Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 23, 2015	2015_267528_0019	H-003106-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE BRAMPTON ON L6T 4B9

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

PEEL MANOR
525 MAIN STREET NORTH BRAMPTON ON L6X 1N9

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

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

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 20, 21, 24, 25, 26, 27, 28, 31, and September 1, 2, 3, 4, 9, 2015

This inspection was done concurrently with Complaint Inspection Log# H-002021-15, Critical Incident Inspection Log#'s H-001853-15, H-001889-15, H-002059-15, H-002714-15, H-002717-15, H-002929-15 and Follow-up Log#'s H-002361-15, H-002362-15, H-002800-15, H-002801-15, H-002802-15, H-002803-15, H-002804-15, H-002805-15

During the course of the inspection, the inspector(s) spoke with the Administrator-Acting, Supervisors of Care (SOC), Supervisor of Dietary, Supervisor of Facility Service, Team Lead Food Service, Resident Assessment Indicator (RAI) Coordinator, Social Worker, Nursing Clerk, Physiotherapist (PT), Registered Dietitian (RD), Nursing Clerk, Document Support Nurse, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), maintenance, housekeeping staff, laundry staff, dietary aides, residents and families

The inspectors also toured the home, observed the provision of care and services, reviewed documents, including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
20 WN(s)
11 VPC(s)
1 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. 134.	CO #004	2014_247508_0020	528
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_247508_0020	528
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #006	2014_247508_0020	528
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #005	2014_247508_0020	528
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #002	2014_247508_0020	528
O.Reg 79/10 s. 52. (2)	CO #002	2014_247508_0021	528
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2014_247508_0021	528

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

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

Specifically failed to comply with the following:

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

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

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

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

Findings/Faits saillants :

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

A. The Minimum Data Set (MDS) assessment from May 2015, for resident #23 indicated their vision was impaired and was able to see large print, but not regular and did not wear eye glasses. Review of the Resident Assessment Protocol (RAP) indicated that the resident was responding to the interventions as outlined in the care plan and the RAP would be care planned with the goal of maintaining current level of functioning and minimize risks. Review of the written plan of care did not indicate impaired vision as a focus, goal or intervention and the Document Support Nurse confirmed that the written plan of care did not set out, the planned care for the resident. [s. 6. (1) (a)]

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

Review of Minimum Data Set (MDS) assessment for resident #25 indicated their vision was impaired and were able to see large print, but not regular print and did not wear eye glasses. Review of the RAP indicated it would be care planned with the goal of maintaining current level of functioning and minimize risks. Review of the written plan of care did not indicate impaired vision as a focus, goal or intervention and the Document Support Nurse confirmed that the written plan of care did not set out the planned care for the resident [s. 6. (1) (a)]

3. The licensee failed to ensure that there was a written plan of care for each resident that set out clear direction to staff and others who provided direct care to the resident.

A. Review of the plan of care for resident #60 identified that they were a high risk for falls. Interventions on the resident's Kardex, under Falls Prevention, indicated that the resident was to be in a public area after meals as per Power of Attorney (POA) request, and that staff were to porter resident as soon as they were finished eating in the dining room to toilet and assist them to bed to prevent risk of falling. PSW stated that the resident does not go back to bed after breakfast as they would climb out of bed and only went to bed after lunch. Registered staff confirmed that the written plan of care including the Kardex did not provide clear direction to front line staff related to when the resident was assisted back to bed.

B. Review of the written plan of care for resident #62 indicated that they wore two different sizes of briefs, stating they wore one when going out of the home and a different size when in the home. Interview with PSWs identified that they wore a larger size brief when going out of the home; however, there was no clear direction on the Kardex or on the logo as to what brief was to be used at specific times. Review of the logo at bedside identified the resident wore large/extra large briefs on all three shifts. Review of the Resident Profile Worksheet which identified the type of continence products the residents used revealed that on all three shifts they wore stretch large/extra large but received and extra large brief on day shifts three times a week. Interview with Nursing Clerk who was responsible for continence products in the home confirmed that the logo at bedside for continence products did not indicate the resident wore a different brief when going out of the home and the written plan of care and Kardex did not give clear direction to front line staff as to what size brief the resident wore when in and out of the home.

C. Review of the written plan of care for resident #62 identified that the resident required two staff for total assistance with transferring using a mechanical lift and that the resident was transferred using two different sling types. PSWs stated the resident was transferred for all transfers by the sling of the resident's choice not according to manufacturers instructions. The registered staff confirmed there was no clear direction to the front line staff as to what sling was to be used when being transferred. [s. 6. (1) (c)]

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

A. During the course of the inspection, resident #22 reported that they preferred to sleep with their dentures in and have their teeth cleaned after meals. Interview with regular day staff PSWs and a night staff PSW confirmed that the resident always slept with their dentures in. Review of the plan of care directed staff to ensure that their dentures were in their mouth and cleaned after meals and remove and soak dentures every night. Registered staff confirmed that the resident's plan of care was not based on their needs and preferences.

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

A. On August 27, 2015, resident #22 was observed in bed with two half rails railed. The MDS assessment from May 2015, coded the resident as using "other side rails" daily. However, in July 2015, MDS Assessment coded the resident did not use bed rails. Interview with PSWs and Registered staff confirmed the resident used two half rails when in bed daily and the MDS Assessments from May and July 2015, were inconsistent with and did not complement each other.

B. MDS Assessment from late June 2015, for resident #26 identified that the resident had a respiratory infection. Review of the progress notes and the Shift Report for Infections during the month of June 2015, did not indicate the resident had any symptoms of respiratory infection. The Document Support Nurse confirmed that the resident did not have a respiratory infection in June 2015, and that the MDS Assessment from June 2015 was not consistent with documented assessments of registered staff for the same month.

C. The MDS assessment for resident #27 from May 2015, identified the resident had a respiratory infection. Review of the progress notes for the month of May 2015, did not indicate that the resident had any symptoms of respiratory infections. The RAI Co-ordinator confirmed the resident did not have a respiratory infection in May 2015 and the MDS Assessment and registered staff assessment from May 2015, were not consistent nor complemented each other. [s. 6. (4) (a)]

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

A. Resident #47's plan of care identified that they were at high nutritional risk related to swallowing difficulty and inability to physically support their neck, and required thickened fluids. On August 20, 2015, during lunch meal service, the resident was observed receiving assistance from a PSW with their food and fluid intake. The PSW was interviewed about the resident's care needs at meals, and reported they were to receive thickened fluids. The fluid provided to the resident appeared to be a different consistency than required, which the PSW also identified. Registered staff confirmed the resident was not provided with the appropriate thickened fluids as specified in their plan of care.

B. Resident #10's plan of care stated they were at high nutritional risk, but not limited to inadequate energy intake and unplanned weight loss. The plan indicated they were to receive a nutritional supplement, at two out of three snack passes to optimize energy intake. Review of task documentation indicated they did not receive their supplement on three out of four occasions, which was also reported by the resident. A PSW and dietary staff who worked during identified period reported the supplement was not provided as it was not available. The Food Service Manager reported that the product was available; however, confirmed that the supplement was not provided, and the care set out in the plan of care was not provided to the resident as specified in their plan.

C. On August 26, 2015, during breakfast in the large dining room on second floor, resident #44 informed the Long-Term Care Homes (LTCH) Inspector that they did not receive prune juice for breakfast. The plan of care was reviewed and indicated they were to receive prune juice at breakfast to promote bowel regularity. PSWs and the dietary aide present stated the resident was to receive prune juice; however, the juice was not available in the home. The Food Service Manager was interviewed and confirmed the home was out of stock of prune juice that day, and the resident did not receive prune juice as per their plan of care.

D. In early 2015, resident #26 had symptom of a respiratory infection. Review of the plan of care identified that the Physician ordered a chest x-ray. Interview with registered staff stated that a chest x-ray was ordered and the requisition was faxed; however, the resident did not receive a chest x-ray. The SOC confirmed that the resident did not receive a chest x-ray and care set out in the plan of care was not provided to the resident as specified in the plan.

E. On August 27, 2015, resident #60 was observed in bed with one quarter bed rail raised. Review of the written plan of care indicated that the resident was to have two quarter bed rails raised when in bed to assist in bed mobility, turning and positioning. Interview with the PSW reported they were unaware the resident was to have both bed rails raised when in bed. Registered staff confirmed that the resident was to have both bed rails raised when in bed and that care was not provided as specified in the plan. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the rights of residents were fully respected and promoted, including having his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On August 20, 2015, between 1030 to 1130 hours, resident #40, 41, 42 and 43's admission records, which contained personal health information (PHI), were observed sitting on an empty wheelchair against the wall in the Blue Jay Lounge. Other residents were present in the lounge at the time of observation. Registered staff reported that the records contained PHI and were not stored in a confidential manner. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the rights of residents are fully respected and promoted, including having his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #3: 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 put in place, was complied with.

A. The home's policy "Call bell, LTC 09-06.10", last revised June 2013, identified a process in place to ensure that staff act promptly when the call bell sounds. Appendix III - Peel Manor Call Pager Procedure, directed staff, at the beginning of all shifts to pick up pager that corresponds with their team assignment and sign with registered staff that they received the pager. When going on break, each staff member must hand over the pager to their team member covering their assignment to ensure prompt response to any calls.

i. From approximately 1500 to 1530 hours, two pagers were noted to be in the nursing station on Blue Jay Way. Registered staff on the home area confirmed the home was

missing two evening personal support workers, and as a result, the pagers remained unattended in the nursing station. Interview with the SOC confirmed that either PSW or registered staff on the floor should have been assigned to cover the extra call bell until evening staff arrived so that residents received prompt assistance.

ii. At approximately 1505 hours, while evening staff were receiving report, two day PSWs placed their pagers in at basket at the central nursing desk, separate from where evening staff were receiving report, and left the floor. Evening staff remained in report until approximately 1535, leaving the pager on the desk. Interview with PSW staff confirmed that they did not know where the pagers were and were therefore unattended while they were received report. Interview with SOC and the Adminsitrator-Acting confirmed that staff were to carry the pagers at all times, including change of shift, to ensure that the residents received prompt assistance when necessary.

B. The home's Medical Directive Hypoglycemia Protocol, effective May 2015 defined mild to moderate hypoglycemia as a blood sugar between 2.8 and 4 millimol per litre (mmol/L). If residents were conscious and able to swallow, the protocol directed staff to ensure resident ingested 15 grams of carbohydrates (three dextrose tablets or three tablespoons of table sugar and retest blood sugar in 15 minutes. If the resident's blood sugar read les than 4.0 mmol/L the directive advised staff to keep retreating.

i. On an unidentified day in June 2015, resident #60 had a low blood sugar reading . Review of the plan of care identified that the resident's subcutaneous insulin was held and the resident ate 75 to 100 percent (%) of their breakfast, but a blood sugar was not retested until prior lunch time.

ii. The plan of care for resident #90 identified that resident received long acting subcutaneous insulin throughout the day as well as daily corticosteroid, blood sugar checks were done four times a day with an as needed fast acting subcutaneous insulin sliding scale.
a. On an unidentified day in June 2015, resident #90 had a low blood sugar reading . Review of the plan of care identified that resident had blood sugar checks four times a day, received long acting subcutaneous insulin throughout the day as well as daily corticosteroid. The resident was documented as eating dinner on that day and blood sugar was not retested until the next scheduled time, at 2100 hours.
b. On an unidentified day in June 2015, the resident had a low blood sugar reading . The residents dinner meal was documented as taken and blood sugar was not retested until the next scheduled time.

Discussion held with SOC related to above findings. It was confirmed that in each of the three examples, the resident's were eating well and the next scheduled blood sugar reading were within normal limits; however, a follow up retest in blood sugar did not occur according nor was their any documentation to include why the protocol was not followed in these instances. [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 put in place, is complied with, to be implemented voluntarily.

WN #4: 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 licensee has failed to ensure that resident #84 was protected from sexual abuse by resident #83.

A. In February 2015, resident #84 reported to staff that resident #83 came into their room made inappropriate sexual comments and gestures. In the days following the incident, resident #84 also revealed that resident #83 touched them inappropriately.
i. Review of resident #84's plan of care and investigation notes included documentation that they reported inconsistent allegations to the social worker, registered staff, and other residents; however, each report included one or more of the following, resident #83 touched themself, made sexual inappropriate comments, and touched resident #84's inappropriately. Resident #84 referred to the incident as harassment and investigation notes revealed they were upset.
ii. The plan of care for resident #83 identified that in the months prior to the incident the resident displayed responsive behaviours towards staff and co-residents. A Behavioural Support Ontario (BSO) note from the beginning of 2015, indicated that a number of staff revealed that the resident was making inappropriate sexual comments and attempting to touch them inappropriately. Interventions included, but were not limited to, redirect the resident when near or in other resident's room as needed and not to position other residents in close to resident #83 and or redirect mobile residents from them to provide some distance so they can not reach or redirect completely.
iii. Interview with resident #84 about the incident, approximately six months later and they were able to recall resident #83 entering their room. When asked the resident what happened they stated the resident touched them inappropriately.

Resident #84 was not protected from non-consensual touching behaviour or remarks of a sexual nature, as defined in Ontario Regulations 79/10. [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 ensure that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #5: 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 has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy "Prevention, Reporting and Elimination of Abuse/Neglect, LTC1-05-01", last revised March 2014, stated "the person(s) first having knowledge of an allegation of abuse/neglect or who witnessed abuse/neglect shall immediately notify the MOHLTC by calling the Long Term Care Action Line..."

A. In early 2015, resident #84 reported to registered staff that resident #83 sexually harassed them. The following day, the SW documented resident #84's reports that resident #83 was sexually inappropriate, including remarks gestures and touching. At that time an email was sent to the SOCs, DOC, and Administrator. The incident was not reported until two days after the email was written. Interview with the SOCs confirmed that staff did not immediately report the allegations as outlined in the home's policy. [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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #6: 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:
19. Safety risks. 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 plan of care was based on, at a minimum, interdisciplinary assessment with respect to the resident's safety risk.

The plan of care for resident #61 indicated that the resident was transferred with two staff using a mechanical lift. Review of the progress notes revealed that in 2014, a representative from Arjo- Huntley came in to the home to make recommendations for toileting and transferring the resident. Interview with the resident and POA during the course of the inspection and both stated they did not like the transfer approved by the Arjo Representative and the resident was more comfortable when the sling was used not according to manufacturers instruction. Resident's transfer was observed using the sling not according to manufacturers instructions with two staff, and was transferred safely and without incident. Review of the plan of care did not include an assessment of the resident being transferred with the sling different that recommended by the manufacturer. The SOC stated that they were unaware that the PSWs were assisting the resident not according to manufacturers instructions. Interview with the PT confirmed there was no transfer assessment completed to determine whether the transfer currently being used was safe.

2. The licensee failed to ensure that a plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's sleep patterns and preferences.

During the course of the inspection, resident #13 reported it was always their preference to go to sleep was between 1900 and 1930 hours. Review of clinical records indicated the resident's preference was to go to bed between 2000 and 2100 hours. Interview with a regular evening PSW reported the resident's preference was to go to sleep between 1900 and 1930 hours. Registered staff confirmed the resident preferred to go to bed earlier and the plan of care was not based on an assessment of the resident's sleep preferences. [s. 26. (3) 21.]

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 is based on, at a minimum, interdisciplinary assessment:
i. with respect to the resident’s safety risk
ii. of the resident's sleep patterns and preferences, to be implemented voluntarily.

WN #7: 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 the resident.

A. In early 2015, the transfer status for resident #80 was changed from sit to stand lift to a full mechanical lift. Registered staff documented in the progress notes that the resident's status had changed and the care plan was updated. Review of Point of Care (POC) documentation, revealed that PSW staff continued to transfer the resident was using a sit to stand lift 21 times. In April 2015, staff noticed the resident signs of injury and was required further testing, with a confirmed diagnosis of injury four days later. Interview held with three PSW staff and one registered staff, each staff were asked what the transfer status of the resident was prior to the new injury, and all four staff members stated that the resident was using a sit to stand lift. Staff did not ensure that they used safe transferring techniques when they continued to use a sit to stand lift 21 times after the resident's transfer status changed. [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 the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

The plan of care for resident #62 indicated they wore two different sizes of briefs, one when going out of the home and one when in the home. In August 2015, the residents continence care product was changed to a larger brief to prevent leakage. The Continence Care and Bowel Management Program stated that residents would be assessed for continence care products using the Continence Care Product Evaluation Form to ensure the product was based on the residents individual needs and properly fit the resident. Review of the plan of care did not include an assessment of the continence care products specifically the Continence Care Product Evaluation Form when the resident's continence product changed. Interview with the SOC confirmed the resident was not assessed using the form as outlined in their Continence Care and Bowel

Management Program when resident #62 continence care products were changed. [s. 51. (2) (b)]

2. The licensee failed to ensure that residents who required continence care products have sufficient changes to remain clean, dry and comfortable.

On the evening of August 27, 2015, continence care provided to resident #22 was monitored.

i. Rhe resident was transferred to bed by two PSWs. Approximately 20 minutes later, the resident was interviewed, at which time, reported the PSWs checked their brief and stated it did not need to be changed; however, the resident stated they had been incontinent prior to supper and itchy because of it. During the interview, a strong incontinent odour was noted.
ii. An hour and a half hours later, the resident reported a PSW provided them with an evening nourishment and their brief had not yet been changed. A strong odour of incontinence remained.
iii. Almost three hours later, a PSW was observed entering the resident's room and to provide continence care. Both PSWs were interviewed and reported the resident was wet when they first transferred her back to bed hours and one confirmed the resident was not changed until almost three hours later. Registered staff reported the home's expectation was that residents be changed right away if found incontinent.

The licensee failed to ensure that resident #22, who required continence care products, received sufficient changed to be clean, dry and comfortable for approximately three hours. [s. 51. (2) (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following:
i. that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented
ii. that residents who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

On August 20, 2015 at 1115 hours on Woodhill Way, domestic storage room #1913 was found unlocked. Plastic was wedged in the latch, disabling it to close properly. Cleaning chemicals, including but not limited to stainless steel cleaner, cream cleanser, spray buff, and floor neutralizer were present. Registered staff reported the door was to be locked as the room was storage for chemicals and cleaning supplies; however confirmed the door could not close properly as the latch was disabled by plastic. The Facility Services Supervisor confirmed the door was to be locked as was storage of hazardous substances. [s. 91.]

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 hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #10: 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:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
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 failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows:

a. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
b. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
c. 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.

A. In June 2015, family of resident #86 expressed concerns with the safety of the resident's room. Review of the clinical health record included a documentation from the SOC in June 2015, indicating an email was sent to the FSS related to the concerns. An interview was held with a maintenance worker and the FSS in September 2015, at which time, they both denied being aware of any concerns or investigations completed related the families concerns. The home did not investigate the safety concerns brought forward by the family of resident #86, nor did they follow up with the complainant. [s. 101. (1)]

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

The plan of care for resident #62 identified that the resident was incontinent of both bladder and bowels and required the use of a continent product day and night. Review of the progress notes from October 2014 to July 2015, revealed that the family of the resident communicated to the home, on three separate occasions, concerns about the types of continent products staff were using. Review of the home's complaints and

concern log did not include any documentation of the families ongoing concerns related to resident #62's continent products, type of action taken, resolution if any, or dates in which a response was provided to the complainant. Interview with direct care staff confirmed that the home was aware of the families concerns and, as a result, changes were made to the plan of care. Interview with the SOC confirmed the concerns made by resident #62's family were not included in the home's complaint log. [s. 101. (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 the following:

A. 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:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances
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

B. The licensee shall 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., to be implemented voluntarily.

WN #11: 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 failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

A. On August 20, 2015, at 1140 hours, a medication cart was observed unlocked in the Blue Jay home area on Anderson Avenue, with residents present in the hallway. The Long Term Care Homes (LTCH) inspector was able to open the cart containing resident medications, with no staff present. A registered staff confirmed the cart was unlocked and unattended, and the expectation was for it to be locked at all times when unattended.

B. On August 21, 2015, at 0855 hours, a medication cart was observed unlocked outside the Woodhill Way Dining room, with the top drawer partially open. The LTCH inspector was able to open the top cart containing resident medications, with no staff present. Registered staff, confirmed the cart was unlocked when unattended, and the expectation was for it to be locked at all times when unattended. [s. 129. (1) (a) (ii)]

Additional Required Actions:

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

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. On an unidentified day in August 2015, PSWs provided care to resident #22, at which time the resident was incontinent of bowel, as reported by one of the PSWs who provided care. Review of PSW flow sheets noted the resident did not have a bowel movement during the shift. Registered staff confirmed that documentation did not indicate the resident had a bowel movement and the expectation was that such outcome would be documented.

B. Resident #17 and their family reported they had concerns regarding the resident's skin integrity and continence care product which were discussed with the Supervisor of Care (SOC) in August 2015. Clinical records were reviewed which identified a progress note written by the SOC in August 2015, indicating they would reassess the resident's toileting routine, skin products being used, and incontinent product being used with possible change to another more suitable product. The SOC reported in an interview that they completed the investigation to assess the resident and followed up with the family the same month; however, actions taken with respect to assessing the resident under the continence and skin and wound program were not documented. [s. 30. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident’s plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident’s plan of care.

On August 24 and 27, 2015 resident #22 was observed sitting in a tilted wheelchair. Interview with direct care staff revealed that the resident used the tilt chair for comfort and positioning; however, review of the plan of care did not indicate that any assessment was completed for the use of the chair. Interview with registered staff confirmed that the seat belt was used positioning and comfort, and was not included in the plan of care in a manner satisfying all requirements under subsection (4). [s. 33. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions that reduced or relieved pain, promoted healing, and prevented infection, as required.

In early 2015, resident #19 was admitted to the home with an area of altered skin integrity. The previous treatment orders were discontinued on admission and not reordered until five days after the Skin and Wound Care Consultant assessed the resident and suggested treatment, approximately three weeks after admission. Interview with registered staff confirmed that wound care was discontinued on admission and not reordered until approximately three weeks later. The resident was not provided immediate treatment to promote healing for an area of skin breakdown that was present on admission. [s. 50. (2) (b) (ii)]

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

A. In early 2015, resident #19 was admitted to the home with two areas of skin breakdown. On admission, registered staff documented one of the two wounds as healed. Review of the plan of care did not include weekly assessments of altered skin integrity for three out of four weeks in 2015. Interview with registered staff confirmed that wound has since healed, but weekly assessment were not consistently completed after admission in 2015.

B. The plan of care for resident #63 identified that the resident was at high risk for altered skin integrity with two recurrent areas of skin breakdown. In late 2014, areas of skin breakdown were identified and the electronic treatment records (eTARs) included treatment for the altered areas of skin integrity. For three months after the area was identified weekly wound assessments were not completed for five out of nine weeks. Interview with the Supervisor of Care confirmed that resident #63's altered skin integrity was not consistently reassessed weekly by registered staff, as required by the home's Skin and Wound Care Program. [s. 50. (2) (b) (iv)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours strategies were developed and implemented to respond to the behaviours, where possible.

A. In January 2015, two PSW's provided bedtime care to resident #85 while the resident was verbally and physically aggressive with them. The plan of care for resident #85 identified that the resident had verbal and physical aggression reponsive behaviours towards staff and often refused care. Interventions included assistance of one to two staff for activities of daily living when the resident is agreeable and instructed staff to leave the resident when the yelling starts. Review of the investigation notes identified that the PSWs continued to provide care despite the resident yelling and hitting them. Interview with the Supervisor of Care confirmed that behaviour strategies for resident #85 were not implemented when the two PSWs continued to provide bedtime care to they resident when they were resistive. [s. 53. (4) (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all foods were served at a temperature that was palatable to the residents.

A. During stage 1 of the RQI, multiple residents reported that hot foods were not always served hot enough.

B. On August 25, 2015, baked salmon was on the planned menu and served in the Pleasant View dining room. During meal service, a resident reported the salmon was not hot enough. The salmon was observed in the steam table uncovered and was probed at a temperature of 46.5 degrees Celcius. Review of the home's Food Temperature and Leftovers Audit form stated that hot foods were to be served between 60-85 degrees Celcius. The dietary aide serving reported they recorded temperatures upon arrival to the servery; however, the expectation was that hot foods were to stay within the acceptable range for the course of the meal. Interview with a cook confirmed the temperature was to remain above 60 degrees Celcius when served and the food was not served at a temperature that was palatable for residents. [s. 73. (1) 6.]

WN #17: 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 shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in any other areas provided for in the regulations.

As defined in Ontario Regulation 79/10 in section 221 (2), staff must receive annual training in all the areas required under subsection 76 (7) of the Act. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs.

Review of the home's education records included orientation for approximately 22 registered agency staff. The education records identified that in January and May 2015, agency staff received "General Orientation"; however, did not include any additional training. Interview with the Program Support Nurse confirmed that one the home's registered staff received additional training and agency registered staff did not receive the additional training on the new medical directive or managing residents with Diabetes Mellitus, as specified on the Compliance Plan. The Program Support Nurse stated that it would be up to the registered staff on the floor to review any changes with the agency registered staff before start of their shift. [s. 76. (7) 6.]

WN #18: 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,
(b) cleaning and disinfection of the following in accordance with manufacturer’s specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented for the cleaning and of resident care equipment, including shower chairs.

On August 20 and September 3, 2015 in the Woodhill Way spa room, and on September 3, 2015 in the Blue Jay 1 spa room, significant amounts of hair were observed in the wheels of beige shower chairs. PSWs from each home area reported they were responsible for cleaning the chairs after each use between residents, and confirmed the presence of the hair in the wheels as being unclean. The SOC confirmed PSWs were responsible for cleaning the chairs. [s. 87. (2) (b)]

2. The licensee failed to ensure that procedures were implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids in accordance with manufacturer’s specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if none, in accordance with prevailing practices.

A. On August 24, 27, 28 and 31 2015, a resident was observed in their wheelchair with dirt and debris on the arms and around both brakes, which was confirmed by the SOC on August 31, 2015. PSW stated that wheelchairs were cleaned on nights according to the schedule in a binder kept at the nursing desk. Review of the Wheelchair Cleaning Schedule on Woodhill Way indicated that resident #23 had her wheelchair cleaned every Friday night. Review of Point of Care indicated that the resident refused to have their wheelchair cleaned on Friday August 28, 2015. Interview with SOC stated that the wheelchair was not cleaned on the scheduled day but should have been cleaned on the next night shift and confirmed this was not done and the wheelchair was still dirty.

B. On August 21, 27, and 28, 2015, in resident #17’s shared washroom, the underside of the commode chair and back of the toilet bowel was observed with brown flecks on it. Interview with housekeeping staff stated that all toilets and commodes on all surfaces were to be cleaned daily in all resident’s rooms. Interview with the Facility Service Supervisor (FSS) confirmed that the under surface of the commode chair was still dirty and not cleaned properly. [s. 87. (2) (b)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of laundry services that procedures were developed and implemented to ensure that, there was a process to report and locate residents' lost clothing and personal items.

The home's policy, "Lost and Found Clothing, Policy No: LTC-05.03", Effective Date, January 7, 2011 indicated that the lost item form, Missing Property Investiagation, (NF-90) was to be completed by nursing staff and forwarded to the laundry department to check the lost and found items. If the article reported lost was not found the registered staff were to be informed so that the resident and family could be notified.
i. Resident #24 and #17 were interviewed and stated they had reported missing items and clothing to PSWs, registered staff and management. Interview with registered staff and PSWs identified that there was no formal process for tracking lost items and indicated that staff would look for the missing items on the unit and then verbally tell laundry staff when something was missing. Registered staff stated they would document the missing items in the progress notes and notify families and residents or family members would often go to the laundry room to look for the items.
ii. A review of the progress notes for resident #24 indicated that the registered staff had documented missing clothing and personal items reported by the resident; however, there was no documentation of the missing clothing items for resident #17 in the progress notes. The registered staff stated they were not aware of any formal process for the documentation of missing items or the results of their search.
iii. Residents interviewed during the course of the inspection confirmed lost clothing and personal items were still missing.
iv. The SOC confirmed that the home had a process for reporting and locating lost clothing and personal items but the Missing Property Investigation Form had not been implemented in the home but was being rolled out to all units in the home in the next couple of weeks. [s. 89. (1) (a) (iv)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

A. The home's policy "Routine Practices - Hand Hygiene, LTC8-03-01", last revised May 2015, directed staff to follow the four moments of hand hygiene, based on Provincial Infectious Diseases Advisory Committee (PIDAC) best practice document, Best Practices for Hand Hygiene in All Health Care Settings, 4th Edition, April 2014. The policy provided examples of when staff should perform hand hygiene, including but not limited to, between each resident contact.

On August 31, 2015, before lunch service, the RPN administered medications to four residents outside of the dining room. The RPN was observed opening medication packets, handling medications, touching the medication cart and electronic medication administration record (eMAR) screen, and then made contact with each resident to administer the medications. At no time during the observation did the RPN complete hand hygiene. Interview with registered staff confirmed hand hygiene was to be completed between each resident contact.

B. The home's policy “Infection Prevention and Control, Policy No: LTC-07.02”, effective date September 1, 2011, stated that when the program nurse was notified of a possible outbreak of respiratory illness, the following actions would be taken to determine the presenting symptoms and initiate a line listing for symptomatic residents.

i. The plan of care for resident #26 identified that in early 2015, resident #26 had

respiratory symptoms and infection. Review of the Monthly Surveillance Form for the months of infection indicated that the resident was on the line list for one month only and the documentation was not completed for all the days they exhibited symptoms. The SOC confirmed that the line list was not completed, as required in the home's policy.

ii. Resident #27's plan of care was reviewed and indicated they had a respiratory infection in early 2015. As part of the home's Infection Prevention and Control Program, staff were to complete the Monthly Surveillance Form (MSF) for all residents exhibiting respiratory symptoms. Review of the (MSF) revealed that the documentation was not completed for all the days that the resident exhibited symptoms and this was confirmed by the SOC. [s. 229. (4)]

2. The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices and the symptoms were recorded.

Resident #26 exhibited respiratory symptoms in early 2015 for a week and a half and was on isolation precautions. Review of the plan of care identified that resident was not monitored and their symptoms were not documented every shift. Specifically, respiratory symptoms were not documented in the progress notes on four shifts during the time the resident displayed symptoms. Interview with the SOC stated that registered staff were to monitor and document their symptoms on every shift in the progress notes when the resident was exhibiting signs and symptoms of infection and confirmed that staff did not monitor and document resident #26 respiratory symptoms on every shift. [s. 229. (5)]

Issued on this 23rd day of September, 2015

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

Original report signed by the inspector.

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2015_267528_0019
Log No. / Registre no:	H-003106-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 23, 2015
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF PEEL 10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9
LTC Home / Foyer de SLD :	PEEL MANOR 525 MAIN STREET NORTH, BRAMPTON, ON, L6X-1N9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rani Calay

To THE REGIONAL MUNICIPALITY OF PEEL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_247508_0020, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all residents receive the care set out in their plan of care, specifically:

a. that all residents, including but not limited to, resident #47, #10, #44; receive meals snacks and supplements, as outlined in their plans of care
b. that physicians orders, including diagnostic imaging, are completed as ordered.

Grounds / Motifs :

1. Previously issued as a CO in January 2015
(581)

2. Resident #47's plan of care identified that they were at high nutritional risk related to swallowing difficulty and inability to physically support their neck, and required thickened fluids. On August 20, 2015, during lunch meal service, the resident was observed receiving assistance from a PSW with their food and fluid intake. The PSW was interviewed about the resident's care needs at meals, and reported they were to receive thickened fluids. The fluid provided to the resident appeared to be a different consistency than required, which the PSW also identified. Registered staff confirmed the resident was not provided with the appropriate thickened fluids as specified in their plan of care.

3. Resident #10's plan of care stated they were at high nutritional risk, but not limited to inadequate energy intake and unplanned weight loss. The plan indicated they were to receive a nutritional supplement, at two out of three snack

passes to optimize energy intake. Review of task documentation indicated they did not receive their supplement on three out of four occasions, which was also reported by the resident. A PSW and dietary staff who worked during identified period reported the supplement was not provided as it was not available. The Food Service Manager reported that the product was available; however, confirmed that the supplement was not provided, and the care set out in the plan of care was not provided to the resident as specified in their plan.

4. On August 26, 2015, during breakfast in the large dining room on second floor, resident #44 informed the Long-Term Care Homes (LTCH) Inspector that they did not receive prune juice for breakfast. The plan of care was reviewed and indicated they were to receive prune juice at breakfast to promote bowel regularity. PSWs and the dietary aide present stated the resident was to receive prune juice; however, the juice was not available in the home. The Food Service Manager was interviewed and confirmed the home was out of stock of prune juice that day, and the resident did not receive prune juice as per their plan of care.

5. In early 2015, resident #26 had symptom of a respiratory infection. Review of the plan of care identified that the Physician ordered a chest x-ray. Interview with registered staff stated that a chest x-ray was ordered and the requisition was faxed; however, the resident did not receive a chest x-ray. The SOC confirmed that the resident did not receive a chest x-ray and care set out in the plan of care was not provided to the resident as specified in the plan.

6. On August 27, 2015, resident #60 was observed in bed with one quarter bed rail raised. Review of the written plan of care indicated that the resident was to have two quarter bed rails raised when in bed to assist in bed mobility, turning and positioning. Interview with the PSW reported they were unaware the resident was to have both bed rails raised when in bed. Registered staff confirmed that the resident was to have both bed rails raised when in bed and that care was not provided as specified in the plan. (581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 23rd day of September, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Cynthia DiTomasso

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