risk and that the resident's safety in the bed had not been assessed.(192)

B) Resident #014 was observed in bed with two full side rails in the raised position and this was confirmed by the Director of Care.

Eight days later, the resident was observed resting in bed however, there were no side

rails attached to the bed.

A Registered Practical Nurse reported that the family of the resident consented to removing the side rails and the side rails were removed. The Registered Practical Nurse was uncertain if there was an assessment that was completed before the side rails were removed.

The Director of Care reported that the home was working towards removing the side rails and they had 20 beds with full/half rails remaining and the goal for the home was to remove all side rails by the end of 2014.

The Director of Care confirmed that where bed rails were used, resident #014 was not assessed and the bed system evaluated for entrapment risk as well as, for 15 residents in the home. [s. 15. (1) (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 where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #11: 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 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: 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.

Resident #015 who was assessed to be dependent on staff for all mobility and activities of daily living, was observed to have a specified injury in 2014. The alleged abuse was reported to the Administrator and Director of Care through the home's risk management system.

The home's policy Abuse and Neglect with a review date of August 2014 identified the specified injury as a sign of potential physical abuse. The Director of Care identified that the injury to resident #015 had the potential to have been caused by a staff member.

Record review and interview with the Director of Care and the Administrator confirmed that the potential incident of alleged abuse was not investigated and the Director was not notified of the incident of alleged abuse when resident #015 was identified to have a specified injury. [s. 24. (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 a person who had 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: 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, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was not restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

Resident #015 was observed to have a physical device in place while up in their wheelchair. The resident was observed on multiple occasions attempting to exit the wheelchair.

Resident #015 was observed to be in bed with two full rails in place. The resident was restless in bed and was attempting to exit at the time of both observations.

Interview with PSWs and a Registered Practical Nurse confirmed that the use of the bed rails was to keep the resident from exiting the bed. PSWs confirmed that the physical device was in place to prohibit the resident from exiting the wheelchair.

The RAI Coordinator confirmed that for resident #015 the bed rails and the use of the physical device when the resident was in the wheelchair would be restraints. The RAI Coordinator confirmed that the use of restraints was not included in the plan of care and the resident was not monitored for restraint use. [s. 30. (1) 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 residents are not restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee failed to ensure that resident's desired bedtime and rest routine was supported and individualized to promote comfort, rest and sleep.

Resident #011 reported that they would prefer to sleep in some days however, their choice was not supported by staff.

Resident #010 identified in interview that they prefer to get up at 0700 or 0730 but staff insist the resident get up at 0600. The resident indicated that getting up at 0600 feels like they are getting up in the middle of the night.

Resident #014 stated that they get up at 0600 hours but prefer to get up at 0800 hours. A staff member reported that the resident was assisted in the morning between 0600 -0730 hours as breakfast started at 0815 hours and staff had to get everyone in the dining room by 0800 hours.

Record review for all three residents indicated that there was no assessment completed that identified resident's preferences for rest routines to promote comfort, rest and sleep.

The RAI Coordinator confirmed that there was no assessment for the resident's desired bedtime and rest routine and reported that it would be the expectation to have the individualized routines documented in the plan of care to promote comfort, rest and sleep.

Interview with the Director of Care identified that the home has received resident complaints related to staff waking residents early in the morning when they would prefer to sleep later. The home has been working with Personal Support staff to ensure that resident rights were respected and that each resident has opportunity to wake at their chosen time in the morning. (165, 192) [s. 41.]

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 has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep., to be implemented voluntarily.

WN #14: 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 of the long term care home failed to ensure that the nutrition care program included a weight monitoring system to measure and record with respect to each resident's weight on admission and monthly thereafter.

Eight residents reviewed did not have admission weights completed and documented on admission. The Director of Care reported that staff were to complete and document resident's weights in Point Click Care on the evening of admission. The Director of Care confirmed that admission weights were not completed on admission. [s. 68. (2) (e) (i)]

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 that the nutrition care program included a weight monitoring system to measure and record with respect to each resident's weight on admission and monthly thereafter, to be implemented voluntarily.

WN #15: 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 there were schedules and procedures in place for routine, preventive and remedial maintenance.

On October 24, 2014, the Inspector requested to view the schedule for maintenance of the home's elevator. The home's Administrator reported that the scheduled visits would be outlined in the home's contract with the elevator service contractor which was available from the home's corporate office. The contract provided on October 24, 2014, indicated that the maintenance agreement and the home would provide no less than 9 visits per year however, the agreement would be terminated at the end of five years on June 30, 2012 unless a new agreement was negotiated. A request for the new agreement outlining the scheduled visits was requested on October 24, 2014.

On October 27, 2014, the Administrator provided a copy of the contract from the elevator service provider dated October 27, 2014, which indicated that a five year agreement was currently in place and to keep in line with the maintenance requirements and safety of the elevator, the elevator service provider would continue to service the elevator on a month to month basis.

A review of the home's elevator log indicated that the home had only three regular maintenance services from the elevator service provider (February 26, May 8 and August 22, 2014). The Administrator reported that service to the elevator on a month to month basis was not completed and a schedule for preventive and remedial maintenance was not in place. [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 there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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

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

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that falls prevention and management training shall be provided to all staff who provide direct care to residents.

A review of education records for 2013, indicated that 27% of direct care staff did not receive the annual training for falls prevention and management. The Director of Care

confirmed that education was not completed for all direct care staff listed on the education records. [s. 221. (1) 1.]

2. The licensee has failed to ensure that direct care staff provided training in skin and wound care.

Review of the attendance at Mandatory Training for 2013 identified that 4 of 63 direct care staff received training on skin and wound care.

Interview with the Director of Care identified that training for 2014 has been changed to ensure participation of all staff however not all staff have received their mandatory training for 2014. [s. 221. (1) 2.]

3. The licensee has failed to ensure that direct care staff provided training in pain management including pain recognition of specific and non-specific signs of pain.

Review of the attendance at Mandatory Training for 2013 identified that pain management training was not completed in 2013 by direct care staff.

The Director of Care identified that 4 of 10 registered staff have received a pain management course in 2014. [s. 221. (1) 4.]

4. The licensee has failed to ensure that training been provided for all staff who apply physical devices or who monitor residents restrained by a physical device, including application of these physical devices, use of these physical devices and potential dangers of these physical devices.

Record review and interview with the Director of Care confirmed that no training on restraining by a physical device, including application, use of and potential dangers of these physical devices was completed in 2013.

Interview with the DOC identified that restraining is included in the mandatory training for 2014, but not all staff have received mandatory training to date in 2014. [s. 221. (1) 5.]

5. The licensee has failed to ensure that training been provided for all staff who apply PASDs or who monitor residents with PASDs including application of these PASDs, use of these PASDs, and potential dangers of these PASDs.

Record review and interview with the Director of Care confirmed that no training on PASD's including application of these PASD's, use of these PASD's, and potential dangers of these PASD's was completed in 2013.

Interview with the DOC identified that use of PASD's is included in the mandatory training for 2014, but not all staff have received mandatory training to date in 2014. [s. 221. (1) 6.]

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 falls prevention and management, skin and wound care, restraints and Personal Assistive Services Devices training shall be provided to all staff who provide direct care to residents, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During observation of medication administration on October 24, 2014 it was observed that the registered nurse performed hand hygiene following administration of medication on only one of three occasions observed.

Staff interviewed on October 29, 2014 confirmed that hands would be washed between the administration of medications to residents.

The license failed to ensure that staff participate in the implementation of the infection

prevention and control program. [s. 229. (4)]

2. On October 16, 17, 2014 unlabeled toothbrushes were observed in the shared bathrooms of room 210 and 203.

On October 21, 2014 a used basin was stored on the floor of the shared bathroom in room 236 with pajamas placed in side and a unlabeled denture cup was observed in the shared bathroom of room 243.

During a tour with the Administrator on October 29, 2014, the following was observed:

A soiled brief was hanging over the garbage can located in a shared bathroom of room 240. Feces was observed on the toilet and floor.

A urinal was hanging on the back of the bathroom door located in a shared bathroom of room 240. The Administrator confirmed that this was not the practice of the home.

In room 209 a tooth/denture brush was unlabeled in the shared bathroom.

In room 225 there were two toothbrushes and a deodorant that were unlabeled in the shared bathroom.

In room 238 there were two unlabeled electric shavers and one disposable shaver that were unlabeled in the shared bathroom.

The Administrator confirmed the items were not labeled and the expectation was for the items to be labeled. [s. 229. (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 staff participate in the implementation of the infection prevention and control program., to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

On October 28, 2014, at 1305 hours the doors to the small and large dining room were left propped open with no staff present. The servery doors in both dining rooms were unlocked and opened and the steam tables were hot to touch.

A PSW confirmed that the servery doors were unlocked and opened and entry to the servery was accessible by residents wandering in the area. The PSW reported that the servery doors and dining rooms were to be locked when unattended by staff. [s. 5.]

WN #19: 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:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the resident's Physical functioning, and the type and level of assistance that was required relating to activities of daily living, including hygiene and grooming.

Resident #001's MDS assessment, indicated that the resident required limited assistance of one staff for personal hygiene.

The resident's plan of care for hygiene and grooming indicated the resident required supervision.

A review of point of care indicated that the resident required supervision only twice in the last 14 days and required limited assistance a majority of the time. Resident #001's plan of care was not based on the assessment of the resident's physical functioning and the type and level of assistance required for hygiene and grooming. [s. 26. (3) 7.]

2. The license failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences for the resident.

Resident #009 reported that the staff assist the resident to bed after evening meal however, the resident preferred to choose when to go to bed when they feel like it.

The admission assessment indicated that the resident preferred not to stay up late at night.

Review of the resident's clinical record indicated that there was no plan of care based on the interdisciplinary assessment of the resident's sleep patterns and preferences.

The RAI Coordinator confirmed that there was no plan of care for the resident's sleep patterns and preferences and reported that it would be the expectation for the registered staff to include resident's preferences in the plan of care based on an assessment. [s. 26. (3) 21.]

WN #20: 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 has 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 interventions are documented.

Resident #013 was identified to have a long standing skin impairment which a review of the progress notes indicated was assessed by the skin and wound nurse and would be documented in the homes skin and wound electronic program. The home was able to provide confirmation of the wound assessments on only three occasions.

Interview with the skin and wound nurse confirmed that she documented in the progress notes that the weekly wound assessment would be recorded in the electronic program, but often when she went to document the assessment, she was unable to access the electronic program and that training on the program had been insufficient for her to problem solve completing the assessment.

The skin and wound care nurse confirmed that weekly assessments were not documented. [s. 30. (2)]

WN #21: 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 failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Resident #009 reported that there was a set time for baths and they preferred more bath time.

Clinical record review for three indicated the following:

One month the resident had seven out of nine scheduled baths.

One month the resident had six out of eight scheduled baths.

One month the resident had four out of seven scheduled baths.

A PSW reported that the resident searched for staff on the baths days and the resident confirmed that they were bathed once per week but would not miss an opportunity to get in the tub.

The RAI Coordinator confirmed that the resident was not bathed twice a week and indicated that if the resident had refused then the expectation was that staff document the refusals. There was no indication in the clinical health record that the resident had refused baths. [s. 33. (1)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received fingernail care, including the cutting of fingernails.

Resident #015 was observed to have long, dirty fingernails. The RAI Coordinator confirmed that finger nails on the residents right hand were not clean and trimmed. Staff interviewed identified that the bath shift nurse would be responsible for the trimming of nails. [s. 35. (2)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device undertaken on a monthly basis.

Interview with the Director of Care identified that no analysis of the restraining of residents by use of a physical device was completed on a monthly basis in the home.

During observation resident #015 was observed to be positioned in bed with two full bed rails and was attempting to exit the bed and in a physical device and was attempting to exit the wheelchair.

Interview with the RAI Coordinator, the Director of Care and staff confirmed that use of the bed rails and the physical device were to provide safety for the resident and were intended to prevent the resident from exiting the bed and wheelchair. The RAI Coordinator confirmed that this would meet the home's definition of restraint.

The licensee failed to complete analysis of the restraining of residents by use of a physical device on a monthly basis. [s. 113. (a)]

Issued on this 17th day of December, 2014

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TAMMY SZYMANOWSKI (165), DEBORA SAVILLE (192), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2014_202165_0029
Log No. / Registre no:	L-001399-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 24, 26, 2014
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE FERGUS NURSING HOME 450 QUEEN STREET EAST, FERGUS, ON, N1M-2Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATHY COOK

To CARESSANT-CARE NURSING AND RETIREMENT HOMES 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. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee is required to ensure that the Head Injury Routine policy and the Pain Policy is complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

The home's Head Injury Routine (HIR) Policy indicated that when a resident sustained any trauma to the head or had an unwitnessed fall, Registered staff were to complete a HIR using the Glasgow Coma Scale as a documentation tool including vital signs, for at least 72 hours with the following frequency:
Every half hour for the first 2 hours following the injury
Every hour for the next 4 hours
Every 4 hour for the next 8 hours
Every shift for the remainder of the 72 hours.

A) Record review indicated that resident #005 had a fall in 2014 and sustained an injury.

Record review indicated that the HIR was initiated on the day of the fall and vital

signs were assessed for the first hour and a half. However, the HIR was not completed and the resident was not monitored for the 72 hours as indicated in the policy.

On October 22, 2014 a Registered Practical Nurse reported that staff monitor residents and initiate HIR, however, once a resident was observed as doing well, the HIR would be stopped and not completed.

The Director of Care confirmed that the expectation was that the HIR was completed for the 72 hours as indicated in the policy and that the homes policy and procedure in place was not complied with. (532)

B) In 2014, resident #012 was found to have an injury and the resident reported that they had a fall the previous night. The Registered Nurse on duty at the time of the fall confirmed that the fall had been unwitnessed by staff.

A review of the resident's clinical health record and the Registered Nurse confirmed on October 22, 2014, that there was no HIR completed post fall. The Director of Care verified that the expectation was for a HIR to be completed as indicated in the home's HIR Policy.

C) In 2014, resident #030 sustained an unwitnessed fall. The resident was sent to the hospital for assessment and returned to the home with injury.

The RAI Co-ordinator reported that a HIR would be expected to be completed as outlined in the home's policy.

A review of the resident's clinical health record indicated there was no HIR initiated for the resident, this was confirmed by the RAI Co-oridnator. [s. 8. (1) (a),s. 8. (1) (b)]

2. The home's policy titled Pain Assessment dated April 2010 indicated that the Caressant Care Pain Assessment Tool on Point Click Care would be utilized when a resident exhibits behaviour that may herald the onset of pain or a resident exhibits distress related behaviours.

Resident #013 was admitted to the home in 2014 and was identified at that time to be calm, quiet and polite. The resident sustained a fall one month later that resulted in a transfer to hospital with injury. The resident returned to the home,

documentation review and interview confirmed that no pain assessment was completed post injury.

Documentation indicated that the resident began demonstrating behaviours ten days later. Documentation review and interview confirmed that no pain assessment was completed with escalating behaviours.

The licensee failed to comply with their Pain Policy when resident #013 sustained an injury that could have resulted in pain and demonstrated an exacerbation in behaviours.

B) Resident #015 had a new pain medication initiated in 2014. Interview with the RAI Coordinator confirmed that no pain assessment was completed at the time this pain medication was initiated.

Resident #015 was observed to be exhibiting pain symptoms especially with a change in position.

The licensee failed to ensure that a Pain Assessment was completed when a new pain medication was initiated. (532)

2. The home's policy titled Pain Assessment dated April 2010 indicated that the Caressant Care Pain Assessment Tool on Point Click Care would be utilized when a resident exhibits behaviour that may herald the onset of pain or a resident exhibits distress related behaviours.

Resident #013 was admitted to the home in 2014 and was identified at that time to be calm, quiet and polite. The resident sustained a fall one month later that resulted in a transfer to hospital with injury. The resident returned to the home, documentation review and interview confirmed that no pain assessment was completed post injury.

Documentation indicated that the resident began demonstrating behaviours ten days later. Documentation review and interview confirmed that no pain assessment was completed with escalating behaviours.

The licensee failed to comply with their Pain Policy when resident #013 sustained an injury that could have resulted in pain and demonstrated an exacerbation in behaviours.

B) Resident #015 had a new pain medication initiated in 2014. Interview with the RAI Coordinator confirmed that no pain assessment was completed at the time this pain medication was initiated.

Resident #015 was observed to be exhibiting pain symptoms especially with a change in position.

The licensee failed to ensure that a Pain Assessment was completed when a new pain medication was initiated. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents 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.

The plan will be submitted electronically to Long Term Care Home Inspector Tammy Szymanowski, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, London Service Area Office, 130 Dufferin Avenue, 4th floor, London, Ontario N6A 5R2 at tammy.szymanowski@ontario.ca by end of day December 5, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that the 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.

A) Resident #013 was identified to have altered skin integrity. Record review and interview with the wound care nurse confirmed that no weekly wound assessment was completed for four identified weeks over a two month period.

B) Resident #006 was admitted to the home in 2014 with impaired skin integrity. The first recorded assessment of the wound was completed 26 days later. Interview with the Director of Care confirmed that wounds were to be assessed weekly on Wednesday and that weekly assessments were not consistently completed for resident #006.

Record review identified that weekly wound assessments were not completed for 11 identified weeks over the past five months.

The wound care nurse indicated that they were the only person completing wound assessments and that they were often pulled from wound care to cover staffing on the care area. When this occurs or if she was absent, weekly wound assessments were not completed.

The licensee failed to ensure that resident #013 and #006 who were exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

Order / Ordre :

The licensee shall ensure that, for each resident demonstrating responsive behaviours, 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.

Grounds / Motifs :

1. The licensee has 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.

In 2014, resident #030 sustained a fall with an injury.

Six weeks prior to the fall, the Registered Nurse indicated in the progress notes that the residents behaviour changed, and requested that staff provide a specific intervention. Twenty two days after the Registered Nurses request, the Physician also indicated that the specific intervention was to be done. The RAI Coordinator confirmed that the specific intervention was not completed and there was no action taken to respond to the needs of the resident.

A review of the residents clinical health record indicated that the resident was experiencing increasing behaviour for six weeks. There was no reassessment and interventions developed to respond to the needs of the resident until after the resident sustained a fall with injury. (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

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 : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall ensure that each resident is offered a minimum of three meals daily.

Grounds / Motifs :

1. The licensee failed to ensure that each resident was offered a minimum of three meals daily.

On October 16, 2014, during lunch meal service at least seven identified residents were not offered the lunch meal. Six residents were identified to be in their bedrooms in the Central wing and one resident was in the hallway outside the dining room.

It was observed that two trays were prepared for residents in the North wing however, no other trays were prepared and offered to residents in the Central wing. The Dietary Aide confirmed that only two trays were prepared for residents that were not in the dining room during lunch service.

The RPN was unaware of all the residents that were not present in the dining room for the lunch meal and confirmed that resident #031 was placed in the hallway prior to meal service commencing and was left in the hallway during the entire lunch meal. The resident was identified as high nutritional risk by the home's Registered Dietitian and weight records indicated the resident has lost 2.6 kilograms over the past week.

On October 16, 2014, resident #032 reported that staff did not enter their bedroom to remind them of lunch meal service or offer a lunch meal. The resident was deemed high nutritional risk by the home's Registered Dietitian and the resident's plan of care indicated that the resident commonly remains in their room rather than going to the dining room and staff were to offer a tray.

On October 16, 2014, resident #033 did not have a lunch meal offered. The resident experienced a significant weight loss in October 2014 and was deemed high nutritional risk by the home's Registered Dietitian. The resident's plan of care indicated for staff to encourage food and fluids and provide alternatives for the resident.

Four of four residents interviewed reported that staff did not remind them of lunch meal service or offer the lunch meal October 16, 2014. (165)

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 : Dec 31, 2014

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the flooring in the large dining room and north wing hallway where the floor is not level and tiles are cracked and broken are repaired. The plan will be submitted electronically to Long Term Care Home Inspector Tammy Szymanowski, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, London Service Area Office, 130 Dufferin Avenue, 4th floor, London, Ontario N6A 5R2 at tammy.szymanowski@ontario.ca by end of day December 5, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During a tour of the home with the Maintenance Supervisor October 28, 2014, it was confirmed that the current flooring in the North wing and the large dining room were not level and the tiles were cracked and broken.

During a tour of the home with the Administrator October 29, 2014 the Administrator confirmed that the identified flooring in North wing and the large dining room were not level and tiles were cracked and splitting resulting in a trip hazard for residents. (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 27, 2015

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 : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee of the long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

During observation on October 17, 2014 it was identified that the resident-staff communication and response system in room 226 was not functioning and could not be activated by residents in beds three and four.

Interview with the Administrator confirmed that the home was aware that some call bells were not functioning and the home was awaiting the arrival of Georgian Bay, the contractor responsible for repair of the system. The Administrator identified that call bells in rooms 211, 219 and 230 were known to be non-functioning however, was not aware of concerns with call bells in room 226. Bed alarms were provided to the resident's with non-functioning call bells and repairs were anticipated in the next few days.

On October 24, 2014 the call bells in room 226 beds three and four were again checked and found to be non-functioning. A bed alarm system was provided to the resident in bed three as an interim means of communication, however, no alternative was provided for the resident in bed four.

On October 28, 2014 the call bells in room 226 beds three and four were checked and found to be non-functioning. Interview with the Maintenance Supervisor confirmed that repair to the resident-staff communication and response system had not been completed and the home continued to await the return of Georgian Bay with the necessary parts to repair the system. The Maintenance Supervisor also identified that the system in room 219, 222 and 230 had been non-functioning for some time prior to the start of this inspection on October 16, 2014.

The licensee failed to ensure that the resident-staff communication and response system could be easily seen, accessed and used by residents, staff and visitors at all times in rooms 219, 222, 226 and 230 for a minimum of twelve days between October 17, 2014 and October 28, 2014.

(192)

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 : Nov 28, 2014

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 :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents. The plan will be submitted electronically to Long Term Care Home Inspector Tammy Szymanowski, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, London Service Area Office, 130 Dufferin Avenue, 4th floor, London, Ontario N6A 5R2 at tammy.szymanowski@ontario.ca by end of day December 5, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

During observation on October 28, 2014 it was observed and confirmed by staff of the home that a resident-staff communication and response system was not available in the large lounge on the North wing, the small dining room on the North wing and the small lounge at the end of the Central wing. Interview with staff confirmed that no alternative communication system was available in these areas and someone requiring assistance would have to call out.

The licensee failed to ensure that every area accessible by residents has a resident-staff communication and response system available. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 29, 2015

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 : 008

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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee of the long term care home shall ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee is immediately investigated.

Grounds / Motifs :

1. Previously issued during CIS inspection 2014_229210_0007 January 28, 2014 as a VPC.

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that was reported to the licensee, was immediately investigated.

Resident #015 was admitted to the home in 2014. A head to toe assessment was completed at the time of admission that did not identify any injuries. Minimum Data Set (MDS) Assessment completed ten days later related to physical functioning and structural problems identified that resident #015 required total assistance for bed mobility, and all activities of daily living.

Documentation one month later identified that the resident had a specified injury. An internal incident report was completed at the time the specified injury was reported, was signed off by the Director of Care and by the Administrator.

Interview with the Director of Care identified that the specified injury would be an indicator of potential abuse of the resident and confirmed that the incident was not investigated.

Interview with the Administrator confirmed that she had not investigated the incident of reported injury.

Review of the home's policy Abuse and Neglect last reviewed August 2014 identified the specified injury as a potential sign of physical abuse that should be reported and investigated.

The licensee failed to investigate a reported injury of resident #015. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 05, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 24th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : TAMMY SZYMANOWSKI

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