Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 9, 2015	2015_182128_0001	L-001712-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA
369 Frederick Street KITCHENER ON N2H 2P1

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

PeopleCare A.R Goudie Kitchener
369 FREDERICK STREET KITCHENER ON N2H 2P1

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

RUTH HILDEBRAND (128), DONNA TIERNEY (569), JULIE LAMPMAN (522)

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): January 12-16, 19-23, 27-28, 2015

Inspectors #609 and #610 were at this inspection on orientation.
Three Critical Incidents #006800-14, #004089-14 and # 000881-15 were inspected during this RQI.

During the course of the inspection, the inspector(s) spoke with the Corporate Chief Operating Officer, Corporate Director Accommodation, Corporate Director Nursing Services, Corporate Director Policy and Legislation, Director of Resident Care/Hilltop, Executive Director, Director of Nursing Care(DONC), Director of Resident Quality Outcomes/RAI Coordinator, 8 Registered Nurses, 5 Registered Practical Nurses, 19 Personal Support Workers(PSW), Registered Dietitian(RD), Director Food Services, 1 Cook, 2 Dietary Aides, 3 Housekeeping Aides, Maintenance Person, Director Program Services, Interim Director Program Services, Social Services/Family Council Assistant, 1 Recreation Aide, 1 Physiotherapy Aide, 3 Family Members and 40+ Residents.

The Inspectors conducted a tour of all resident home, dining and common areas, and a medication storage area. The Inspectors observed resident care, resident-staff interactions, dining service, and a partial medication pass. Relevant clinical records, home policies, procedures and meeting minutes were reviewed. Posting of required information was confirmed.

The following Inspection Protocols were used during this inspection:

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

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

- **18 WN(s)**
- **12 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status, as evidenced by:

A clinical record review for Resident # 33, who is at high nutrition risk, revealed the resident was assessed by the Registered Dietitian and interventions were implemented related to unplanned weight loss. At that time the resident was 5 % below the desired goal weight range.

The Resident continued to lose weight the following month. The Registered Dietitian (RD) noted the progressive weight loss and indicated that the current plan of care should be continued and a snack would be added if the weight loss persisted.

There was no documented evidence in the clinical record to support that there was further follow-up and evaluation of outcomes.

The Resident's weight had decreased to the point where it equated to a significant weight change of 10.8% in the 6 months.

The Registered Dietitian and the Director of Food Services both confirmed the significant weight change and acknowledged that the resident should have been reassessed with additional interventions implemented. They also indicated that a referral to the RD should have been made related to the unplanned weight change. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. A clinical record review, for Resident # 32, revealed that the resident had a 13.4 % weight loss in 3 months.
The resident had been below the identified goal weight during the 3 months. The resident was assessed by the Registered Dietitian and an intervention was added.

The resident was reassessed by the Registered Dietitian the following two months with no new interventions implemented despite ongoing weight loss.

The Registered Dietitian and the Director of Food Services both confirmed the weight loss and acknowledged that no new actions were taken nor were outcomes related to the significant weight change evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

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: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the dining and snack service included monitoring of all residents during meals, as evidenced by:

The first floor secure unit dining room was observed unattended for 8 minutes. There were 18 cognitively impaired residents in the dining room and 16 of them had food &/or beverages in front of them.

After 8 minutes, a Cook entered the dining room and acknowledged the potential risk and confirmed the presence of the 18 residents. He/she indicated that a Personal Support Worker should have been present in the dining room to monitor the residents and indicated that dietary staff are not expected to supervise the dining room. A Dietary Aide arrived and agreed that dietary staff are not responsible for monitoring the residents.

Two minutes later (10 minutes with no monitoring by nursing staff), a Personal Support Worker entered the dining room. She acknowledged that there should have been a PSW in the dining room.

A Registered Nurse entered the dining room twelve minutes later and acknowledged the potential risk to residents while the dining room was unattended. [s. 73. (1) 4.]

2. Continuous observation outside of Resident #20's room revealed a breakfast tray was delivered to the resident and then the staff left the room. Resident #20 was in his/her room alone eating breakfast unmonitored for 34 minutes, except for a housekeeper who was cleaning in the room next door for part of the time.

Record review for Resident #20 revealed the care plan indicated the resident was at risk of choking or aspiration.

Review of the home policy "Dining Supervised - Tray Service", #01802.03, dated May 21, 2009 revealed:
"The PSW will:#3. Bring the covered tray to the resident's room and supervise their meal. All residents will be monitored during meal service".

Interview with the Director of Nursing Care confirmed that it was the home's expectation that any resident receiving room tray service should be monitored by a PSW. [s. 73. (1) 4.]

3. Resident #35 was observed for 30 minutes eating from a tray containing breakfast food and fluids. The cognitively impaired resident was not monitored by staff nor provided any assistance &/or encouragement for 30 minutes.

A Registered Nurse confirmed that the resident was unattended and indicated that residents are not to be left unattended with food, in their rooms, related to the risk of choking.

The Corporate Director Nursing Services acknowledged that the home's policy was that Personal Support Workers are responsible for monitoring residents while they are eating.

The Executive Director indicated that the expectation was that the residents should have been monitored while eating. [s. 73. (1) 4.]

4. The licensee has failed to ensure that the food service workers and other staff assisting residents were aware of the residents' preferences, as evidenced by:

During a meal observation it was noted that the Diet Type Report did not identify any preferences for residents.

A Cook and the Director of Food Services acknowledged that preferences were not identified on the list.

The Executive Director confirmed that the expectation was that there was a process in place to ensure food service workers and other staff assisting residents were aware of the residents' preferences. [s. 73. (1) 5.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions; the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, as evidenced by:

A. Review of Resident # 2's clinical record revealed the resident has chronic pain. The resident experienced an increase in pain and received a doctor's order for an increase in analgesic for pain control. Further record review revealed an absence of a documented pain assessment related to the resident's change in condition, noting the last

documented pain assessment was completed two months earlier.
This was confirmed by a Registered Nurse.

Review of Resident #2's last Quarterly MDS Assessment, revealed the resident had mild pain less than daily and the resident would be referred to the physician for an increase in analgesic. Review of the 3 previous MDS Assessments revealed the resident had no pain. Further record review revealed an absence of a documented pain assessment related to the resident's change in condition and the absence of a physician's referral for an increase in analgesic as stated in the resident's MDS Assessment. This was confirmed by the Director of Resident Quality Outcomes.

B. Review of Resident #8's clinical records revealed the resident was started on an analgesic twice daily for 4 weeks. Almost a year later the resident began receiving an analgesic four times per day.
Further record review revealed the absence of a documented pain assessment for Resident #8. The resident last received a formal pain assessment seventeen months prior to the last increase in analgesic. This was confirmed by the Director Policy and Legislation. [s. 52. (2)]

2. Review of the home's Pain Assessment Program Policy reference number 005300.00 dated June 3, 2011 revealed:
"Each resident must have a formal pain assessment on admission and be reassessed on readmission, quarterly and at significant condition changes."

Review of the home's Annual Pain Management Program Evaluation dated July 2014 revealed "documentation is not being completed consistently"(in relation to pain).

Interview with the Corporate Director Policy and Legislation and the Corporate Director Nursing Services confirmed the expectation that when both residents' pain was not relieved by initial interventions; the residents should have been assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that for a resident taking any drug or combination of drugs, that there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, as evidenced by:

Review of Resident #2's clinical record revealed the resident was receiving two analgesics three times daily for chronic pain.

Review of Resident #8's clinical record revealed the resident was receiving an analgesic four times daily for pain.

Further record reviews for Resident #2 and Resident #8 revealed the absence of documentation related to the monitoring of the residents' response and the effectiveness of the medications. This was confirmed by a Registered Nurse and Corporate Director Policy and Legislation.

Interview with the Corporate Director Policy and Legislation and the Corporate Director Nursing Services confirmed the expectation that there was monitoring and documentation of the resident's response and the effectiveness of the drugs for residents taking any drug or combination of drugs. [s. 134. (a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 has failed to ensure every resident has the right to 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 as evidenced by:

A) Observation of the second floor east hallway revealed the Point of Care (POC) terminal to be unlocked and unattended with resident personal health information visible. This was confirmed by the Personal Support Worker.

B) Observation of the POC terminal on the third floor east hallway revealed it was unlocked and unattended with resident personal health information visible. This was confirmed by the Registered Nurse.

C) Observation of the second floor hallway revealed the POC terminal to be unlocked and unattended with resident personal health information visible. This was confirmed by the Registered Practical Nurse.

D) Observation of the POC terminal on the third floor west hallway revealed it was open and unattended with resident personal health information visible. This was confirmed by the Personal Support Worker.

E) Observation of the POC terminal on the first floor west hallway revealed it was unlocked and unattended with resident personal health information visible. This was confirmed by the Registered Nurse.

Interview with the Director of Nursing Care confirmed the expectation that the Point of Care terminals are locked at all times when not in use to ensure residents personal health information is kept confidential. [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 the right to have his or her personal health information kept confidential, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

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

The door to the first floor chute room was observed open and unattended by Inspector #609, on January 16, 2015. The door to the garbage chute was accessible and it was noted that it was open to the basement, which is a full building story drop.

The Maintenance Person confirmed that he was aware that the lock on the door was broken and that it had not shut properly for at least a week. He indicated that he had contacted a contractor to look at it.

The Executive Director was notified. He confirmed the potential risk to residents and indicated that the expectation was that the door was to be kept locked.

On January 19, 2015 the door to the chute room was observed open and unattended again. The Interim Director of Programs confirmed the observation.

The Executive Director again acknowledged that the door should have been locked.

The Executive Director advised Inspector #128, on January 20, 2014 that a contractor had repaired the lock mechanism in the door. [s. 5.]

2. The third Floor Activity/Physio room was found unlocked and unattended, by Inspector #610. The room contained a Hydrocollator, used to heat hot packs, which was too hot to touch, as well as a container of hot wax. Additionally, an electrical wire box, with no cover on it, containing exposed wires was observed.

A Personal Support Worker confirmed that the door was to be locked and asked a Registered Nursing staff member to lock the door.

The Executive Director acknowledged the potential risk to residents and confirmed that the door should have been locked when the room was unattended. [s. 5.]

3. Inspector # 610 noted that elevator #1 had damaged flooring near the door of the elevator. The flooring was ripped and jagged and posed a potential tripping hazard. The Maintenance Person confirmed that he was aware of the issue and had contacted a company to have this issue fixed. He stated that gluing it down did not work.

The Executive Director acknowledged the potential tripping hazard and temporarily repaired the floor by taping it down. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #7: 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. (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 has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to a resident, as evidenced by:

A clinical record review for Resident #34 revealed that the resident was at high risk for falls. The resident was unable to ambulate using identified interventions after a fall. A clinical record review revealed, in the mobility and falls foci, that the identified interventions were still in the plan of care for the identified resident.

Two Personal Support Workers confirmed that the resident had not been able to use the identified interventions since the last fall.

A Registered Nursing staff member confirmed that the plan of care still did not reflect the correct interventions.

The Corporate Director Nursing Services confirmed that the plan of care did not provide clear direction to staff and indicated that it would be updated to reflect that the resident's current needs. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan, as evidenced by:

Resident # 38 was observed eating regular texture meal in a dining room. The diet type list indicated that the resident was to receive a minced texture diet.

Inspector #128 identified the potential risk to the Director Food Services and she changed the texture to minced.

A review of the plan of care for Resident #38 revealed that the resident was at potential choking risk and required a minced texture diet.

The Director of Food Services acknowledged that the resident was given the incorrect diet and the care set out in the plan of care was not provided to the resident. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of a Critical Incident Report revealed an incident of alleged abuse occurred but was not reported to the Ministry until 7 days later.

Review of the home's investigative notes related to the alleged abuse of Resident #2 by a staff member revealed a Personal Support Worker reported the alleged abuse of Resident #2 to the Director of Nursing Care 3 days before it was reported to the Ministry.

Review of the home's Abuse or Suspected Abuse/Neglect of a Resident policy #005010.00, dated October 23, 2012 revealed "The Executive Director or designate will notify the Director immediately by completing a Mandatory Critical Incident Report."

Interview with the Executive Director confirmed that the critical incident was submitted to the Ministry three days after the alleged abuse was reported to the Director of Nursing Care.

The Executive Director confirmed the expectation that the suspected abuse of a resident should be immediately reported to the Ministry. [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 the policy related to reporting abuse is complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident; and to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, as evidenced by:

Observation of Resident #3's bed system revealed a raised side rail. Interview with a Personal Support Worker revealed the resident uses the side rail while in bed for bed mobility.

Resident #5 was observed sleeping in bed with a raised side rail. Interview with a Personal Support Worker and a Registered Practical Nurse revealed the resident uses a side rail while in bed for bed mobility.

Observation by Inspector #569 of Resident #9's bed system revealed a raised side rail.

Review of the Resident #5, #3 and 9's plan of care revealed the absence of a documented assessment of the residents for the use of side rails.

Interview with the Director of Nursing Care and Corporate Director Policy and Legislation confirmed the absence of a documented assessment of the residents.

Interview with the Executive Director and the Corporate Director Policy and Legislation

revealed the home was unaware that the assessment of the resident and evaluation of the resident's bed system needed to be documented.

Interview with the Director of Nursing Care revealed that the home completed a bed entrapment assessment of all beds on September 26, 2012.

Review of the Medical Mart bed entrapment survey results revealed that Resident #3 and #9's bed system failed zone 2 and Resident #5's bed system was not assessed. Further review revealed 67 out of 80 (84%) of beds failed the bed entrapment assessment. This was confirmed by the Corporate Director Policy and Legislation (DPL).

Interview with the DPL revealed that measures were taken such as replacing beds or mattresses based on suggested solutions from Medical Mart but a bed entrapment assessment was not conducted after these measures were implemented to ensure the bed systems were safe.

Review of the home's Mattress Replacement Schedule revealed on April 25, 2013 Resident #5 received a new mattress. There was no documentation to support that Resident #3 and #9 received a new mattress. As per the Medical Mart bed entrapment survey 67 out of 80 (84%) of residents required a new mattress. However, the Mattress Replacement Schedule indicated 10 out of 67 (15%) received a new mattress. There was no documentation to support the remainder of residents received a new mattress.

Interview with Corporate Director Policy and Legislation (DPL) revealed that although it was not documented, Resident #3 had received a new mattress. The DPL confirmed that the home did not complete follow up bed entrapment assessments when the residents received new mattresses.

Interview with the Executive Director, Corporate Director Policy and Legislation and Corporate Director Nursing Services revealed the home was unaware that bed entrapment assessments were to be completed after the home implemented corrective action.

On January 22, 2015 the home completed a bed rail risk assessment for Residents #3, #5 and #9. On January 23, 2015 Medical Mart completed a bed entrapment assessment for each of the above residents. Medical Mart was scheduled to complete bed entrapment assessments for all bed systems in the home on January 29, 2015. [s. 15. (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 where bed rails are used, the resident is assessed and his or her bed system is evaluated and steps are taken to prevent resident entrapment, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The following housekeeping concerns were identified throughout the course of this inspection, in 40 resident rooms, on all 3 floors of the home:

-10% had black soot-like matter around the room air vents.
-28% had indentations and gouges in the floors with dirt embedded within the divots.
-63% of the rooms had white paint chips embedded in the floors of the residents' rooms.
-23% of the rooms observed had debris accumulated in the corners of the room.
-25% of rooms observed had stained or dusty lampshades.
-25% of the rooms observed had black markings and stains to the resident room's flooring.

A member of the Housekeeping staff confirmed the presence of divots with embedded dirt, soot around the air vent, paint flecks on the floors, accumulation of dust on the base boards and lampshades and indicated the room was not clean.

The Corporate Director of Accommodation acknowledged that the cleanliness of the floors has been a challenge but indicated that the home plans to rebuild and there is not adequate monies to replace the flooring. (#609) [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home furnishings and equipment were maintained in a safe condition and in good state of repair as evidenced by:

Observation of 21 resident rooms by Inspector #610 throughout the course of the inspection identified the following:

-57% of the resident's wardrobes, dressers, and floor mouldings in the resident's rooms were scratched and gouged.
-47% of the bathroom bi-fold doors in resident bathrooms had a ripped seam at the bottom of the door.
-19% of the resident's rooms had a hole in the wall.

Observation of resident common areas on all 3 floors identified the following:

-100% of the shower rooms inspected had rust on the radiators
-100% of dining room radiators were chipped and scratched with black scuff marks. Dining room doors were scraped along the lower portion of the door.Dining rooms on the second and third floors had paint flecks, black scuff marks and divots on the floor.
- On all three floors hand rails, wooden mouldings in hallways and hallway wall shelves between rooms were scratched.
-Eye wash station doors were scratched with black marks along the bottom of the door on all three home areas. Oxygen room doors on the second and third floor home areas were scratched with black marks along the bottom of the doors.
-Resident common bathrooms on first and second floor had unrepaired holes in the walls. Bathrooms on all three floors had peeling paint.

These observations were confirmed by the Maintenance Person.

Interview with the Executive Director and Maintenance Person confirmed that resident

rooms were only repaired after resident's were discharged and there currently was no plan in place for common area repairs.

It was noted that during the inspection deep cleaning and maintenance repairs were initiated including resident rooms and handrails. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are kept clean and sanitary and maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #11: 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 residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home, as evidenced by:

Review of a Critical Incident Report submitted to the Ministry revealed an incident of alleged abuse occurred.

Review of the home's investigative notes related to the alleged abuse of Resident #2, by a staff member, revealed a Personal Support Worker (PSW) reported the alleged abuse of Resident #2 to the Director of Nursing Care (DNOC) four days after it occurred.

Further review of the home's investigative notes revealed the Personal Support Worker in question had previous disciplinary measures on file but the PSW continued to work for 2 days after the alleged abuse was reported.
This was confirmed by the Executive Director.

Review of the home's Abuse or Suspected Abuse/Neglect of a Resident policy #005010.00, dated October 23, 2012 revealed "The RN in Charge will assess the situation – remove suspected individual from resident access."

Interview with the Executive Director confirmed the expectation that the PSW should have been removed from work immediately when the Director of Nursing Care was made aware of the suspected abuse. [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 and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius, as evidenced by:

The temperatures of two rooms were taken on January 14, 2015 and noted to be below the minimum temperature of 22 degrees. One room was 20.1 degrees Celsius and the other room was 19.1 degrees.

The Director of Resident Quality Outcomes verified that the temperatures in the rooms were below 22 degrees. She stated that she would place extra blankets on the beds immediately.

The Executive Director acknowledged the expectation that the home was to be maintained at 22 degrees and called the Maintenance Person to come back into the home.

On January 15, 2015, the Executive Director provided Inspector #128 with a log of temperatures taken by the home throughout the night. The log documented that one room was 22 degrees or higher throughout the night. However, the other room was recorded to be 21 degrees at 2200 and 0200.

The Executive Director indicated that the Maintenance Person had made some adjustments and the temperatures should be above 22 degrees.

Subsequent temperatures taken by Inspectors were noted to be 22 degrees or higher. [s. 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 home is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of a Critical Incident Report submitted to the Ministry revealed an incident of alleged abuse occurred.

Review of the home's investigative notes related to the alleged abuse of Resident #2 by a staff member revealed a Personal Support Worker reported the alleged abuse of Resident #2 to the Director of Nursing Care 4 days after the alleged incident.

Further review of the investigative notes revealed that an investigation into the alleged abuse was not initiated until 3 days after it was reported.

Interview with the Executive Director confirmed that the abuse was reported to the Director of Nursing Care and an investigation into the abuse was not initiated until three days later.

The Executive Director confirmed the expectation was that the alleged incident of abuse should have been immediately investigated. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected of witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

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

Staff interview and chart review revealed Resident #17 had altered skin integrity.

Clinical record review revealed the absence of documented weekly skin assessments for 4 periods of time where there were 14 days between assessments.

Review of the home's "Skin and Wound Care Management Program" policy, Reference number: 006020.00, dated October 1,2014, revealed "Registered staff will: Assess each resident with skin breakdown weekly or more frequently, if needed and complete documentation in PCC (Point Click Care)."

Interview with the Director of Resident Quality Outcomes revealed that weekly skin assessments should be documented by the Registered staff in the progress note section of the electronic chart system.

Interview with the on-site Director of Resident Care from Hilltop confirmed there was no documented evidence of skin assessments being completed for Resident #17 during the time periods outlined above and that it was the home's expectation that skin assessments were to be done weekly. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #15: 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 has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times, as evidenced by:

Hazardous chemicals, including RTU disinfectant, were observed in the unlocked cupboards, in the open and unattended "nursery room" in the first floor secure unit.

The Director of Resident Quality Outcomes and the Executive Director both confirmed the potential risk and indicated the expectation related to hazardous substances was to ensure that they were kept inaccessible to residents. [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 kept inaccessible to residents at all times, to be implemented voluntarily.

WN #16: 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, as evidenced by:

Observation of an identified room revealed a urinary collection hat was stored on the bathroom counter beside the resident’s denture cup and toothbrush.(522)

Observation of 40 resident rooms conducted throughout the inspection revealed that 20% of the rooms had unlabelled personal care items including tooth and denture brushes, toothpaste, hair brushes and combs, razors, deodorants, and bedpans.

Personal Support Workers and a Housekeeping staff member confirmed that the personal care items that were not labelled in resident rooms and that it was the home’s expectation that all personal items were to be labelled within 48 hours of acquiring these items. (522)(609)

Interview with a Registered Practical Nurse and the Director of Nursing Care confirmed the expectation that all personal care items in shared resident bathrooms should be labelled and also confirmed that urinary collection hats should not be stored in the resident's bathroom with personal care items. (522)

Observation of Resident #22's room revealed precaution signage posted on the door directing staff and visitors to wear Personal Protective Equipment when in direct contact with the resident.

Further observation revealed a PSW providing treatment requiring contact with Resident #22 without wearing any Personal Protective Equipment(PPE).

Interview with the Director of Resident Quality Outcomes confirmed that it was the expectation of the home that staff would follow the required precautions when in direct contact with the resident. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the infection prevention and control program as related to labelling of personal care items, proper storage of personal care items, hand hygiene/hand washing and following precautions where Personal Protective Equipment is required, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response was provided in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, as evidenced by:

A review of the minutes of the Residents' Council meetings revealed that concerns were expressed by residents at the following meetings:

October 20, 2014 - Residents requested that their floors be better cleaned beneath their beds as they are finding a collection of dust.

November 10, 2014 - Residents again expressed concerns related to housekeeping and the cleanliness of their rooms in regard to more thorough dusting. They also expressed concerns related to curtains being required in the lounges because of the heat generated and the glare caused from the brightness of the sun. Additionally, they expressed concerns related to "proper" chairs in the lounges for them to do their exercises in as Residents were sitting on the couches to do their exercises and they felt that they would be able to complete the exercises more effectively if there were suitable chairs, with arms for them to use.

December 8, 2014 - Residents expressed the same concerns related to their wish to have curtains in the lounges related to the intensity of the heat generated from the sun as well as the glare on the television.

There was no documented evidence to support that written responses were provided to the Residents' Council within 10 days of receiving the concerns.

The Director of Programs and the Executive Director confirmed that written responses had not been provided to Residents' Council. [s. 57. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital, as evidenced by:

A review of a Critical Incident revealed that Resident #33 was taken to hospital after falling and returned to the home with a significant change in health condition.
The Critical Incident was not reported to the Director until 3 days after the incident.

The Director Policy and Legislation confirmed that the Critical Incident was not submitted within one day and recognized that since it had been established that the resident had a significant change in condition that it should have been. [s. 107. (3)]

Issued on this 9th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RUTH HILDEBRAND (128), DONNA TIERNEY (569), JULIE LAMPMAN (522)
Inspection No. / No de l'inspection :	2015_182128_0001
Log No. / Registre no:	L-001712-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 9, 2015
Licensee / Titulaire de permis :	THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA 369 Frederick Street, KITCHENER, ON, N2H-2P1
LTC Home / Foyer de SLD :	PeopleCare A.R Goudie Kitchener 369 FREDERICK STREET, KITCHENER, ON, N2H-2P1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dale Shantz

To THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 69 to ensure that weight changes are assessed using an interdisciplinary approach and that actions are taken and outcomes are evaluated related to weight changes.

The plan must include confirmation that the Resident #32 and Resident #33 were reassessed and interventions put in place to address their ongoing weight loss.

The plan must include who will be responsible for managing the weight monitoring system on an ongoing basis to ensure unplanned weight changes are identified, actions are taken, interventions are monitored and outcomes evaluated.

The plan must also identify how and when education related to using an interdisciplinary approach to managing weight changes will be provided to all applicable staff.

Please submit the plan, in writing, to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London, ON N6A 5R2, by email at ruth.hildebrand@ontario.ca, by February 25, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status, as evidenced by:

A clinical record review for Resident # 33, who is at high nutrition risk, revealed the resident was assessed by the Registered Dietitian and interventions were implemented related to unplanned weight loss. At that time the resident was 5 % below the desired goal weight range.

The Resident continued to lose weight the following month. The Registered

Dietitian (RD) noted the progressive weight loss and indicated that the current plan of care should be continued and a snack would be added if the weight loss persisted.

There was no documented evidence in the clinical record to support that there was further follow-up and evaluation of outcomes.

The Resident's weight had decreased to the point where it equated to a significant weight change of 10.8% in the 6 months.

The Registered Dietitian and the Director of Food Services both confirmed the significant weight change and acknowledged that the resident should have been reassessed with additional interventions implemented. They also indicated that a referral to the RD should have been made related to the unplanned weight change.
(128)

2. A clinical record review, for Resident # 32, revealed that the resident had a 13.4 % weight loss in 3 months.
The resident had been below the identified goal weight range during the 3 months. The resident was assessed by the Registered Dietitian and an intervention was added.

The resident was reassessed by the Registered Dietitian the following two months with no new interventions implemented.

The Registered Dietitian and the Director of Food Services both confirmed the weight loss and acknowledged that no new actions were taken nor were outcomes related to the significant weight change evaluated.

(128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 73(1) 4. to ensure that the dining and snack service includes monitoring of all residents during meals.

The plan must include who will be responsible for ongoing monitoring to ensure that a sustainable system is put in place to monitor meal service to safeguard residents.

The plan must also identify how and when education will be provided to all staff, including registered nursing staff, as well as who will be responsible for providing the education.

Please submit the plan, in writing, to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London, ON N6A 5R2, by email at ruth.hildebrand@ontario.ca, by February 25, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that the dining and snack service included monitoring of all residents during meals, as evidenced by:

The first floor secure unit dining room was observed unattended for 8 minutes. There were 18 cognitively impaired residents in the dining room and 16 of them had food &/or beverages in front of them.

After 8 minutes, a Cook entered the dining room and acknowledged the potential risk and confirmed the presence of the 18 residents. He/she indicated that a Personal Support Worker should have been present in the dining room to monitor the residents and indicated that dietary staff are not expected to supervise the dining room. A Dietary Aide arrived and agreed that dietary staff are not responsible for monitoring the residents.

Two minutes later (10 minutes with no monitoring by nursing staff), a Personal Support Worker entered the dining room. She acknowledged that there should have been a PSW in the dining room.

A Registered Nurse entered the dining room twelve minutes later and acknowledged the potential risk to residents while the dining room was unattended. (128)

2. Continuous observation outside of Resident #20's room revealed a breakfast tray was delivered to the resident and then the staff left the room. Resident #20 was in his/her room alone eating breakfast unmonitored for 34 minutes, except for a housekeeper who was cleaning in the room next door for part of the time.

Record review for Resident #20 revealed the care plan indicated the resident was at risk of choking or aspiration.

Review of the home's "Dining Supervised - Tray Service" policy, #01802.03, dated May 21, 2009 revealed:
"The PSW will bring the covered tray to the resident's room and supervise their meal. All residents will be monitored during meal service".

Interview with the Director of Nursing Care confirmed that it was the home's expectation that any resident receiving room tray service should be monitored by a PSW. (569)

3. Resident #35 was observed for 30 minutes eating from a tray containing breakfast food and fluids. The cognitively impaired resident was not monitored by staff nor provided any assistance &/or encouragement for 30 minutes.

A Registered Nurse confirmed that the resident was unattended and indicated that residents are not to be left unattended with food, in their rooms, related to the risk of choking.

The Corporate Director Nursing Services acknowledged that the home's policy was that Personal Support Workers are responsible for monitoring residents while they are eating.

The Executive Director indicated that the expectation was that the residents should have been monitored while eating.
(128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 52(2) to ensure that residents with pain are assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The plan must include confirmation that Resident #2 and Resident #8 received pain reassessments.

The plan must also identify how and when education will be provided to Registered Nursing staff related to the pain management program to include assessment of pain when it is not relieved by initial interventions.

Additionally, the plan must identify whether the home will revise the pain management program to include clinically appropriate assessment and reassessment instruments.

Please submit the plan, in writing, to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London, ON N6A 5R2, by email at ruth.hildebrand@ontario.ca, by February 25, 2015

Grounds / Motifs :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions; the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, as

evidenced by:

A. Review of Resident # 2's clinical record revealed the resident has chronic pain. The resident experienced an increase in pain and received a doctor's order for an increase in analgesic for pain control. Further record review revealed an absence of a documented pain assessment related to the resident's change in condition, noting the last documented pain assessment was completed two months earlier. This was confirmed by a Registered Nurse.

Review of Resident #2's Quarterly MDS Assessment revealed the resident had mild pain less than daily and the resident would be referred to the physician for an increase in pain medication. Review of the 3 previous MDS Assessments revealed the resident had no pain. Further record review revealed an absence of a documented pain assessment related to the resident's change in condition and the absence of a physician's referral for an increase in pain medication as stated in the resident's MDS Assessment. This was confirmed by the Director of Resident Quality Outcomes.

B. Review of Resident #8's clinical records revealed the resident was started on an analgesic twice daily for 4 weeks. Almost a year later, the resident began receiving an analgesic four times per day.
Further record review revealed the absence of a documented pain assessment for Resident #8. The resident last received a formal pain assessment seventeen months prior to the last increase in analgesic. This was confirmed by the Director Policy and Legislation.

(522)

2. Review of the home's Pain Assessment Program Policy reference number 005300.00 dated June 3, 2011 revealed:
"Each resident must have a formal pain assessment on admission and be reassessed on readmission, quarterly and at significant condition changes."
Review of the home's Annual Pain Management Program Evaluation dated July 2014 revealed "documentation is not being completed consistently"(in relation to pain).

Interview with the Corporate Director Policy and Legislation and the Corporate Director Nursing Services confirmed the expectation that when both residents' pain was not relieved by initial interventions; the residents should have been

assessed using a clinically appropriate assessment instrument specifically designed for this purpose.
(522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s.134 to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

The plan must confirm that Resident #2 and Resident #8's medications are being monitored and responses & effectiveness are documented.

The plan must include who will be responsible for ensuring that the effectiveness of drug regimes for all residents are monitored, including documentation of this by Registered Nursing staff, on an ongoing basis.

The plan must also demonstrate how education will be provided to Registered Staff related to monitoring and documenting the effectiveness of medications and who will be responsible for providing the education.

Please submit the plan, in writing, to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London, ON N6A 5R2, by email at ruth.hildebrand@ontario.ca, by February 25, 2015

Grounds / Motifs :

1. The licensee has failed to ensure that for the resident taking any drug or combination of drugs, that there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Review of Resident #2's clinical record revealed the resident was receiving two analgesics three times daily for chronic pain.

Review of Resident #8's clinical record revealed the resident was receiving an analgesic four times daily for pain.

Further record review for Resident #2 and Resident #8 revealed the absence of documentation related to the monitoring of the Residents' response and the effectiveness of the medications. This was confirmed by the Registered Nurse and Director of Policy and Legislation.

Interview with the Director of Policy and Legislation and the Director of Nursing Services confirmed the expectation that for the resident taking any drug or combination of drugs, that there is monitoring and documentation of the resident's response and the effectiveness of the drugs.
(522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 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 9th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RUTH HILDEBRAND

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