Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 4, 2016	2016_325568_0015	015931-16	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

DOROTHY GINTHER (568), AMIE GIBBS-WARD (630), ANN POGUE (636), SHARON PERRY (155)

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): June 15, 16, 17, 21, 22, 23, 24, 27, 28, 29, and 30, 2016

The following intakes were completed within the RQI:
034685-16 - 2603-000032-15 Critical Incident related to responsive behaviours;
010904-16 - 2603-000008-16 Critical Incident related to a fall with injury;
011178-16 - 2603-000009-16 and 005536-16 - 2603-000005-16 Critical Incidents related to responsive behaviours/ alleged abuse;
001115-16 - 2603-000001-16 and 016039-16 - 2603-000010-15 Critical Incidents related to alleged abuse;
016576-15 - 2603-000013-16 Critical Incident related to alleged sexual abuse;
010032-16 IL-43973-LO Complaint related resident's safety;
008297-16 IL-43582-LO Complaint related to alleged abuse and improper care;
021029-16 Complaint related to alleged staff to resident abuse;
032581-15 Follow-up to CO #002 Inspection # 2015_448155_0020(A1) related to the home furnishings and equipment being kept clean and sanitary;
032578-15 Follow-up to CO #001 Inspection # 2015_448155_0020(A1) related to the home's Pain Assessment policy.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, Resident Care Coordinator, Food and Nutrition Manager, Recreation Manager, Physiotherapist, Administrative Assistant, Maintenance Staff, RAI Coordinator, Registered Dietitian, one Activation Aide, one Housekeeper, three Registered Nurses, four Registered Practical Nurses, twenty-one Personal Support Workers, one Personal Support Worker student, Resident Council Representative, residents and their families.

The inspectors also toured the home, observed meal service, medication administration, medication storage; reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, posting of required information, investigation notes; observed the provision of resident care, resident-staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

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
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **23 WN(s)**
- **16 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2015_448155_0020	568

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. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Review of a Critical Incident (CI) report identified that a resident had an altercation with another resident. The CI report indicated that one of the resident's had a history of responsive behaviours.

During an interview with an identified resident, they reported that they remembered the incident in question. They recalled that the resident had demonstrated responsive behaviors toward them and it was upsetting.

During an interview with a Personal Support Worker (PSW) they reported there had been a history of altercations between the identified resident and other residents.

During an interview with a second identified resident, they reported problems with the same resident which lead to several altercations. It had taken a long time for them to get over the incidents as they were all very upsetting.

Clinical record review identified a number of documented altercations between the identified resident and other residents over a one year period. There was no documented evidence of further assessment for resident injury by nursing staff following two physical altercations, and an "Internal Incident Report Form" had not been completed.

The Behavioral Support PSW documented that they talked to the staff that worked on a particular weekend and they indicated that the identified resident had exhibited a number of responsive behaviors. The Resident Care Coordinator (RCC) and Behavioral Supports RPN indicated that none of the responsive behaviors had been reported over the weekend.

A Physician note stated that the medical management team reviewed concerns related to

the identified resident's escalating responsive behaviours over a two week period. There was no documented evidence of interviews by the DON with residents involved in the incidents or the Substitute Decision Makers; nor was there evidence of an action plan to address the resident's escalating behaviours including reassessment, referral to outside resources, or initiation of one to one staffing.

During an interview with the home's Behavioural Supports (BS) PSW they said the identified resident had multiple altercations with other residents.

Review of the home's policy titled "Abuse & Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" with a review date of August 2014 indicated that for Resident to Resident Abuse the Caressant Care Internal Incident Report Form would be completed by the DON. In addition, residents involved in abuse of other residents would not be permitted to make visits to other resident rooms unattended. The policy did not include direction for staff on what to do if the residents shared a room.

During an interview with the Director of Nursing (DON), they reported that there had been multiple altercations between the identified resident and other residents in the home over a one year period. The DON acknowledged that following an incident where there was potential injury to another resident, she had not documented interviews with the residents involved, nor was there documented evidence of an assessment for injury following the incident. She acknowledged that the interventions that were implemented within the home to minimize altercations between the identified resident and other residents were ineffective as incidents continued to occur.

The DON reported they had tried many external referrals, contacted law enforcement, and reached out to specialized resources. She said they had difficulties with timely acceptance of their referrals for hospital treatment. The DON also shared that when the identified resident returned from a leave, the home did not reassess the resident's responsive behaviours, and relied on previous assessments. The DON also said there was no documented evidence of the home's Behavioral Supports involvement with the resident when there was documented evidence that the resident's responsive behaviors were escalating. The home acknowledged that they had not implemented the one to one monitoring for the identified resident that had been recommended as they thought it would not be effective.

The licensee has failed to ensure that procedures and interventions for the identified

resident were developed and implemented such that the risk of potentially harmful interactions between this resident and other residents was minimized. [s. 55. (a)]

2. A Critical Incident (CI) described an incident where an identified resident demonstrated responsive behaviors toward another resident.

A CI submitted six weeks prior to the first described a similar type of incident involving the same two residents. In both situations, staff notified the Substitute Decision Makers (SDM) for each resident and the Ontario Provincial Police (OPP).

Record review identified that the two resident's involved in the CI's had impaired cognition. The plan of care for one of the residents indicated under responsive behaviors that staff were to complete 15 minute checks to ensure the resident was not near other residents, and staff were to supervise each time the resident left their room.

During the inspection the identified resident was observed in a common area of the home where a program was taking place. The identified resident was seated very close to the resident involved in both of the critical incidents. There were no residents between them and staff were occupied with the activity and other residents.

During an interview with an activity staff member they said they were not aware that the identified resident should not be in close proximity to other residents. A Personal Support Worker said to this inspector that they were aware of the identified resident's history of responsive behaviors, specifically toward the resident sitting near by, and acknowledged that the identified resident should not be seated in such close proximity without direct supervision.

The licensee has failed to ensure that procedures and interventions for the identified resident were implemented such that the risk of potentially harmful interactions between this resident and other residents was minimized.

The scope of this issue was isolated and the severity was actual harm. The compliance history was a two, one or more unrelated noncompliance in the last three years. [s. 55. (a)]

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. 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 strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Review of an identified resident's plan of care indicated that the resident demonstrated responsive behaviours. Progress notes revealed that on two days during a one week period the resident demonstrated these behaviours but staff were able to to redirect the resident before they were harmed. Despite re-orientation by staff the resident continued to exhibit these behaviours and on several occasions it was documented that the resident was not easily redirected. Following one of the incidents the resident was placed on 15 minute checks. Despite this intervention, there was another incident. At this point the resident's pattern of behaviours was reviewed and it was identified that there was a specific period when the behaviours were most prevalent. The home implemented a specific intervention for this time period over the next two weeks before it was discontinued. There were six documented incidents of responsive behaviors that put the resident at risk of harm after the intervention was discontinued. During two of these documented incidents staff had difficulty redirecting the resident safely.

During observations on three days of the inspection the identified resident was found sitting in the hall for two hour periods either sleeping or staring straight ahead. On two days the resident was observed demonstrating the identified behaviours in the afternoon hours. Staff in the area did not intervene until the DON either redirected the resident or asked staff to do so.

During interviews with two Personal Support Workers and a Registered Practical Nurse they indicated that they were aware of the identified resident's responsive behaviours. A PSW indicated that the resident was on 15 minute checks. These checks would be documented by staff on their Point of Care (POC). Staff had been verbally told by registered staff that if the identified resident began to demonstrate these behaviours they were to redirect them back to their room or the hall near their room. When asked if any other interventions had been put in place to mitigate the risk related to these behaviours the staff were not aware of anything.

Interview with an Activity Aide revealed that the identified resident attended many of their activities when asked. When asked if they had a schedule to engage the resident, particularly during periods when their behaviors were more prevalent, the staff member was not aware of a specific activity schedule for the identified resident.

Review of the Point of Care documentation on Point Click Care for a thirty day period prior to the inspection revealed that there was no alert for staff related to 15 minute checks and that there was no documentation that the checks had been completed for the identified resident. During an interview with RAI Coordinator they acknowledged that staff were not able to document the 15 minute checks during the last thirty days because this function had not been enabled.

During an interview with the Director of Nursing they acknowledged that the identified resident had responsive behaviours and there had been several incidents where the resident's safety was at risk. The DON reported that the resident's behaviours were heightened during the late afternoon and evening. In terms of strategies to address the these behaviours the DON reported that they had instituted 15 minute checks and staff had been instructed to redirect the resident when they exhibited the behaviors. They had also planned on keeping the resident busy during those times when the resident's behaviours were heightened. When asked what activities were planned or scheduled during these periods of heightened behaviours, the DON indicated that specific strategies and activities had not been put in place.

The licensee failed to ensure that specific strategies were developed and implemented to respond to resident #018's exit seeking behaviours. [s. 53. (4) (b)]

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

Review of a Critical Incident (CI) report identified a resident that had exhibited responsive behaviors toward another resident which resulted in injury. This CI report also indicated that the identified resident had been recently discharged from the Behavioral Support program in the home as per the psychogeriatric consultant recommendations. The CI also stated that there seemed to be a relationship between the resident's incidents of responsive behaviours and the presence of an Infection.

Progress notes identified more than 30 incidents where the identified resident exhibited responsive behaviors. The documentation reported that all of the resident's behaviours had been controlled by current interventions and medications. Even when the resident exhibited behaviours staff were aware of the interventions.

Review of progress notes for the last eight months identified seven incidents of documented responsive behaviours which resulted in harm or risk of harm to other residents. At one point the resident was identified as having "escalating behaviours". Medication was administered with no effect; staff tried to calm the resident down by gentle approach; and met all their demands with no results. It was documented that staff had asked the Resident Care Coordinator to consider a specific intervention for this resident in order to safe guard them, the staff and other residents from harm.

Further review of the clinical record indicated that the identified resident was re-enrolled in the Behavioral Supports program approximately five months after the first documented incident of "escalating behaviours".

The DON provided inspector #630 with the documentation by Behavioral Support PSWs which was completed in a separate document and kept on a USB key in the home. Notations on the USB key identified several incidents where the resident exhibited responsive behaviors. At one point the staff indicated that an infection was making the behaviours worse.

During an interview with Behavioural Supports(BS) RPN and PSW they reported that the identified resident had ongoing behaviours and was recently added back into the home's BS program. They identified that as far as they knew the resident had not been reassessed for responsive behaviours and interventions until the PIECES assessment was initiated earlier in the month. The RPN reported that the resident had behavioural tracking completed and they were not aware of the resident being referred to external resources. The staff member also shared that the resident tended to have specific triggers which they believed increased the resident's behaviours. Monitoring and treatment of these conditions was a part of the interventions to manage the resident's behaviours. The RPN acknowledged that the plan of care had not been updated to include these triggers.

Review of the plan of care for responsive behaviours, including the Kardex and the MAR, for the identified resident reported the resident as having a problematic manner in which they act characterized by ineffective coping; Agitation related to: Cognitive impairment , physical aggression toward other residents and staff. There were specific Interventions to address the identified behaviours. The plan of care did not include possible triggers for the responsive behaviours,nor did it identify related interventions.

During the inspection the identified resident was observed on more than one occasion sitting in the hallway outside the dining room with residents passing by on their way to the dining room. No staff were in the the area. On a particular day during the inspection the resident was found in their room with the door open and a specific intervention not in place. Five residents were in the hallway right outside the identified resident's room and one of the resident's was wandering in their wheelchair. This was brought to the attention of a staff member who put the specified intervention in place.

During an interview with an RPN they reported the identified resident was on PRN pain medications as well as PRN medications for their responsive behaviours. At times the PRN medications were not effective as the resident would refuse the medication.

During an interview with the Resident Care Coordinator (RCC) they said that the identified resident often had increased behaviours related to infections. When RCC reviewed the plan of care for the resident with this inspector it did not include the identification of infections as possible triggers, nor did it include interventions related to these triggers. The RCC acknowledged that the plan of care and MAR did not give direction to staff on when to use the PRN medications. She also acknowledged the

Medication Administration Records (MAR) did not identify the effectiveness of PRN medication on two occasions in the last month. The RCC said that there had not been further reassessments done on the identified resident after they were discharged from the BS program in late 2015 as it was deemed that the interventions in place were known by staff and were thought to be effective.

During an interview with the Director of Nursing (DON) she said that the identified resident was discharged from the Behavioral Supports program in late 2015 and as far as she knew there was no documentation related to re-assessments, referrals to external resources or referrals to the home's physician related to responsive behaviours. The DON acknowledged that the Medication Administration Record did not give direction to staff on when to use the PRN medications for responsive behaviours apart from stating "as needed". She reported that staff discuss the responsive behaviours of all residents in the home but that these were not consistently documented. The DON could not locate documentation of ongoing evaluation of the responsive behaviours for the identified resident. She said that it was the expectation in the home that the plan of care would be updated to reflect discussions at the "huddles" or from the BS team. The DON was not aware that the resident had been readmitted to the behavioral supports program as the quarterly summary regarding responsive behaviours was not due to be completed until July 2016.

The licensee failed to ensure that when the identified resident demonstrated on-going 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.

The scope of this issue was a pattern. The severity was a level two, the potential for actual harm. The compliance history was a three, one or more related noncompliance in the last three years. A compliance order was issued for s. 53.(4) (a), (b), (c) on November 24, 2014. This order was complied on August 18, 2015. [s. 53. (4) (c)]

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 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 has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

1) During the initial tour of the home, as well as observations of the resident's rooms and common areas throughout this inspection the following was observed:

a) The window and the screen at the top of the stair way to the second floor was dirty with spider webs, dead insects and dirt stains.
b) The baseboards in seven out of 22 (32 per cent) of the resident bathrooms were noted to have a build-up of black dirt and debris notably around the edges.
c) The screen and windows in the central activity room and two out of 22 rooms (9 per cent) were noted to be dirty with spider webs, dead insects and dust build-up.
d) The fan/skylight in the hallway was noted to have dirt and dust hanging down from the vents and boards.
e) The floor in the north tub room under the beige shelf had a build-up of dust.
g) Privacy curtains were soiled in the central and north tub rooms.
h) The baseboard heater in the bathroom in two out of 22 rooms (9 per cent) were noted to be dirty and stained.
i) The door frame to the shared bathroom in five out of 22 (23 per cent) rooms were noted to have brown stains, debris and/or hand prints.
j)The wall in the bathroom in four out of 22 (18 per cent) were noted to have brown dirt stains.
k) The floor tiles in the shared bathroom of seven out of 22 (32 per cent) were noted to have brown dirt stains.

During an interview with an identified resident they shared a concern that the floor in their

bathroom and the baseboards could be cleaner.

During an interview with a Housekeeping Aide they said they had daily job routines and then monthly cleaning schedules to follow. The Housekeeping Aide reviewed the printed copies of "Daily Routine Cleaning" and the monthly cleaning schedule with the inspector and it was acknowledged that they did not provide direction regarding frequency of cleaning walls or baseboards. The Housekeeping Aide also stated that during outbreaks they decreased the amount of time spent on the monthly cleaning schedule from one hour daily to a half hour daily to focus on cleaning high contact surfaces. She reported they have difficulty completing the monthly cleaning items within the assigned hour for some of the rooms.

Review of the home's policy titled "Cleaning Guidelines – Resident Rooms" reviewed April 2016 did not identify cleaning baseboards, door frames or walls of the bathroom or bedroom. This policy identified that "thorough cleaning" consisted of "clean walls, windows and baseboards".

Review of the home's policy titled "Cleaning Guidelines – Common/General Areas" reviewed April 2016 did not identify cleaning windows or screens in the lounge.

During an interview with the Administrator they stated that during outbreaks they have heightened cleaning. During this time they split the regular monthly cleaning time of one hour in half and spend the extra time on surface cleaning. She acknowledged that they had recently been in an enteric outbreak for over a month. The Administrator spoke about cleaning of the vinyl baseboard. In regards to the vinyl base boards the Administrator said they tried stripping these some time ago but found that whatever they used it looked worse afterward.

During a tour of the home with the Administrator they acknowledged the observations and agreed with the identified concerns with regard to cleanliness of the home.

This has been previously issued as a written notification and voluntary plan of correction on November 24, 2015 during inspection 2014_202165_0029 and a written notification with compliance order on November 6, 2015 during inspection 2015_448155_0020.

The scope of this issue was widespread and severity a level two, minimal harm or potential for harm. The compliance history was a level four, despite Ministry Of Health action (VPC, order) noncompliance continues with original area of noncompliance. [s. 15.

(2) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's right to have his or her lifestyle and choices respected.

During an interview with a resident's Substitute Decision Maker (SDM) they shared that since the resident changed rooms there had been a number of issues. The SDM stated that the resident had demonstrated increased responsive behaviors and they had tried to work hand in hand with staff but no one seemed to be on the same page. The SDM further stated that they had provided the home with several special directions related to the provision of personal care for the identified resident.

During an interview with a Personal Support Worker they stated that they had only worked part time in the home for two months. This was the first shift that they had been assigned to provide care for the identified resident. The staff member indicated that the resident sometimes refused care depending on their mood. The staff member was told that if needed, they could ask other staff for help. The PSW stated that the identified resident had refused their assistance with care that morning and they had to ask staff to provide some of the resident's care. They were not aware of any special request related to the provision of care for the identified resident.

A progress note identified that a special request was made by the SDM related to care

for the identified resident. The plan of care for the resident reflected this request under hygiene/grooming.

During an interview with the Administrative Assistant they said they were responsible for creating the schedule and assignment for Personal Support Workers. The staff member indicated that they were not aware of any special instructions related to the identified resident.

During an interview with the Director of Nursing (DON) they said they were aware of the special directions/requests made by the family of the identified resident pertaining to the provision of care. The request had been communicated to staff via the communication book and on a one to one basis. The DON acknowledged that a special request for the identified resident's care provision had not been respected because they had not had an opportunity to communicate this information to a new staff member.

The licensee failed to ensure that the identified resident's choices were respected.

The scope of this issue was isolated. The severity of this issue was determined to be level two with potential for harm to the resident. The compliance history of this issue was determined to be level three, one or more related noncompliance in the last three years. [s. 3. (1) 19.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following resident rights were fully respected and promoted:
- 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.
- the right to have his or her lifestyle and choices respected,, to be implemented voluntarily.

WN #5: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Record review done during stage one of this inspection revealed that a resident had altered skin integrity.

The Registered Nurse/Resident Care Coordinator shared that the resident had two areas of altered skin integrity. Review of documentation in the Pixalere program done with Registered Nurse/Resident Care Coordinator, revealed that the resident had two areas of altered skin integrity which were documented in April 2016.

Review of the resident's Minimum Data Set (MDS) quarterly assessment, section M, skin condition done in April 2016 showed that the resident had one area of altered skin integrity.

During an interview with the Director of Nursing they agreed that the specified MDS quarterly assessment done in April 2016 showed that the resident had one area of altered skin integrity was not correct as the resident had two areas of altered skin integrity. The Director of Nursing #101 agreed that the assessments were not consistent and did not complement each other. [s. 6. (4) (a)]

2. Record review done during stage one of this inspection revealed that a resident had altered skin integrity.

The Registered Nurse/Resident Care Coordinator shared that the resident had two areas

of altered skin integrity. Review of the documentation in the Pixalere program done with Registered Nurse/Resident Care Coordinator, revealed that on a specified date the resident had two areas of altered skin integrity.

Review of the resident's Minimum Data Set (MDS) most recent quarterly assessment, section M, skin condition showed that the resident had no areas of altered skin integrity. The Resident Assessment Protocol (RAP) for the same MDS assessment, stated that the resident was at risk of altered skin integrity but had none at this time.

During an interview with the Director of Nursing they agreed that the MDS quarterly assessment showing that the resident had no areas of altered skin integrity was not correct as the resident had two areas of altered skin integrity. The Director of Nursing acknowledged that the assessments were not consistent and did not complement each other.

The scope of this issue was isolated and the severity was a level two, minimal harm/potential for actual harm. The compliance history was a level three with one or more related noncompliance in the last three years. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff who provide direct care to the resident, and that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the Caressant Care Nursing & Retirement Homes Ltd., Wound Assessment policy and procedure, review date of May 2015, stated that after completion of the wound assessment the registered staff shall determine the appropriate treatment utilizing the 3M wound treatment algorithms. Registered staff shall enter the skin/wound treatment on the electronic treatment administration record (E-TAR) indicating the specific treatment frequency of dressing application/changes, i.e. 3M products to be used.

Review of the algorithm for wound management, irrigate wound according to policy/protocol, apply 3M Cavilon No Sting barrier film to peri-wound tissue and lists 3M wound products to be used to manage the different types of wounds.

Record review and staff interview identified that the resident had two areas of altered skin integrity. The treatment administration record for the resident revealed an entry made on a specified date stating that a specific treatment was to be completed on the areas of altered skin integrity. The Resident Care Coordinator shared that this treatment decision was made by the Registered Nurse/Wound Care Champion.

During an interview with the Director of Nursing they shared that the RN/Wound Care Champion had made an error in the treatment plan for the resident's altered skin integrity. The treatment applied to the areas of altered skin integrity were not consistent with the home's policy.

The licensee failed to ensure that their Wound Assessment policy and procedure was complied with when the RN/Wound Care Champion wrote the treatment plan for the identified resident.

The scope was isolated and the severity of harm a level two, minimal harm/potential for actual harm. The compliance history was a level two, one or more unrelated noncompliance in the last three years. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are 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.

During observations in stage 1 and stage 2 of the Resident Quality Inspection, it was noted that a resident had a bed rail up on one side of the bed.

During an interview with a Personal Support Worker (PSW) they stated that the identified resident used their bed rail when transferring from sit to stand, and to maintain their position while care was being provided. When asked how they were made aware of what bed rails were to be used for a resident, the staff member shared that it would "pop up" on their Point of Care tablet.

During a review of the identified resident's health care record there was no documentation to indicate that the resident used bed rails.

The Resident Care Coordinator (RCC) told inspector #568 that the home does not have a formalized assessment related to bed rails. Based on discussion with staff they determine if bed rails will aid a resident's function and this would be documented in the progress notes and care plan. In terms of the identified resident, the staff member reported that there was no documented assessment in the plan of care with respect to the resident's use of bed rails.

The scope was isolated and the severity of harm a level two, minimal harm/potential for actual harm. The compliance history was a level three, one or more related noncompliance in the last three years. A VPC was issued in November 2014. [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 evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The home failed to ensure that all residents were protected from abuse by anyone.

A Critical Incident report identified that a resident had an altercation with another resident resulting in injury. The identified resident had a history of responsive behaviours involving other residents.

During an interview with the injured resident they reported that they still remembered the incident and that they were hurt.

During an interview with another resident they reported concerns with how they had been treated by the same identified resident. They recalled several altercations with the resident which caused them to be fearful. The resident reported that it had taken a long time to get over the incidents as they were very upsetting.

During an interview with a PSW it was reported that there had been multiple altercations between the identified resident and other residents in the home. Often the identified resident had done something which was very upsetting to co-residents.

During an interview with a PSW they reported that the identified resident was seen by the home's Behavioural Support team soon after admission. The PSW said the identified resident exhibited multiple responsive behaviours toward other residents and had to be watched closely.

Clinical record review identified a number of documented incidents of responsive behaviours between the identified resident and multiple co-residents from their admission until one year later. On a particular date the Behavioural Support (BS) PSW documented that they had spoken with staff that were working on the weekend and they indicated that the identified resident exhibited a number of behaviours that were extremely upsetting to the other residents. The PSW then spoke with the Resident Care Coordinator and BS RPN and they indicated that none of that was reported over the weekend.

During an interview with the Director of Nursing they said they had ongoing issues with the identified resident after admission and had tried a number of referral options. She said they had difficulties with timely acceptance of their referrals for hospital treatment and had not been successful with trying to transfer the resident to another facility.

The home was not able to protect other residents from abuse by resident #046. [s. 19. (1)]

2. A Critical Incident described an situation where resident #001 exhibited inappropriate behaviours toward resident #002. Staff intervened and separated the residents.

A second Critical Incident was submitted which described a similar incident involving the same two residents. In both incidents, staff notified the Substitute Decision Makers (SDM) for each resident and the Ontario Provincial Police (OPP).

Record review revealed that resident #001's Cognitive Performance Scale (CPS) was 3/6 where six would be the least cognitive. Resident #002's CPS was 5/6.

There was no documentation in the plan of care for resident #002 related to behaviours or record of the resident being the recipient of two incidents of inappropriate behaviour.

The plan of care for resident #001, identified the resident as exhibiting inappropriate

behaviours and staff were to complete checks every 15 minutes and staff were to supervise each time resident #001 left their room for any reason.

Progress notes identified that on two occasions over a six week period resident #001 was observed by staff exhibiting inappropriate behaviours toward resident #002.

During the inspection resident #001 was observed sitting very close to resident #002 and they were not being closely supervised. Not all staff were aware that resident #001 demonstrated inappropriate behaviours and that specific interventions were in place to ensure close monitoring. The inspector brought this to a PSW's attention and they immediately commenced close supervision of resident #001.

The licensee has failed to protect resident #002 from abuse by resident #001 on two occasions. Not all staff were aware of the restrictions related to resident #001 put in place to minimize risk to other residents.

The scope of this issue was a pattern. The severity of harm was actual harm and the compliance history was a level three, one or more related noncompliance in the last three years. A compliance order was issued for s. 19(1) February 24, 2014 and complied April 30, 2014. [s. 19. (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 be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

During stage one of RQI, a resident reported that a short time ago they had an incident with a staff member and they had reported this to staff on the floor.

Record review revealed that the identified resident reported to a Registered Nurse that they had concerns regarding a PSW that had provided care for them. The RN notified the Director of Nursing by phone.

The identified resident also reported this incident to a PSW the next day. The PSW reported this to the RN who then notified the Director of Nursing.

The home's policy and procedure, subject abuse and neglect, staff to resident with a review date of May 2015 states:
-The Director of Nursing and/or Administrator will interview all parties and maintain a written record using the Abuse-Resident Incident Report (Appendix A). At this time, the employee may be sent home until the investigation is complete.
-The Director of Nursing, or in his/her absence the Charge Nurse, will complete a Head to Toe assessment of the resident and document the same.
-The Director of Nursing and/or Administrator will contact the attending physician and request a complete medical exam of the resident.
-The Director of Nursing and/or Administrator will notify the resident's POA of the alleged abuse immediately.
-The Director of Nursing/Administrator will notify the police of the alleged, suspected or witnessed incident of abuse or neglect.

The Director of Nursing shared that the Abuse-Resident Incident Report (Appendix A) was not completed when the identified resident reported the incident of alleged abuse; that the charge nurse did not complete a head to toe assessment, that the attending physician was not contacted to complete a medical exam, that resident's POA was not notifed immediately of the alleged abuse, and that the police were not notified.

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

The scope was isolated and severity of harm a level two, minimum risk/potential for actual harm. The compliance history was a level three, one or more related noncompliance in the last three years. A VPC was issued in January 2014. [s. 20. (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 there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #10: 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).

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

Findings/Faits saillants :

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

resident by anyone.

During stage 1 of the Resident Quality Inspection, resident #040 reported that there was an incident with a staff member.

Record review revealed that a resident reported to Registered Nurse that they had concerns with a PSW that was providing care for them. The RN notified the Director of Nursing by phone.

The identified resident also reported this to a PSW the next day. The PSW reported this to the RN who then notified the Director of Nursing.

The home's policy and procedure, subject abuse and neglect, staff to resident with a review date of May 2015 states:
-The Director of Nursing and/or Administrator will interview all parties and maintain a written record using the Abuse-Resident Incident Report (Appendix A).

During an interview with the Director of Nursing (DON) they said that they did not speak with the identified resident until several days after the alleged incident of abuse. The DON did not speak to the PSW that reported the incident nor did they speak to the staff member that provided care to the resident on the specified dates.'

The Director of Nursing shared that they did not keep any notes regarding the investigation and that an Abuse-Resident Incident Report was not completed. The Administrator #100 also acknowledged that the Abuse-Resident Incident Report was not completed for this incident.

The alleged abuse reported by the identified resident was not immediately investigated.

The scope was isolated and severity of harm a level two, minimum risk/potential for actual harm. The compliance history was a level three, one or more related noncompliance in the last three years. A VPC was issued in January 2014. [s. 23. (1) (a)]

2. The licensee failed to ensure that the results of every investigation of alleged, suspected or witnessed abuse of a resident and every action taken with respect to the incident was reported to the Director.

Documentation review revealed a Complaint form which made reference to an attached letter signed by a resident. The letter made reference to an incident involving a staff member and the resident.

During an interview with the Director of Nursing they said that immediately upon receiving the written complaint from the identified resident they initiated an investigation. The DON reported that they were advised by their Administrator that the letter should be forwarded to the Director via the Central Intake and Assessment Team (CIATT). The DON acknowledged that they had not informed the Director of the results of the investigation or actions taken with respect to the alleged incident of verbal abuse. [s. 23. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated:
(i) abuse of a resident by anyone;
and that the results of every investigation undertaken under clause (1) (a) and every action under clause (1) (b) is reported to the Director, 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 failed to ensure that when there were reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm may have occurred, that this suspicion and the information upon which it was based was immediately reported to the Director.

Record review revealed that a resident reported an incident involving a staff member to the Director of Nursing that took place the day before.

During an interview with the resident that reported the incident they acknowledged having gone the the Director of Nursing with their concern.

The Director of Nursing confirmed that the identified resident had reported an incident of alleged verbal abuse involving a staff member and two residents. The DON indicated that the home conducted an investigation which included interviewing the residents and staff involved where possible. DON stated that the Administrator was made aware of the incident and the investigation notes were submitted to head office once completed. When asked if the home had notified the Director with regard to this incident the DON reported that they had not.

The licensee failed to ensure that where there were reasonable grounds to suspect that abuse of resident #023, #065 and #066 may have occurred, that this suspicion and the information on which it was based was immediately reported to the Director.

The scope was isolated and severity of harm a level two, minimum risk/potential for actual harm. The compliance history was a level three, one or more related noncompliance in the last three years. A VPC was issued in January 2014. [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 when there were reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm may have occurred, that this suspicion and the information upon which it is was based was immediately reported to the Director, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home has his or her personal care items labelled.

During the initial tour of the home there were four stick deodorants, and one container of zinc oxide cream observed in the central tub room not labelled. In the north tub room there were three stick deodorants unlabelled. A Personal Support Worker shared that they used the deodorants on multiple residents as they did not have enough to give each resident their own. (155)

During observations on second day during the inspection in the north tub room it was noted that there was an unlabelled open container of Infazinc 15% cream on the shelf. In the central tub room there was one Mennon deodorant and one Axe deodorant on the shelf. Both deodorants had been used and were not labelled.

During an interview with the Resident Care Coordinator and the Director of Nursing they said that it was the home's expectation that all personal care items for residents including deodorant and zinc cream should be labelled for a specific resident. The Director of Nursing acknowledged that the deodorant and zinc 15% cream found in the tub rooms were not labelled.

The scope was widespread and the severity of harm a level one, minimum risk. The compliance history was a level two, one or more unrelated noncompliance in the last three years. [s. 37. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #13: 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,
(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 O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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).

Findings/Faits saillants :

1. The licensee failed to ensure that equipment, supplies, devices and positioning aids are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds to promote healing.

An identified resident had altered skin integrity. The resident was referred for an consultation related to seating. Record review indicated that the identified resident's family could not afford the recommended pressure relieving device.

During this RQI the identified resident was observed sitting in a wheelchair with no pressure relieving device.

The identified resident's plan of care under the problem of skin integrity stated apply pressure relief interventions.

During an interview with the RN/Wound Care Nurse they shared that the home had special mattresses for beds for pressure relief, however they did not have any cushions for wheelchairs that would provide pressure relief unless the family purchased these items.

During interview with the Resident Care Coordinator they shared that the home had no equipment to relieve pressure for a resident's chair.

The licensee failed to ensure that equipment, supplies, devices and positioning aids were readily available at the home as required to relieve pressure for resident #011 exhibiting pressure ulcers. [s. 50. (2) (c)]

2. The licensee failed to ensure that 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, and while asleep if clinically indicated.

During stage one a resident was identified as having altered skin intergrity.

Interview and record review of the Pixalere documentation with the Resident Care Coordinator revealed that the identified resident had altered skin integrity.

During interviews with three PSWs they shared that the identified resident could reposition themselves in bed but would not be able to do it when up in their wheelchair. Staff would reposition when they toileted the resident.

The Resident Care Coordinator shared that the identified resident could reposition themselves because they could propel their wheelchair.

Record review revealed that the care plan indicated that the identified resident was to be turned and repositioned with skin care.

During observation of the identified resident it was noted that they were not repositioned between the hours of 0830 and 1030 hours and they remained in their wheelchair during

this time. The resident did not reposition themselves during this time.

The licensee failed to ensure that the identified resident was repositioned at least every two hours.

The scope was isolated and the severity of harm a level two, minimum risk/potential for actual harm. The compliance history was a level three, one or more related noncompliance in the last three years. [s. 50. (2) (d)]

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 equipment, supplies, devices and positioning aids were readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and to ensure that 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, and while asleep if clinically indicated, 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 has failed to ensure the nutrition care and hydration programs included the implementation of interventions to mitigate and manage the identified risks related to nutrition care.

Clinical record review for a resident identified that they had experienced a significant weight loss after being admitted to the home. The resident lost five point eight kilograms (equal to nine point three per cent) in one month.

Further review of the clinical record for the identified resident revealed the following:
- Progress note documented by Nutrition Manager (NM) stated the the resident's appetite on admission was poor and they were below their healthy weight range.
- Admission Minimum Data Set (MDS) Assessment documented by the Registered Dietitian (RD) stated that the BMI was below the ideal range and the resident was a high nutrition risk.
- Progress note documented by RD showed RD had assessed resident for poor fluid intake based on a referral from nursing but included no assessment of poor food intake.
- No documented referral or assessment by the Nutrition Manager or Registered Dietitian

regarding poor food intake
- No documented assessment by RD regarding the resident's significant weight loss
- Point of Care monitoring of food intake at meals and snack showed that for a two month period the resident's documented food intake was seven or fewer units out of a maximum daily total of 16 for 54 per cent of the days (34 out of 63).

Review of the home's relevant Nutrition Care policies identified the following:
- Policy titled "Monthly Weights" with review date November 2015 indicated that residents who have lost or gained a significant amount of weight are to be followed up by the Food Nutritional Manager/Registered Dietitian immediately.
- Policy titled "Food and Fluid Intake Tracking" with review date June 2015 indicated tracking that indicates poor intake of food e.g. food not consumed (less than 8 units for 3 days) must be referred to the FNM or RD using the Nutritional Referral on point clickcarecom.
- Policy titled "Enteral Feeding" with review date November 2015 stated that the RD must liaise with the dietitian at the discharging facility regarding the present feed protocols and with a new admission, the RD will closely monitor the progress of the resident weekly. Regular documentation from a nutritional perspective will take place.

During an interview with a registered staff, it was reported that the identification of residents who were eating poorly was mainly based on observations in the dining room. The RN said that the night registered staff created a list using Point of Care (POC) of residents who have sub-optimal fluid intake but they did not do that for food intake. She was unclear how referrals were made based on poor food intake documented in POC.

During an interview with the RD, Nutrition Manager, and DON, they acknowledged that the clinical record for the identified resident showed poor food intake and a significant weight loss since admission. The RD said she had not assessed their weight "immediately", as stated in the policy, as her usual practice was to assess the residents with significant weight loss by the end of the month. The RD said that she did not monitor the identified resident weekly after admission as they seemed to be eating well when first admitted. The RD and DON #103 said they had not spoken with the RD from the discharge facility for the identified resident regarding their nutritional history. In terms of poor food intake, they acknowledged that that the home's policy stated if a resident's intake was less than 8 units for three days a referral was to be made through the electronic system. The RD and NM said they had not received a referral for poor food intake for the identified resident. The DON said they were unclear as to the process in the home for tracking poor food intake through point of care and how staff used that to

make referrals.

Based on these interviews, policy reviews and clinical record review this inspection found that the identified resident had been identified as being at nutritional risk at admission and declined nutritionally within two months of admission to the home. The resident experienced a significant weight loss and poor food intake. The home's policies to mitigate and manage the identified nutritional risk through referrals to the RD, close monitoring until stable post admission, immediate RD or NM response to weight loss as well as consultation with the discharge facility were not fully implemented. [s. 68. (2) (c)]

2. Observations of an identified resident during the inspection revealed that they were not in the dining room on multiple occasions during mealtimes. The resident was observed to be in bed during lunch meal service and breakfast meal service on two days of the inspection.

Clinical record review for the identified resident revealed the following:
- Quarterly Nutrition Assessment note documented by Nutrition Manager (NM) stated that the resident's appetite was poor at both meals and snacks.
- Progress note documented by the RD identified a verbal referral with regard to less than ideal intake. RD to initiate 90ml Resource 2.0 TID. RD to also update resident to high nutrition risk. There was no other documentation of RD follow-up or referral until three weeks later.
- Point of Care monitoring of food intake at meals and snacks during that three week period indicated that seven or fewer units out of a maximum daily total of 16 units were consumed on 90 per cent of the days (19 out of 21 days) and no intake on five out of 21 days (24 per cent).
- Medication Administration Record (MAR) documentation showed that the identified resident did not consume the prescribed supplement on 29 of the 62 times (47%) over the same three week period.
- Nursing progress notes indicated the resident had been receiving clear fluids or liquids only at most meals for a seven day period.
- Physician visit progress note identified the resident had not been well and there were weight loss issues. The physician spoke with family and expressed concern about not seeing the resident sooner.

Review of the home's relevant Nutrition Care policies identified the following:
- Policy titled "Food and Fluid Intake Tracking" with review date June 2015 identified tracking that indicates poor intake of food e.g. food not consumed (less than 8 units for 3

days) must be referred to the FNM or RD using the "Nutritional Referral" on pointclickcare.com.
- Policy titled "Clear Fluids" with reviewed date November 2015 indicated that the clear fluid diet does not include solids and is provided on a temporary basis as it is nutritionally inadequate, often provides less than 3 g protein/day and is deficient in calories (less than 1000 Kcal/day). Clear fluid diets should not be provided for more than 48 hours.
- Policy titled "Nutrition Referral Form (PCC) with review date November, 2015 identified the Nutrition Referral Form in PCC is to be used by Registered Staff to communicate issues related to the resident's nutritional needs or concerns, all information relating to the resident's nutrition or nutritional needs are to be communicated electronically on this tool only. It further identified "reason for referral" "to notify the FNM/RD of any concerns or change of condition that would affect the resident nutritional status, food and/or fluid intake.

During an interview with the identified resident's Substitute Decision Maker (SDM), they reported a concern about the resident's health decline and how the home had responded. This family member expressed that the types of food and fluids the resident needed were not always being provided. The SDM was unsure if the resident was continuing to receive their supplement.

During an interview with a registered staff, it was reported that the identification of residents who were eating poorly was mainly based on observations in the dining room. The RN said that the night registered staff create a list using Point of Care (POC) of residents who have sub-optimal fluid intake but they did not do that for food intake. She was unclear how referrals were made based on poor food intake documented in POC.

During interview with the Registered Dietitian, Nutritional Manager and Director of Nursing, they acknowledged that the clinical record for the identified resident showed poor food intake for a period of three weeks. The RD said she was in the process of assessing the resident on the day of the interview. She said she had assessed the resident in the past related to concerns expressed by his family. In terms of poor food intake, they acknowledged that the home's policy stated if a resident's intake was less than 8 units for three days a referral was to be made through the electronic system. The DON acknowledged that the policy regarding clear fluids identified that residents should not be on this diet for more than 48 hours but she said it was not clear on how this was implemented in the home. This contradicted the directive from the the Public Health Unit. The DON also acknowledged that the physician had not seen the identified resident for poor intake for more than a three week period and neither the NM or RD received a

referral for poor food intake over the same period.

Based on these interviews, policy reviews and clinical record review this inspection found that resident #007 had been identified as being at nutritional risk at admission. Resident #007 was on clear fluid or liquid diet for over 7 days with documented poor food intake, inconsistent intake of the ordered nutritional supplement and weight loss. Communication to the physician regarding family concerns about the nutritional decline of this resident was not done in a timely manner. The home's policies to mitigate and manage the identified nutritional risk through referrals to the NM and RD and length of time on clear fluid diet were not fully implemented.

The scope of this issue was a pattern. The severity of harm was determined to be level two with potential for actual harm to the resident. The compliance history of this issue was determined to be level three, related noncompliance in the last three years. A VPC was issued in a similar area on November 24, 2014. [s. 68. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the nutrition care and hydration programs included the implementation of interventions to mitigate and manage the identified risks related to nutrition care, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were used to assist residents

with eating.

a) During observations in the home it was identified that a resident was being fed thickened fluids by a Personal Support Worker who was standing above the resident. The identified resident #042 was observed to cough intermittently and clear their throat. The inspector alerted the DON, who was near the area at the time, and they acknowledged that it was not an acceptable practice in the home for staff to stand while assisting residents with feeding.

During a second observation a PSW was noted to be standing above the resident that was seated, while providing assistance with feeding their pudding snack. The identified resident was noted to be coughing while being fed and the pudding was running out of their mouth.

Clinical record review of the resident's plan of care identified that they required assistance for eating related to oral disabilities and were a high risk to feed. The most recent quarterly Minimum Data Set (MDS) assessment documented by the Registered Dietitian stated that the resident remained a high risk feed.

b) During observations an identified resident was noted to be sitting in their wheelchair in the north hallway. The resident requested staff to provide them assistance with feeding. A Personal Support Worker started to feed the resident while they were standing approximately 45 cm above the height of the resident. The resident occasionally coughed while being fed.

The Personal Support Worker shared that there are times that the resident feeds themselves. They also shared that when doing snack cart, if a resident needed to be fed, they usually would go into the resident's room and sit to feed them. When the PSW was asked if standing to feed residents was the normal practice in the home, they shared that it was not and that they were to sit to feed residents.

Record review revealed that the identified resident was a high nutritional risk. (155)

During an interview with the Nutrition Manger (NM) they acknowledged that staff should not be standing while providing assistance with fluids at snacks. The NM said they could not locate a policy regarding proper techniques for feeding assistance but the home did have a "Dietary In-service" safe feeding practices dated January 2016. Review of this document with the NM identified that it directed staff to follow safe feeding techniques

which included sitting at eye level to the resident.

The scope of this issue was isolated. The severity of this issue was determined to be level two with potential for actual harm. The compliance history of this issue was determined to be level two with previous unrelated non-compliance. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that proper techniques were used to assist residents with eating, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provided direct care to residents have received training related to behaviour management.

During interviews with several staff throughout the inspection they were asked what training they had received related to responsive behaviours and behaviour management. Staff responses were all similar in that they could not recall having received specific training related to behaviour management by the home.

During an interview with a Registered Practical Nurse (RPN) they reported not being aware of the Behavioural Supports Ontario (BSO) program which provides staff training on responsive behaviours that are common for residents with cognitive impairment. The RPN was not able to identify responsive behaviours when the inspector asked about specific residents in the home. This staff member did not recall having had any training provided by the home related to behaviour management.

A Personal Support Worker (PSW) indicated that not all staff have Gentle Persuasive Approach training (GPA) and identified that all staff need to have GPA training. Another PSW reported that they received GPA training as part of their school program, but since working at the home they had not received any education related to responsive behaviour management. A third PSW indicated that they did not have any training in responsive behaviours and behaviour management.

The DON could not provide this inspector with training logs or an education program that had been provided to staff related to behaviour management. The DON stated that they had an in-service planned for the month of June in which the Behavioural Supports lead would meet with a small number of staff to discuss the program. This had not taken place at the time of the inspection.

The licensee failed to ensure that all staff who provided direct care to residents had received training related to behaviour management.

The scope was identified as widespread. The severity of harm was identified as minimal with potential for actual harm. The compliance history was a level two, one or more unrelated noncompliance in the last three years. [s. 76. (7) 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 all staff who provide direct care to residents receive training related to behaviour management, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented for addressing incidents of lingering offensive odours.

During an interview with a resident during stage 1 of the Resident Quality Inspection, they shared that there was a very strong odour in their room and that they had tried using an air freshener of their own but it did not seem to help.

During observations of the identified room on five days of the inspection a strong offensive odour was noted in the room. During an interview with the Administrator #100 acknowledged there had been concerns from staff and residents regarding the odour in the identified room. She said they had recently changed their procedure for room odours and were now using Volcanic Rock to absorb the odours in some of the resident rooms.

During observations of the identified room with Housekeeping staff, they acknowledged a strong, offensive odour in the room. The Housekeeping Aide said she had already cleaned the room and had reported the concern about the odour to the DON earlier in the day. The DON told her there was no more Volcanic Rock available in the home at that time. The Housekeeping Aide indicated that they only had Volcanic Rock in the shared bathroom and the door to the bathroom was closed during our observations.

During observations of the identified room on a second day with the Administrator they acknowledged the strong, offensive odour in the main area of the room and indicated that there should have been volcanic rock in the bedroom area as per their procedure for managing room odours.

The DON reported to this inspector that they had placed more Volcanic rock in the main area of the identified room and acknowledged that there had been an offensive odour.

The scope was a pattern. The severity of harm was minimal with potential for actual harm. The compliance history was a level two, one or more unrelated noncompliance in the last three years. [s. 87. (2) (d)]

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 procedures were implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During observation of the noon medication pass a Registered Practical Nurse (RPN) was observed to administer a resident their medication. The Registered Practical Nurse opened the bottom drawer of the medication cart and opened the separate area in the medication cart where the controlled substances were kept without any key. The RPN then placed the card containing the remaining medication back in the separate area of the medication cart, closing the lid, but did not lock the separate area,. They then closed the drawer and locked the medication cart and administered the medications to the

resident. The RPN returned to the mediation cart and continued to administer medications to residents.

When the RPN got to another resident, they opened the bottom drawer of the medication cart and flipped open the lid to the separate area containing the controlled substances and obtained the resident's medication. The RPN returned the remaining medication to the separate area in the medication cart and closed the lid, but did not lock the separate area. The RPN then locked the medication cart and administered medications to the resident.

A resident then stopped by the medication cart requesting pain medications. The RPN unlocked the medication cart and opened the bottom drawer of the mediation cart and flipped open the separate area containing the controlled substances and obtained the resident's medication. When the RPN was asked about the separate area containing controlled substances, they shared that the area should be locked. After obtaining the medication for the identified resident, the RPN replaced the remaining medication in the separate area and closed the lid tightly demonstrating that the separate area was locked.

During observations of the noon medication pass on a second day, a RPN was observed to be administering medications from the north medication cart parked outside the large dining room door in the north hall way. The RPN was observed to open the medication cart and open the bottom drawer of the medication cart and flipped open the separate area containing controlled substances without using a key. The RPN then obtained the medication from the area containing controlled substances for a resident. The RPN replaced the remaining medication in the separate area and closed the lid tightly.

The Director of Nursing shared that the practice in the home was to lock the separate area in the medication cart that contained controlled substances.

The licensee failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

The scope was a pattern and the severity of harm minimal. The compliance history was identified as a level two, with no related noncompliance in the last three years. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #19: 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 all staff participated in the implementation of the infection prevention and control program.

During stage 1 of the Resident Quality Inspection (RQI), the Administrator reported to inspectors that the home was in an "enteric outbreak" but there were no longer residents with active symptoms.

During an interview with a resident in stage 1 of the RQI they were observed in bed vomiting into a small garbage container. The resident resided in a shared room with four other residents and no infection precaution sign was observed on the door. The resident then reported to the inspector that they had thrown up two other times earlier that morning, as well as the previous night and had not eaten breakfast because they were not feeling well.

This Inspector reported to a Personal Support Worker (PSW) that the resident had vomited in their room and the PSW said they would follow-up with the resident. This Inspector observed the PSW go into the room to speak with the resident.

During an interview with a RPN on the same day a couple of hours later, they said when residents had enteric symptoms the PSWs were to report it right away to the registered staff and then they would isolate the resident, add precaution signage to the door and use gloves and gowns when providing care. The RPN said that no one had reported any symptoms to them that day for any residents. During this interview the inspector observed an Activation Aide come to the desk and report to the RPN that the identified resident had just vomited during an activity.

This Inspector observed the identified resident with six other residents in the shared space. The RPN was observed speaking with the resident and then they helped the resident to their room. The RPN later reported to the inspector that the resident told them that they had vomited three times earlier in the day.

During a review of the clinical record for the identified resident there was no documentation of emesis for the day in question. A progress note later in the day indicated that the resident reported 3 emesis within the shift and the resident had been placed on enteric isolation.

During an interview with the Director of Nursing, she acknowledged that the PSW should have reported that the resident had vomited to the registered nurse right away. She further indicated that it was the home's practice to isolate residents to their room if they have exhibited enteric signs or symptoms including vomiting or diarrhea. The DON acknowledged that the resident being with other residents after having enteric symptoms posed a risk of transmitting infection to other residents. The DON acknowledged that the staff did not follow the home's practices with respect to communication of signs/symptoms of infection.

The scope of this issue was isolated. The severity of this issue was determined to be level two with potential for harm. The compliance history of this issue was determined to be level three with previous related non-compliance with VPC issued on November 24, 2014. [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 all staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #20: 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:
18. Special treatments and interventions. 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 failed to ensure that the the plan of care was based on an interdisciplinary assessment with respect to the resident's special treatments and interventions.

Record review revealed that resident #029 was admitted to the home on April 15, 2016 and had a medical intervention in place at the time of admission.

On June 22, 2016 record review revealed that resident #029 did not have a physician's order for the medical intervention.

On June 22, 2016 interview with Registered Nurse #121 revealed that an order for the medical intervention was to be written in the physician orders section when a resident is admitted with a specific medical intervention, however Registered Nurse #121 could not locate the order. Review of the physician's admission medical done on a specified date in 2016 indicated for genito-urinary section that resident #029 had some incontinence.

On June 23, 2016 the Director of Nursing #103 confirmed that there was no physician's order for resident #029's medical intervention and indicated that it was the expectation of the home that the physician be made aware if a resident had a medical intervention in place so that the physician would assess and write an order.

The plan of care was not based on an interdisciplinary assessment of resident #029's special treatments and interventions. [s. 26. (3) 18.]

2. The licensee has failed to ensure that the plan of car was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

During stage 1 of the Resident Quality Inspection resident #008 shared with inspector #630 that they often get up at 0600 but they would prefer to get up closer to breakfast time. Now that they are retired they would rather sleep later.

The Minimum Data Set (MDS) assessment Section AC. Customary Routine indicated that the resident did not stay up late at night and liked to nap regularly during the day. There was no documentation as to what time the resident preferred to get up in the morning. Review of resident #008's plan of care revealed that it did not include sleep patterns and preferences.

During an interview with the Resident Care Coordinator (RCC) #101 on June 21, 2016 they shared that a resident's preferences and sleep patterns should be documented in their plan of care. When asked if resident #008's plan of care included their sleep patterns and preferences the RCC #101 said that this was not documented.

The scope of this issue was isolated and the severity minimal harm. The compliance history was a level two, no related noncompliance in the last three years. [s. 26. (3) 21.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the initial tour of the home and throughout this inspection the following was observed:
a) Broken / damaged floor tiles in the shared washrooms of room three resident rooms.
b) Drywall damage was noted in three shared washrooms, as well as rooms three resident rooms.
c) Missing and/or damaged vinyl baseboard in two shared resident washrooms and three resident rooms.
d) Broken lower edge of vanity cabinets in the shared washroom of five resident rooms.
e) Wall protect peeling off door in the shared washroom of one resident room and the dining room doors.
f) Damaged counter in the shared washroom of one resident room.
g) Ceiling curtain rod for privacy curtains had pulled away from the ceiling in one area in one resident room.
h) Walls had been plastered but not painted in four resident rooms.
i) Paint was scraped and chipped on bathroom and/or bedroom door frames of seven resident rooms and the Central Tub Room
J) Grout / caulking was cracked and separating around the bathroom sink in the shared washroom of one resident room.
K) Resident #022's towel bar was broken
L) Missing towel bar and hole in drywall in the bathroom of one resident room.
L) Edge of window sill broken in one resident room.
M) Flooring in the elevator was noted to have several cracked and chipped tiles
N) Vinyl flooring in one shared bathroom - edge into the room was noted to be lifting
O) Central tub room noted to have missing tiles on the half wall by the sink and the wood has chipped on the bottom of the closet doors.

P) Handrails throughout the home have lost there finish and there were areas noted where there were cracks and the wood had splintered.

Review of the home's policy for preventative maintenance program for Resident's Rooms / Common areas dated January 2015 and reviewed August 2015 indicated that on a quarterly basis the Administrator and/or maintenance staff would inspect every room. Any items found faulty would be recorded for repair using the Action Plan form. The Administrator and maintenance staff would prioritize the Action Plan and review on an on-going basis.

Record review revealed painting checklists completed on Caressant Care Fergus Performance Indicator History Summary forms. The checklists indicated that in January 2016 three walls, five doors and ten door frames were painted; in February 2016 two resident bathrooms, one central tub room, three doors and three door frames were painted; in March 2016 one and a half resident bathrooms, and one common area were painted. There were no checklists completed since the regular maintenance staff left the home in April 2016. The most recent Action Plan provided to the inspectors was entitled RQI 2015 Action Plan and was not dated. The plan identified a number of areas of disrepair in resident rooms and common areas. Some of the items had been initialed as completed between January and April 2016, however there were still a number of items that had not yet been addressed.

During an interview with the home's Administrator and lead for the maintenance program they shared that their regular maintenance staff resigned approximately two months ago and they have not been able to fill the position. They were able to secure someone on a temporary basis but it's been difficult to keep up with the planned and emergency maintenance needs of the home. In terms of remedial painting this was completed every Tuesday when they had a regular maintenance staff. When asked if the home had a preventative maintenance plan, the Administrator said that quarterly they would complete a walk about with the maintenance staff which included resident rooms and common areas. The maintenance staff would make a list of repairs that needed to be done in their personal log book. The Administrator was not able to produce the lists generated during these tours. In addition, the home's maintenance consultant would attend the home on a regular basis and tour the same areas. Based on this tour an action plan for maintenance was generated. The most recent plan was generated in 2015 following the home's RQI and because of staffing shortages they have not been able to address all the identified areas of disrepair.

The scope of this issue was widespread. The severity was identified as potential risk of harm. The compliance history was a level three, one or more related noncompliance in the last three years. A VPC was issued in November 2014. In August 2015 a compliance order was issued with respect to s. 15.(2)(c) - furnishing not maintained in a safe condition and in a good state of repair. This order remains outstanding with a compliance date of June 30, 2016. [s. 90. (1) (b)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Record review revealed that a resident brought to the attention of the Director of Nursing an incident of alleged verbal abuse by a staff member toward themselves and another resident..

During an interview with the complainant resident they acknowledged having reported an incident that occurred several months back which involved a staff member, themselves and another resident.

During an interview with the Substitute Decision Maker of the second resident, they shared that during a visit to the home a resident had told the SDM about an incident of verbal abuse involving their loved one. The SDM stated that after hearing about this incident she met with the Administrator and Director of Nursing. The SDM stated that the home had never contacted her regarding this incident. [s. 97. (1) (b)]

2. On June 16, 2016 during stage one of this RQI, a resident #040 reported an incident involving a staff member who was providing care to them.

Record review revealed that a resident reported this incident to a PSW and registered staff. The Director of Care was notified by phone by the RN. The resident's SDM was not notified of the incident of alleged abuse until three days later.

The licensee failed to notify the identified resident's SDM within 12 hours upon becoming aware of an incident of alleged abuse.

The scope was isolated and the severity of harm minimal. The compliance history was a level three, one or more related noncompliance in the last three years. A VPC was issued in January 2014. [s. 97. (1) (b)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs are stored were kept locked at all times when not in use.

During the initial tour of the home, the north treatment room door was found not closed tightly, therefore not locked, allowing free entry into the treatment room. It was noted that this room contained fifteen small bottles of mineral oil individually prescribed to residents, Canesten cream 1% dated March 9, 2016 for a resident, three bottles of calamine lotion, seven bottles of Iodine and 19 bottles of rubbing alcohol.

The Resident Care Coordinator was shown that the door to the north treatment room was not locked. They shared that the door was to be kept locked when the room was not in use.

The scope was isolated and the severity of harm identified as a potential for actual harm. The compliance history was a level two, no related noncompliance in the last three years. [s. 130. 1.]

Issued on this 2nd day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568), AMIE GIBBS-WARD (630), ANN POGUE (636), SHARON PERRY (155)
Inspection No. / No de l'inspection :	2016_325568_0015
Log No. / Registre no:	015931-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 4, 2016
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. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee shall ensure that for resident #001, #046 and any other resident exhibiting behaviours that:
1. The behaviours, including responsive behaviours, are identified and there is a process in place to alert staff of those residents that pose a potential risk to themselves or others.

2. Procedures, strategies and interventions are developed and implemented to minimize the risk of altercations and potentially harmful interactions between and among residents.

3. The Behavioural Support team observations, identification of triggers, and suggested strategies/interventions to manage a resident's responsive behaviours are included in the resident's plan of care which is accessible to staff.

4. A monitoring process is in place to ensure that staff are aware of what resident's are high risk and whether interventions are being implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures and interventions were

developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Review of a Critical Incident (CI) report identified that a resident had an altercation with another resident. The CI report indicated that one of the resident's had a history of responsive behaviours.

During an interview with an identified resident, they reported that they remembered the incident in question. They recalled that the resident had demonstrated responsive behaviors toward them and it was upsetting.

During an interview with a Personal Support Worker (PSW) they reported there had been a history of altercations between the identified resident and other residents.

During an interview with a second identified resident, they reported problems with the same resident which lead to several altercations. It had taken a long time for them to get over the incidents as they were all very upsetting.

Clinical record review identified a number of documented altercations between the identified resident and other residents over a one year period. There was no documented evidence of further assessment for resident injury by nursing staff following two physical altercations, and an "Internal Incident Report Form" had not been completed.

The Behavioral Support PSW documented that they talked to the staff that worked on a particular weekend and they indicated that the identified resident had exhibited a number of responsive behaviors. The Resident Care Coordinator (RCC) and Behavioral Supports RPN indicated that none of the responsive behaviors had been reported over the weekend.

A Physician note stated that the medical management team reviewed concerns related to the identified resident's escalating responsive behaviours over a two week period. There was no documented evidence of interviews by the DON with residents involved in the incidents or the Substitute Decision Makers; nor was there evidence of an action plan to address the resident's escalating behaviours including reassessment, referral to outside resources, or initiation of

one to one staffing.

During an interview with the home's Behavioural Supports (BS) PSW they said the identified resident had multiple altercations with other residents.

Review of the home's policy titled "Abuse & Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" with a review date of August 2014 indicated that for Resident to Resident Abuse the Caressant Care Internal Incident Report Form would be completed by the DON. In addition, residents involved in abuse of other residents would not be permitted to make visits to other resident rooms unattended. The policy did not include direction for staff on what to do if the residents shared a room.

During an interview with the Director of Nursing (DON), they reported that there had been multiple altercations between the identified resident and other residents in the home over a one year period. The DON acknowledged that following an incident where there was potential injury to another resident, she had not documented interviews with the residents involved, nor was there documented evidence of an assessment for injury following the incident. She acknowledged that the interventions that were implemented within the home to minimize altercations between the identified resident and other residents were ineffective as incidents continued to occur.

The DON reported they had tried many external referrals, contacted law enforcement, and reached out to specialized resources. She said they had difficulties with timely acceptance of their referrals for hospital treatment. The DON also shared that when the identified resident returned from a leave, the home did not reassess the resident's responsive behaviours, and relied on previous assessments. The DON also said there was no documented evidence of the home's Behavioral Supports involvement with the resident when there was documented evidence that the resident's responsive behaviors were escalating. The home acknowledged that they had not implemented the one to one monitoring for the identified resident that had been recommended as they thought it would not be effective.

The licensee has failed to ensure that procedures and interventions for the identified resident were developed and implemented such that the risk of potentially harmful interactions between this resident and other residents was minimized.

(636)

2. A Critical Incident (CI) described an incident where an identified resident demonstrated responsive behaviors toward another resident.

A CI submitted six weeks prior to the first described a similar type of incident involving the same two residents. In both situations, staff notified the Substitute Decision Makers (SDM) for each resident and the Ontario Provincial Police (OPP).

Record review identified that the two resident's involved in the CI's had impaired cognition. The plan of care for one of the residents indicated under responsive behaviors that staff were to complete 15 minute checks to ensure the resident was not near other residents, and staff were to supervise each time the resident left their room.

During the inspection the identified resident was observed in a common area of the home where a program was taking place. The identified resident was seated very close to the resident involved in both of the critical incidents. There were no residents between them and staff were occupied with the activity and other residents.

During an interview with an activity staff member they said they were not aware that the identified resident should not be in close proximity to other residents. A Personal Support Worker said to this inspector that they were aware of the identified resident's history of responsive behaviors, specifically toward the resident sitting near by, and acknowledged that the identified resident should not be seated in such close proximity without direct supervision.

The licensee has failed to ensure that procedures and interventions for the identified resident were implemented such that the risk of potentially harmful interactions between this resident and other residents was minimized.

The scope of this issue was isolated and the severity was actual harm. The compliance history was a two, one or more unrelated noncompliance in the last three years. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 19, 2016

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. 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 prepare and submit a plan for achieving compliance with O.Reg 79/10. r. 53.(4) (b).

The plan must include:
1. What immediate and long term interventions/strategies would be implemented for resident #018 and any other resident exhibiting a similar type of behaviour to ensure their safety. How these interventions will be tracked and audited.

2. What immediate and long term interventions/strategies would be implemented for resident #027 to prevent further incidents of resident to resident abuse from occurring.

3. What procedures would be implemented for residents with patterns of and escalating aggressive behaviours The procedures should include all possible interventions including access to internal/external supports, triggers and timing for referral to external specialists, access to High Intensity Needs funding for one to one staffing and preferred accommodation.

Please submit the plan in writing, to Dorothy Ginther, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Ave., 4th Floor, London ON, N6A 5R2, by email, to Dorothy.Ginther@ontario.ca by August 22, 2016

Grounds / Motifs :

1. The licensee has failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Review of an identified resident's plan of care indicated that the resident demonstrated responsive behaviours. Progress notes revealed that on two days during a one week period the resident demonstrated these behaviours but staff were able to redirect the resident before they were harmed. Despite re-orientation by staff the resident continued to exhibit these behaviours and on several occasions it was documented that the resident was not easily redirected. Following one of the incidents the resident was placed on 15 minute checks. Despite this intervention, there was another incident. At this point the resident's pattern of behaviours was reviewed and it was identified that there was a specific period when the behaviours were most prevalent. The home

implemented a specific intervention for this time period over the next two weeks before it was discontinued. There were six documented incidents of responsive behaviors that put the resident at risk of harm after the intervention was discontinued. During two of these documented incidents staff had difficulty redirecting the resident safely.

During observations on three days of the inspection the identified resident was found sitting in the hall for two hour periods either sleeping or staring straight ahead. On two days the resident was observed demonstrating the identified behaviours in the afternoon hours. Staff in the area did not intervene until the DON either redirected the resident or asked staff to do so.

During interviews with two Personal Support Workers and a Registered Practical Nurse they indicated that they were aware of the identified resident's responsive behaviours. A PSW indicated that the resident was on 15 minute checks. These checks would be documented by staff on their Point of Care (POC). Staff had been verbally told by registered staff that if the identified resident began to demonstrate these behaviours they were to redirect them back to their room or the hall near their room. When asked if any other interventions had been put in place to mitigate the risk related to these behaviours the staff were not aware of anything.

Interview with an Activity Aide revealed that the identified resident attended many of their activities when asked. When asked if they had a schedule to engage the resident, particularly during periods when their behaviors were more prevalent, the staff member was not aware of a specific activity schedule for the identified resident.

Review of the Point of Care documentation on Point Click Care for a thirty day period prior to the inspection revealed that there was no alert for staff related to 15 minute checks and that there was no documentation that the checks had been completed for the identified resident. During an interview with RAI Coordinator they acknowledged that staff were not able to document the 15 minute checks during the last thirty days because this function had not been enabled.

During an interview with the Director of Nursing they acknowledged that the identified resident had responsive behaviours and there had been several incidents where the resident's safety was at risk. The DON reported that the

resident's behaviours were heightened during the late afternoon and evening. In terms of strategies to address the these behaviours the DON reported that they had instituted 15 minute checks and staff had been instructed to redirect the resident when they exhibited the behaviors. They had also planned on keeping the resident busy during those times when the resident's behaviours were heightened. When asked what activities were planned or scheduled during these periods of heightened behaviours, the DON indicated that specific strategies and activities had not been put in place.

The licensee failed to ensure that specific strategies were developed and implemented to respond to resident #018's exit seeking behaviours. (568)

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

Review of a Critical Incident (CI) report identified a resident that had exhibited responsive behaviors toward another resident which resulted in injury. This CI report also indicated that the identified resident had been recently discharged from the Behavioral Support program in the home as per the psychogeriatric consultant recommendations. The CI also stated that there seemed to be a relationship between the resident's incidents of responsive behaviours and the presence of an Infection.

Progress notes identified more than 30 incidents where the identified resident exhibited responsive behaviors. The documentation reported that all of the resident's behaviours had been controlled by current interventions and medications. Even when the resident exhibited behaviours staff were aware of the interventions.

Review of progress notes for the last eight months identified seven incidents of documented responsive behaviours which resulted in harm or risk of harm to other residents. At one point the resident was identified as having "escalating behaviours". Medication was administered with no effect; staff tried to calm the resident down by gentle approach; and met all their demands with no results. It was documented that staff had asked the Resident Care Coordinator to consider a specific intervention for this resident in order to safe guard them, the staff and

other residents from harm.

Further review of the clinical record indicated that the identified resident was re-enrolled in the Behavioral Supports program approximately five months after the first documented incident of "escalating behaviours".

The DON provided inspector #630 with the documentation by Behavioral Support PSWs which was completed in a separate document and kept on a USB key in the home. Notations on the USB key identified several incidents where the resident exhibited responsive behaviors. At one point the staff indicated that an infection was making the behaviours worse.

During an interview with Behavioural Supports(BS) RPN and PSW they reported that the identified resident had ongoing behaviours and was recently added back into the home's BS program. They identified that as far as they knew the resident had not been reassessed for responsive behaviours and interventions until the PIECES assessment was initiated earlier in the month. The RPN reported that the resident had behavioural tracking completed and they were not aware of the resident being referred to external resources. The staff member also shared that the resident tended to have specific triggers which they believed increased the resident's behaviours. Monitoring and treatment of these conditions was a part of the interventions to manage the resident's behaviours. The RPN acknowledged that the plan of care had not been updated to include these triggers.

Review of the plan of care for responsive behaviours, including the Kardex and the MAR, for the identified resident reported the resident as having a problematic manner in which they act characterized by ineffective coping; Agitation related to: Cognitive impairment , physical aggression toward other residents and staff. There were specific Interventions to address the identified behaviours. The plan of care did not include possible triggers for the responsive behaviours,nor did it identify related interventions.

During the inspection the identified resident was observed on more than one occasion sitting in the hallway outside the dining room with residents passing by on their way to the dining room. No staff were in the the area. On a particular day during the inspection the resident was found in their room with the door open and a specific intervention not in place. Five residents were in the hallway right outside the identified resident's room and one of the resident's was

wandering in their wheelchair. This was brought to the attention of a staff member who put the specified intervention in place.

During an interview with an RPN they reported the identified resident was on PRN pain medications as well as PRN medications for their responsive behaviours. At times the PRN medications were not effective as the resident would refuse the medication.

During an interview with the Resident Care Coordinator (RCC) they said that the identified resident often had increased behaviours related to infections. When RCC reviewed the plan of care for the resident with this inspector it did not include the identification of infections as possible triggers, nor did it include interventions related to these triggers. The RCC acknowledged that the plan of care and MAR did not give direction to staff on when to use the PRN medications. She also acknowledged the Medication Administration Records (MAR) did not identify the effectiveness of PRN medication on two occasions in the last month. The RCC said that there had not been further reassessments done on the identified resident after they were discharged from the BS program in late 2015 as it was deemed that the interventions in place were known by staff and were thought to be effective.

During an interview with the Director of Nursing (DON) she said that the identified resident was discharged from the Behavioral Supports program in late 2015 and as far as she knew there was no documentation related to re-assessments, referrals to external resources or referrals to the home's physician related to responsive behaviours. The DON acknowledged that the Medication Administration Record did not give direction to staff on when to use the PRN medications for responsive behaviours apart from stating "as needed". She reported that staff discuss the responsive behaviours of all residents in the home but that these were not consistently documented. The DON could not locate documentation of ongoing evaluation of the responsive behaviours for the identified resident. She said that it was the expectation in the home that the plan of care would be updated to reflect discussions at the "huddles" or from the BS team. The DON was not aware that the resident had been readmitted to the behavioral supports program as the quarterly summary regarding responsive behaviours was not due to be completed until July 2016.

The licensee failed to ensure that when the identified resident demonstrated on-going 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.

The scope of this issue was a pattern. The severity was a level two, the potential for actual harm. The compliance history was a three, one or more related noncompliance in the last three years. A compliance order was issued for s. 53.(4) (a), (b), (c) on November 24, 2014. This order was complied on August 18, 2015.
(630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 19, 2016

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2015_448155_0020, CO #002;

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 ensure that the home's housekeeping policies and procedures include schedules for the following items; that these schedules/procedures are implemented; and that there is a process in place for monitoring the cleaning schedules to ensure that the home, furnishings and equipment are kept clean and sanitary:
1. Baseboards in all resident rooms, bathrooms and common areas
2. Floor stains in resident washrooms and tub rooms
3. Window screens in resident rooms and common areas
4. Cleaning/dusting of high level areas such as vents in common areas, resident rooms and washrooms; and skylights
5. High touch areas such as railings, door frames to resident rooms and washrooms
6. Washing and replacement of privacy curtains in resident rooms and tub rooms.

Grounds / Motifs :

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

1) During the initial tour of the home, as well as observations of the resident's rooms and common areas throughout this inspection the following was

observed:

a) The window and the screen at the top of the stair way to the second floor was dirty with spider webs, dead insects and dirt stains.
b) The baseboards in seven out of 22 (32 per cent) of the resident bathrooms were noted to have a build-up of black dirt and debris notably around the edges.
c) The screen and windows in the central activity room and two out of 22 rooms (9 per cent) were noted to be dirty with spider webs, dead insects and dust build-up.
d) The fan/skylight in the hallway was noted to have dirt and dust hanging down from the vents and boards.
e) The floor in the north tub room under the beige shelf had a build-up of dust.
g) Privacy curtains were soiled in the central and north tub rooms.
h) The baseboard heater in the bathroom in two out of 22 rooms (9 per cent) were noted to be dirty and stained.
i) The door frame to the shared bathroom in five out of 22 (23 per cent) rooms were noted to have brown stains, debris and/or hand prints.
j)The wall in the bathroom in four out of 22 (18 per cent) were noted to have brown dirt stains.
k) The floor tiles in the shared bathroom of seven out of 22 (32 per cent) were noted to have brown dirt stains.

During an interview with an identified resident they shared a concern that the floor in their bathroom and the baseboards could be cleaner.

During an interview with a Housekeeping Aide they said they had daily job routines and then monthly cleaning schedules to follow. The Housekeeping Aide reviewed the printed copies of "Daily Routine Cleaning" and the monthly cleaning schedule with the inspector and it was acknowledged that they did not provide direction regarding frequency of cleaning walls or baseboards. The Housekeeping Aide also stated that during outbreaks they decreased the amount of time spent on the monthly cleaning schedule from one hour daily to a half hour daily to focus on cleaning high contact surfaces. She reported they have difficulty completing the monthly cleaning items within the assigned hour for some of the rooms.

Review of the home's policy titled "Cleaning Guidelines – Resident Rooms" reviewed April 2016 did not identify cleaning baseboards, door frames or walls of the bathroom or bedroom. This policy identified that "thorough cleaning"

consisted of "clean walls, windows and baseboards".

Review of the home's policy titled "Cleaning Guidelines – Common/General Areas" reviewed April 2016 did not identify cleaning windows or screens in the lounge.

During an interview with the Administrator they stated that during outbreaks they have heightened cleaning. During this time they split the regular monthly cleaning time of one hour in half and spend the extra time on surface cleaning. She acknowledged that they had recently been in an enteric outbreak for over a month. The Administrator spoke about cleaning of the vinyl baseboard. In regards to the vinyl base boards the Administrator said they tried stripping these some time ago but found that whatever they used it looked worse afterward.

During a tour of the home with the Administrator they acknowledged the observations and agreed with the identified concerns with regard to cleanliness of the home.

This has been previously issued as a written notification and voluntary plan of correction on November 24, 2015 during inspection 2014_202165_0029 and a written notification with compliance order on November 6, 2015 during inspection 2015_448155_0020.

The scope of this issue was widespread and severity a level two, minimal harm or potential for harm. The compliance history was a level four, despite Ministry Of Health action (VPC, order) noncompliance continues with original area of noncompliance.
(630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 17, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 4th day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dorothy Ginther

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