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
May 5, 2016	2016_302600_0004	007480-16	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE GUILDWOOD
60 GUILDWOOD PARKWAY SCARBOROUGH ON M1E 1N9

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

GORDANA KRSTEVSKA (600), SUSAN SEMEREDY (501), TILDA HUI (512)

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): March 15, 16, 17, 18, 21, 22, 23, 24, 29, 30, 31, 2016.

The following critical incidents: CSC #001489-15, CSC #030133-15, CSC #030135, #009100-16 and complaints #006179-14, #009342-14, #004398-15, #005750-15, #024974-15, #030218-15, #030233-15, #003193-16, #007006-16 and #008938-16 were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with the administrator, directors of care (DOCs), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), dietary manager, cook, resident program manager, social worker, private care-provider, Family Council president, Residents' Council president, resident assessment instrument-minimum data set (RAI-MDS) coordinators, physiotherapists (PT), clinical coordinator, nursing clerk, residents and substitute decision makers (SDMs).

During the course of the inspection, the inspector(s) conducted a tour of the home, observed meal service, medication administration system, staff and resident interactions and the provision of care, and reviewed health records, complaint and critical incident record logs, staff training records, meeting minutes for Family and Residents' Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident.

Interviews with PSW #135 and RPN #141 indicated the resident #008 displayed an identified behaviour.

Record review of resident #008 revealed the resident was admitted an identified date, with identified diagnosis. Further review of the written plan of care revealed no interventions set up to address the resident's displayed behaviour.

Interview with RPN #141 and the DOC#106 confirmed that strategies were not developed to address the resident's identified responsive behaviour, and the written plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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

Record review of resident #020's progress notes revealed the resident was admitted to the hospital on an identified date. The resident returned to the home on a specified date, with deteriorated physical strength. Review of the resident's current written plan of care indicated the resident required increased assistance for specified activity, staff to provide some physical assistance because the resident was weight bearing. The written plan of care was noted to be last revised on an identified date. Review of the record from physiotherapist's assessment conducted a specified date, indicated the resident required two person assistance with mechanical lift.

Interview with PSW #137 indicated the resident required two staff manually to assist with an identified activity since returning from the hospital. The resident was not able to participate. Interview with RPN #141 stated the resident required one person's extensive assistance for the identified activity. The RPN confirmed that he/she was not aware that the resident was requiring two person to transfer since return from the hospital, and that the current written care plan had not been revised to reflect the resident's current care needs for that activity.

Interview with the administrator confirmed that the resident should have been assessed by all staff involved in the resident's care upon returning from the hospital, staff to

collaborate with each other in the assessment so that their assessments are integrated, consistent with and complement each other. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the resident, resident's SDM and any other persons designated by the resident or SDM have been given an opportunity to participate fully in the development and implementation of the plan of care.

Interview with resident #042's Substitute Decision Maker (SDM) on a specified date, revealed the SDM had not been notified when the resident's health condition changed, for new medication order, or a change in the dosage of a current medication. Further the SDM revealed he/she would become aware of changes in the resident's health condition or alterations to medications when he/she visits the resident on site.

Record review of the resident's medication order record on identified dates revealed the physician had changed or ordered new medications on six occasions for the resident. Review of the doctor orders' section power of attorney (POA) to be notified, did not indicate the staff confirmation that the SDM had been notified about ordering new or changing the existing medication.

Review of resident #042's progress notes indicated that there was change on resident condition on four identified dates. Further review of the progress notes failed to identify the SDM had been notified.

Interview with the RN #100 confirmed they would notify the SDM about the resident's condition and any changes in medication after the SDM came to ask about the resident.

Interview with DOC #106 confirmed that the staff is expected to include the family and SDM in planning of resident's care and to call them every time when the resident's condition or medication changes or new medication is ordered. The DOC also confirmed that he/she had not contacted the SDM to participate in planning of resident's care. [s. 6. (5)]

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

Interview with the resident #017 revealed he/she refused to get out of bed because it was too painful for him/her.

Review of the pain flow monitoring record for two months in 2016 indicated the resident had a pain intensity of seven and eight out of 10. Further record review did not indicate if the resident's pain had been monitored for a third month in 2016.

Review of the MDS assessment report from identified date revealed that resident was bed fast and he/she had significant changes of his/her health condition.
Review of the resident #017's assessment record revealed no assessment was completed when resident's condition had changed.

The RAI coordinator revealed the coding for resident's condition in the MDS record was based on the resident's assessment. The resident's assessment would be completed by the registered staff and then the RAI Coordinator would entered the results in the MDS record. Further the RAI Coordinator confirmed that the staff had not assessed the resident for his/her status when resident had significant change in health condition in the identified month. [S. 6. (10) (b)]

5. The licensee has failed to ensure when the resident was reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care.

Review of a critical incident report revealed an incident of responsive behaviour exhibited by resident #021 towards resident #022. The incident occurred on an identified date, resident #021 pushed resident #022 on the floor unprovoked. Resident #022 fell. He/she was assisted up and was able to stand. He/she was assessed to have sustained no injury on his/her head, however he/she complained of pain in his/her buttock area.

Review of resident #021's progress notes revealed nine responsive behaviour incidents towards other residents and staff after the incident on the previous identified date.

Review of resident #021's written plan of care revealed a revision on an identified date, with the addition of one item to manage the resident's aggressive behaviour which was to monitor the resident hourly.

Interview with PSW #139 indicated the resident #021 displayed ongoing responsive behaviour towards staff especially during morning care. The PSW stated that he/she expected resident #021 to behave aggressively every day when he/she provided care to the resident. The PSW indicated that he/she most often provided care to resident #021

by him/herself as other PSWs were afraid of the resident. The PSW stated that he/she had reported to the charge nurse of the unit several times and nothing has been done to change his/her behaviour. Interview with RN #118 indicated the resident was seen by Behavioural Support Ontario (BSO) team of the home when he/she had worsened responsive behaviour, and that the resident had not been followed up. The RN indicated that there had not been other interventions to manage resident #021's responsive behaviour.

Review of resident #021's progress notes revealed the resident was seen by the BSO team of the home on the identified date.

Interview with the administrator confirmed different approaches have not been considered in the revision of resident's #021's plan of care, when care set out in the plan has not been effective to manage the resident's responsive behaviour. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident
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
to ensure that the resident, the SDM, if any, and the designate of the resident/SDM been given an opportunity to participate fully in the development and implementation of the plan of care
to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be accessed and used by residents at all times.

Review of the home's specific policy reviewed an identified date, revealed that call bells should be easily accessible to the resident at all times.

On an identified date at approximately 1000 hour resident #030 was calling from his/her room and the inspector stopped and asked if he/she needed assistance. Resident #030 stated he/she wanted to get turned around in his/her wheelchair. The inspector noted that the call bell was not within his/her reach and inspector pulled the bell. PSW #115 came and told the resident that he/she cannot have his/her coat on yet because it was too soon. The PSW did not ask the resident what he/she wanted and told him/her that he/she had to wait to get ready for an appointment. Interview with the PSW revealed the home's policy was to ensure that call bells are within the reach of the resident and he/she should have asked the resident what she needed rather than just tell him/her to wait.

Interview with DOC #106 confirmed that resident #030 should have had a call bell within reach. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

Observation made on an identified date, at 1015 hour on an identified wing noted 18 residents sitting around tables in the dining/activity area opposite the nursing station. There was no call bell installed in the area where residents were sitting.

Observation made on the same day at 1025 hour on second identified wing noted 30 residents sitting around tables in the dining/activity area opposite the nursing station. There was no call bell installed in the area where residents were sitting.

Interview with the administrator confirmed that there were no resident to staff communication and response system available in the dining/activity areas of the two wings, and these two areas were accessible by residents. The administrator indicated he did not see that call bells were needed to be installed as there was always some staff at the nursing station. However, the inspector observed on one occasion that there was no staff at the nursing station and residents were sitting in the dining/activity area. [s. 17. (1) (e)]

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 home is equipped with a resident-staff communication and response system that can be accessed and used by residents at all times,
- the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee has failed to ensure that requirements set out in the lighting table were maintained which includes a minimum level of 215.28 lux in resident washrooms.

Observation on March 22, 2016 revealed that light meter readings were as follows:
• In shared washroom of identified room 1: 114 lux at sink and 65 lux at toilet
• In shared washroom of identified room 2: 69 lux at sink and 38 lux at toilet
• In shared washroom of identified room 3: 74 lux at sink and 25 lux at toilet
The readings were taken with the washroom door closed. The lights in the washrooms were two light incandescent lights with matte opal glass.

The long term care home was built prior to 2009 and therefore the section of the lighting table that was applied is titled "in all other homes". A hand held digital light meter was used (Amprobe LM-120, accurate to +/- 5%) to measure the lux in the above mentioned washrooms. The meter was held a standard 30 inches above and parallel to the floor. The lights had been on for over 10 minutes.

Interview with the Environmental Services Manager (ESM) confirmed that if the requirement for lux readings is 215.28 in all other areas of the home, then the above mentioned readings did not meet the requirement. [s. 18.]

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 requirements set out in the lighting table were maintained which includes a minimum level of 215.28 lux in resident washrooms, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that if a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Interviews with resident #013 on two identified dates indicated resident thought he/she was slapped on the face by PSW #105 in his/her room during care on a morning of 2015. The resident stated that the PSW and the "senior nurse" on duty that day came in afterwards to apologize. The PSW stated that he/she was holding an incontinent product in his/her hand at the time and the product accidentally touched the resident's face. The resident stated that he/she mentioned the incident to his/her daughter when he/she was on a leave of absence, and his/her daughter had talked to the home's management about the incident.

Interview with the resident's daughter confirmed that the resident had told her of the incident. The resident's daughter stated that she talked about the resident's complaint at the care conference held on an identified date, at the home when the "senior nurse" and the DOC was present. The resident's daughter stated that the DOC told her that the incident will be looked at. The DOC called the resident's daughter about a week later and left a voice mail message for the daughter to return call. The resident's daughter however

had not returned her call.

Interview with PSW #105 and RN #100 indicated that PSW #105 did report the incident to the RN #100. The PSW re-enacted the incident to inspector in the presence of RN #100. According to the PSW, the incident occurred a long time ago, may be about a year ago. During a morning shift, the PSW was going to change the resident's incontinent products before lunch in the resident's room. The PSW opened an incontinent product and held it in his/her hand while pushing resident in the wheelchair towards the bed where resident could stand up grabbing on to the side rail. While pushing the resident, part of the product in his/her hand accidentally touched the resident's face. Resident was startled and said, "Oh, you hit me!". PSW stated that he/she said to resident, "don't you ever say that. I will never do a thing like that, don't say that please". The resident kept on saying "no, no you hit me." PSW changed the resident's incontinent product in the usual way, and then went to report to RN #100. PSW #105 stated that knowing how the resident was, he/she thought she should report the incident herself to the RN, and requested the RN to speak to the resident to clarify. The RN admitted that he/she did not report the incident to the home's management and the Ministry of Health and Long-Term Care (MOHLTC) as she did not see that as suspected abuse.

Review of the resident's progress notes and the interdisciplinary care conference record of the identified date failed to reveal the resident's complaint of suspected physical abuse was reported to the MOHLTC on the identified date or any dates after the incident was brought to the home's attention.

Interview with RN #100 and the DOC confirmed that during the care conference held on the identified date the resident's daughter mentioned about the resident's concern that he/she was slapped on the face by a staff at the home. The DOC promised to investigate the incident. The DOC confirmed that he/she did not report the resident's complaint to the MOHLTC after the care conference.

Interview with the administrator confirmed that the suspected physical abuse was not reported to the MOHLTC. The administrator forwarded to the inspector copies of a CI report submitted to the MOHLTC on a specific date of the incident, the same day the administrator was made aware of the incident by the inspector. Investigation notes of the incident of the specific date, was also attached. [s. 24. (1)]

2. A critical incident (CI) report was submitted by the home on an identified date, at 1851 hour to the MOHLTC of a suspected abuse of resident #023 by a visitor at the home that

occurred on a specific date, at 1945 hour

Interview with PSW #145 indicated that on a specific date, it was another PSW who witnessed the suspected abuse. The identified PSW went through the washroom of the resident's room which was joined with a room next door, and saw through the mirror in the washroom reflection of a visitor standing beside the resident's bed with his/her hand on his/her upper thigh and his/her clothing lifted. The PSW told what he/she saw to PSW #145 who then went to the room and confronted the visitor. The visitor when questioned said he/she went in to say hello to the resident and then left the building. Record review revealed resident #023 had memory problems and was not able to recall what had happened at time of incident. PSW #145 went on vacation the next day thinking that the identified PSW would report the incident to the charge nurse on duty. PSW #145 returned from vacation and found out the visitor was at the home visiting. PSW #145 reported the incident to the charge nurse on duty who then brought it to the attention of the administrator. An investigation was initiated and the MOHLTC was notified. The identified PSW was disciplined and was on leave at the time of the inspection and was not able to be interviewed.

Interview with the current administrator confirmed that the suspected abuse was not reported to the MOHLTC immediately by the home after its occurrence. [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 if a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

Review of the intake for Critical Incident revealed on an identified date, night shift staff noted resident #041 resisted to move his/her extremity and was expressing discomfort. The next day resident was transferred for further assessment of changes in her extremity. Resident was diagnosed with injury and soon after the intervention he/she passed away.

Record review of resident #041's written plan of care indicated the resident was to be assisted by two staff using a mechanical lift.

Review of the PSW documentation record indicated on an identified date resident #041 was assisted by one staff twice on the evening shift prior to the resident expressing change in the condition of the identified extremity.

Review of the Critical Incident update revealed the PSW #144 confirmed to the clinical coordinator that on the evening of the identified date, he/she had assisted the resident without the use of mechanical lift.

Interview with the DOC confirmed the staff is expected to follow the written plan of care for each resident while providing personal care. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observation made on an identified date contact precaution signs were noted on identified residents' room doors however no protective personal equipment (PPE) were noted stored outside the residents' rooms for staff to use before entering the residents' room to provide care.

Interview with PSW #104 indicated that residents residing in two identified rooms had positive lab result and PPE were not stored outside the residents' room. The PSW indicated that the clinical coordinator was responsible to restock all PPE. Interview with the DOC confirmed that PPE were supposed to be made available for staff's use prior to providing care for residents with contact precautions. [s. 229. (4)]

2. Observation made on an identified date at 1100 hour on an identified wing, noted three bags of soiled linen and two black garbage bags full of garbage sitting on top of a service cart. One soiled linen bag was wet on the outside of the bag and the linen inside was visible.

Interview with PSW #104 indicated that there was no covered garbage bins or linen carts on the identified wing. Staff would store soiled linen bags and used garbage bags on top of service carts in the hallway until all morning care was completed. Then the bags were transported to one of the rooms in the second wing where there was a chute to throw the bags down to the basement.

Interview with the clinical coordinator who was the lead for the infection prevention and control program confirmed that there were covered bins for soiled linen and garbage bags in the soiled utility room on identified wing. The soiled linen bags and garbage bags should have been transported to the soiled linen room and put in covered bins as soon as the bags were full, instead of being stored in the hallway on service carts. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program
- by ensuring PPE is available for contact precaution
- removal and safe disposal of dry and wet garbage and soiled linen, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Review of the identified home's policy reviewed identified date, revealed that staff should respond to calls from the call system in a courteous manner.

On an identified date, at approximately 1000 hours, resident #030 was calling from his/her room and the inspector stopped and asked if he/she needed assistance. Resident #030 stated he/she wanted to get turned around in his/her wheelchair. The inspector noted that the call bell was not within his/her reach and inspector pulled the bell. PSW #115 came and told the resident to wait. The PSW did not ask the resident what he/she wanted and told him/her that he/she had to wait to get ready to go out. Interview with the PSW revealed the home's policy was to ensure that call bells are within the reach of the

resident and he/she should have asked the resident what she needed rather than just tell him/her to wait.

Interview with DOC #001 confirmed that PSW #115 should have asked resident #030 what he/she needed and by not doing so, had not fully recognized the resident's right to be treated with courtesy and respect. [s. 3. (1) 1.]

2. Interview with resident #009 on stage one of the RQI inspection revealed recently he/she talked to the PSW #110 that his/her roommate with impaired health condition needed assistance with toileting. The resident did not feel treated with courtesy and respect by the staff how the staff responded back to him/her. Further the interview revealed the roommate had used the call bell earlier and the PSW came in and told the roommate to wait. The roommate waited and when he/she was not able to wait anymore, he/she asked resident #009 for help. The interview also revealed resident #009 went to the nursing station to remind the PSW to come and assist the roommate with toileting. PSW #110 had told the resident to mind his/her own business and to go back to his/her room. Resident felt he/she was not treated with respect when he/she wanted to help his/her roommate.

Interview with the Administrator confirmed that such attitude by the staff is not acceptable and the home expect the staff to respect the residents' right to be treated with courtesy and respect and to recognize their dignity. [s. 3. (1) 1.]

3. Interview with resident #016 revealed that he/she did not feel the staff respect her privacy, individuality and dignity. Resident resided in basic room where two rooms are connected with joined washroom. There are four residents that share the bathroom and two of them need total assistance of the staff which made staff presence in the washroom more often. Resident #016 further revealed many times when he/she used the washroom for toileting, the staff entered the washroom without knocking, used the sink or did what ever they needed to do, ignoring resident #016 who was using the toilet.

Interview with the DOC #106 confirmed the residents have a right to be treated with dignity and respect and that action by PSW #110 was not appropriate. [s. 3. (1) 1.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed for the use of the bed rails.

Observation made during the inspection period revealed two short bed rails were in the up position when the resident was in bed.

Record review of the resident's current written care plan, Minimum Data Set (MDS) assessments and progress notes did not reveal any indication that the resident has been assessed for the use of the bed rails.

Interviews of PSW #142 and RPN #141 indicated the bed rails were used whenever resident was turned and repositioned in bed. RPN #141 confirmed that the resident has not been assessed for the use of the bed rails. Interview with the administrator confirmed that the resident should have been assessed for the use of the bed rails. [s. 15. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response was made to the person who made the complaint indicating what the licensee has done to resolve the complaint.

Interview with resident #031's SDM revealed that in a identified date, stagnant water from an overhead air conditioner leaked onto tables in the dining room and had once dropped onto resident #31's food. The SDM indicated that it took three times for him/her to complain before anything was done. Resident #031 was moved to another table but other residents were still at risk of having this water drop onto their food.

Review of the home's complaint investigation form an identified date revealed that resident #031 was moved to another table and a report was made in the maintenance book regarding the leaking air conditioner. There was a note that the air conditioner was

serviced on a specified date, however there is no indication what interventions were made to ensure the water did not drop onto resident food between the time of the complaint and the servicing of the unit. There is a blank area on the form where the date of a written response and to whom a response was forwarded to was to have been recorded.

Interview with registered staff #111 revealed he/she initiated the complaint form and did not recall ever speaking with the complainant again regarding the issue. Interview with the complainant confirmed that he/she never received a response to his/her complaint. Interview with the current Administrator confirmed there is no evidence that the home responded to the complainant regarding this concern. [s. 101. (1) 3.]

2. The licensee has failed to ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Interviews on two identified date with resident #013 revealed an alleged incident whereby he/she was slapped on the face by PSW #105 in his/her room during care on a morning of an identified date in 2015. The resident stated that the PSW and the "senior nurse" on duty that day came in afterwards to apologize. The PSW stated that he/she was holding an incontinent product in his/her hand at the time and the product accidentally touched the resident's face. The resident stated that he/she mentioned the incident to his/her SDM when he/she was on a leave of absence, and his/her SDM had talked to the home's management about the incident. Interview with the resident's SDM confirmed that the resident had told him/her of the incident. The resident's SDM stated that he/she talked about the resident's complaint at the care conference held on an identified date at the home when the "senior nurse" and DOC #106 were present. The resident's SDM stated the DOC #106 told her that the incident will be looked at. The DOC called the resident's SDM about a week later and left a voice mail message for the SDM to return the call. The resident's SDM however had not returned the call.

Review of the home's complaint logs for 2015 and 2016 failed to reveal the resident's complaint of suspected incident that was brought to the home's attention in 2015 and at the resident's care conference in 2016.

Interview with the administrator confirmed that the resident's complaint of suspected incident was not recorded in the home's complaint logs for 2015 and 2016. [s. 101. (2)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs stored in an area or a medication cart, complies with manufacturer's instructions for the storage of the drugs.

Observation on an identified date, revealed an open bottle of eye drops ordered on an identified date, and a bottle of another eye drops ordered on another identified date. The direction of the pharmacy located on the side of both eye drops bottles was to discard the drops 28 days after the bottles are open.
Interview with the RPN #126 indicated the bottles were open on the date shown on the bottles as they were ordered and received on the same date. Further more the RPN confirmed that both eye drops had expired dates and he/she confirmed will discard these and order new medication. [s. 129. (1) (a)]

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

Issued on this 13th day of June, 2016

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

Original report signed by the inspector.