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
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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 28, 2014	2014_188168_0017	H000886-14	Resident Quality Inspection

Licensee/Titulaire de permis

WATERDOWN LONG TERM CARE CENTRE INC.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

ALEXANDER PLACE
329 Parkside Drive, P. O. Box 50, Waterdown, ON, L0R-2H0

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

LISA VINK (168), CAROL POLCZ (156), CYNTHIA DITOMASSO (528), SUSAN PORTEOUS (560)

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): July 14, 15, 16, 17, 18, 21, 22, and 23, 2014.

This Inspection Report contains findings of non compliance identified during Critical Incident Inspections H-000438-14 and H-000787-14, and Complaint Inspection H-000040-14, which were conducted concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Directors of Care, Staffing Coordinator, Environmental Services Manager (ESM), Food Service Manager (FSM), Activation Coordinator, Restorative Care Coordinator, Registered Dietitian (RD), Staff Educator, registered staff, Personal Support Workers (PSW), front line staff, families and residents.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to: policies and procedures, meeting minutes, and clinical health records.

The following Inspection Protocols were used during this inspection:

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

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

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

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

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

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

Findings/Faits saillants :

1. The written plan of care for each resident did not include the planned care for the resident.

Resident #18 had a Heat Risk Assessment completed in June 2014, which indicated high heat risk. The plan of care did not include a plan to manage the identified risk, as confirmed during record review and interview with registered staff. [s. 6. (1) (a)]

2. The written plan of care for each resident did not provide clear directions to staff and others who provided direct care to the resident.

A. The current plan of care for resident #26 indicated that staff were to ensure dentures were in place before each meal. On July 21, 2014, PSW staff reported that the resident did not wear dentures. On July 22, 2014, the resident reported they had their own teeth and did not wear dentures. The plan of care did not provide clear direction to staff and others who provide direct care to the resident in relation to the wearing of dentures. (156)

B. The plan of care for resident #17, identified to "put 2 siderails up when resident resting/sleeping". Resident and staff interview confirmed the use of only one rail in the raised position when in bed. Documentation in Point of Care (POC) indicated the use of one rail. The plan of care did not give clear direction to staff providing care regarding the use of the bed rails. [s. 6. (1) (c)]

3. Staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. Resident #10 had an area of altered skin integrity identified on May 21, 2014, which although was healing, continued to require treatment as of July 21, 2014. A review of the clinical record noted assessments completed by dietary and nursing staff which indicated the skin was intact on May 26, 2014, June 1, 2014, June 2, 2014, June 11, 2014, and July 3, 2014. The staff did not collaborate with each other in the assessment of the resident to ensure the assessments were consistent with each other. (168)

B. Resident #29 had an Assessment of Continence completed on February 19, 2014. This assessment indicated full continence of bowel and bladder functioning. The Minimum Data Set (MDS) assessment completed February 18, 2014, noted the resident to be frequently incontinent of bladder and constantly incontinent of bowel functioning. Interview with registered staff confirmed that the assessments were not consistent with each other. (168)

C. Resident #21 identified on July 14, 2014, they were experiencing pain all over. The plan of care noted two diagnoses which characteristically included symptoms of pain, the use of routine analgesia administered both orally and topically, and the use of additional analgesia on an as needed basis. In July 2014, registered nursing staff and physiotherapy staff documented the reported pain, however PSW staff recorded in POC that the resident did not have any pain. The pain assessments of registered

staff and direct care staff were not consistent with each other. (528)

D. In April 2014, resident #12 had an unwitnessed fall with no injuries. The MDS assessment completed post fall, in June 2014, indicated that the resident had no falls in the previous 180 days. Interview with registered staff confirmed that the MDS assessment completed was not consistent with the progress notes completed, related to the falls incident. (528)

E. Resident #29 had a MDS assessment completed April 1, 2014. This assessment noted under accidents a fall in the past 30 days, however did not note a fall in the past 31 to 180 days. According to the progress notes the resident sustained falls in February 2014, which was in the past 31 to 180 days. [s. 6. (4) (a)]

4. Care set out in the plan of care was not provided to the resident as specified in the plan.

A. On July 17, 2014, resident #18 was observed seated in a tilt wheelchair with a table tray. Review of the plan of care identified the use of the tilt wheelchair and tray for safety and positioning and directed staff to remove the tray, reposition, and replace table tray every two hours. On July 17, 2014, from 0920 to 1155 hours, the resident was monitored in the tilt wheelchair with table tray in place and was not repositioned at any time during the observation. (528)

B. The plan of care for resident #33 indicated they had altered verbalization and an inability to express themselves due to decreased/lack of speech. The plan of care instructed staff to ask the resident questions that that required one or two word answers, encourage non-verbal communication, and not to ask the resident to make decisions or ask what was wrong. In 2014, in response to a responsive behaviour incident, registered staff documented in the progress notes that they asked the resident why the behaviour occurred and that they were unable to answer. Interview with registered staff confirmed the resident would be unable to answer a question such as 'why' and that interventions specified in the plan were not provided, related to the incident. (528)

C. The plan of care for resident #19 indicated they were to receive an additive to hot foods. During the lunch meal on July 17, 2014, the resident was not provided with the additive as per the plan of care, which was confirmed with the FSM and front line staff. (156)

D. The plan of care for resident #18 indicated staff were to serve them first and to provide their meal first, if a feeder was available. On July 15, 2014, during the noon meal service a visitor was ready and available to feed the resident, and made a request for the main entree. According to the visitor the entree was not provided initially, or on request, as staff reported they were following the table rotation. The visitor, who was aware of the directions in the plan, verbalized their concern a second time after residents at three other tables were served their entrees, at which time the meal was served. The resident was not provided care as per the plan of care. [s. 6. (7)]

5. The resident was not reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A. The plan of care for resident #12 indicated they were a high falls risk and required a personal alarm on when in bed. On July 21, 2014, the resident was observed to have a personal alarm on when in a wheelchair. Interview with PSW staff identified that due to a recent fall, a personal alarm was to be applied at all times. The plan of care was not revised to include the change in the application of the alarm. (528)

B. Resident #18 was observed in a tilt wheelchair with table top, requiring total assistance of staff for mobility, transfers, and repositioning. The current plan of care included a focus statement regarding activity participation and identified that the resident would attend most activities, stay for a short time then wander in an out. Interview with the resident's family confirmed that due to the resident's diagnosis they no longer wandered nor attended most activities. Interview with registered staff confirmed that the plan of care was not revised when the care needs changed. (528)

C. The plan of care for resident #18 indicated they required a personal alarm applied at all times. The resident was observed in bed and in the wheelchair with no alarm applied. Interview with registered and PSW staff confirmed that due to changes in the resident condition they not longer required the personal alarm. The plan of care was not revised when the care set out in the plan, related to the personal alarm, was no longer necessary. (528)

D. Resident #61 sustained a fall in 2014. As a result of this fall a bed alarm was initiated for safety, which was observed in place on July 21, 2014. The current plan of

care noted that the bed alarm was not effective, and was discontinued in 2013. Interview with PSW and registered staff confirmed the use of the alarm and that it was a current intervention. Registered staff confirmed that the plan of care had not been revised to include the bed alarm as an intervention for falls management. (560)

E. The plan of care for resident #61 instructed staff to encourage the resident to use their walker when in their room. Interview with registered staff confirmed that the resident was not using their walker due to a recent injury and that this intervention should have been removed from the plan of care. (560)

F. The plan of care for resident #29 identified "personal alarm on at all times, including bed mat alarm on at all times". The resident was observed on July 17, and 22, 2014, while up in the lounge, with a walker. The resident did not have a personal alarm on during the observation period. Interview with PSW staff confirmed that the resident no longer used an alarm when out of bed and that it was discontinued with a change in mobility. Interview with registered staff confirmed that the plan of care had not been revised with a change in the resident's care need. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care for each resident includes the planned care; provides clear directions to staff and others who provided direct care; that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complemente each other; that care set out in the plan of care is provided to the resident as specified in the plan; and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 did not ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

The home's policy "Falls Prevention and Management, effective September 16, 2013," identified that for a resident who had a fall, staff were to completed post fall management interventions which were to include, but not limited to, the following:
-assess the resident immediately after a fall prior to moving and provide interventions as per falls algorithm
-complete a post falls huddle for completion of the post falls worksheet
-include the results of post fall worksheet in the incident note
-complete a falls incident report, which was to be printed and attached to completed risk form
-assess the resident post fall including fall follow up progress notes for at least three shifts following the incident
-refer the resident to restorative care and to physiotherapy and/or occupational therapy
-place logo at the bedside for the resident at high risk for falls if not already there.

A. Resident #12 had three falls from December 2013, until July 2014, and the following post falls management interventions were not completed:
i. post fall worksheets for all each of the falls.
ii. a fall follow up note for the first shift following a fall in 2013, a fall follow up note for the third shift following a fall in the spring of 2014, and fall follow up notes for the second and third shift following a fall in summer 2014.
iii. a fall logo placed at the bedside.

B. Resident #21 had three falls from October 2013, to February 2014, and the following post falls management interventions were not completed:

i. post fall worksheets and referrals for restorative care or physiotherapy referrals for all three falls.
ii. an incident risk report for a fall in 2013.
iii. fall follow up notes for the first and third shifts following a fall in 2013, a fall follow up note for the first shift following a fall in early 2014, and a fall follow up note for the third shift following a fall in February 2014.

C. Resident #29 had seven falls from February 2014, to June 2014, and the following post falls management interventions were not completed:
i. post fall worksheets for all seven fall incidents.
ii. an incident risk report for a fall in February 2014, and in March 2014.

D. Resident #61 had six falls from January 2014, to June 2014, and the following post falls management interventions were not completed:
i. post fall worksheets for all six falls.
ii. a fall follow up note for the third shift following a fall in March 2014.
iii. a fall logo placed at the bedside.

Interview with the DOC confirmed that the post fall worksheets and incident risk reports were not completed. Registered staff interviewed on the resident's home areas confirmed that fall follow up notes, referrals, and logos were not put in place, as outlined in the home's policy for the incidents indicated above. (528) [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 is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The home, furnishings and equipment were not maintained in a safe condition and in a good state of repair.

A. Tubs in Home Areas #1 and #2 were noted to be stained. The ESM indicated that the home was aware of the staining and were in the process of getting quotes to have the tubs refinished.

B. Broken tiles were observed on the wall in the tub room on Home Area #3.

C. A rust coloured stain was found on the tiles on the wall in the shower room in Home Area #4, and a soap dispenser was found hanging off of the wall.

D. Home Area #3 had a torn seat on the shower chair covered with tape. The ESM was not aware of the condition of the chair until shown by the inspector at which time it was taken out of commission to be replaced. [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 maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: 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. When bed rails were used, the resident was not assessed and his or her bed system evaluated in accordance with evidence-based practices to minimize risk to residents.

A. Residents #18 and 19 were observed to have both bed rails in the raised position when in bed. Interview with registered staff confirmed that both resident's required two bed rails raised when in bed for safety. Review of the plans of care did not include a formalized assessment of the residents. Interview with the Staff Educator confirmed that the resident's nor the bed systems were evaluated in accordance with evidenced-based practices to minimize the risk to the residents. (528)

B. Resident #17 was observed with a bed rail in the raised position. Resident and staff interview confirmed the use of one raised rail when in bed on request. A review of the clinical record did not include an assessment of the resident for the use of the bed rail. Interview with registered staff confirmed that they did not complete an individualized assessment of the resident for the use of the rails nor did they evaluate the bed system in accordance with evidence-based practices for all potential zones of entrapment. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices to minimize risk to residents, to be implemented voluntarily.

WN #5: 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 resident was not protected from abuse.

The plan of care for resident #60 identified they could be physically and verbally aggressive with care and to approach slowly from the front, not to argue with the resident and to get their attention before speaking or touching them. The resident was incontinent and required the assistance of two staff to complete brief changes at night.

According to written statements reviewed and staff interviews, a PSW who provided continence care to resident #60 during an identified night shift, was identified to be in a "bad mood" and "abrupt and aggressive". The resident attempted to strike out at the staff when approached. The response of the PSW was defensive.

Interview with the Administrator identified that the home's internal investigation into the incident confirmed that the resident was not protected from 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 the resident is protected from abuse, to be implemented voluntarily.

WN #6: 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 PASD described in subsection (1) was not 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.

Subsection 33(4) of the Long Term Care Homes Act, 2007, identified that the use of a personal assistance services device (PASD) may be included in a resident's plan of care only if it was consented to by the resident or substitute decision maker of a resident with the authority to give consent.

A. Resident #18 was observed to have two bed rails in the raised position when in bed. The plan of care indicated that the two bed rails were required when the resident was in bed for safety. Review of the health record did not include a consent for the bed rails. Interview with registered staff confirmed that the consent for bed rail use was not obtained.

B. Resident #19 was observed to have both bed rails raised when in bed. Review of the plan of care did not include the use of bed rails. Interview with registered staff confirmed that the resident required two bed rails raised when in bed for safety and positioning, however bed rails was not included in the plan of care. [s. 33. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a PASD described in subsection (1) is to 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. Each resident was not bathed, at a minimum, twice a week by the method of his or her choice.

i. Resident #28 was scheduled for a bath on the evening shift of July 19, 2014. Point of Care (POC) documentation indicated "not applicable" for bathing activities on the identified date. Interview with the resident confirmed that the scheduled bathing was not completed.

ii. Resident #51 was scheduled for a bath on the evening shift of July 19, 2014. POC documentation indicated "not applicable" for bathing activities on the identified date. Interview with the resident confirmed that the scheduled bathing was not completed.

iii. Resident #27 reported on July 15, 2014, that due to insufficient staff they did not receive their scheduled shower on July 13, 2014. This scheduled shower was not recorded in the POC documentation when reviewed. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident is bathed, at a minimum, twice a week by the method of his or her choice, to be implemented voluntarily.

WN #8: 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 resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A. Resident #25 was observed to have a skin tear covered with a dressing. Review of the plan of care on July 18, 2014, did not include a skin assessment by a member of the registered nursing staff in relation to the skin tear. Interview with registered staff confirmed that the skin tear was not assessed using a clinically appropriate assessment instrument. (528)

B. Resident #17 had a progress note from the day shift of June 4, 2014, which indicated the presence of altered skin integrity which was assessed by the physician and treatment ordered. A review of the clinical record did not include an assessment of the area using a clinically appropriate assessment tool until June 5, 2014, evening shift, which identified the area as three small stage II pressure sores. The identified area of altered skin integrity was not assessed using a clinically appropriate assessment tool when first identified, which was confirmed by the registered staff during a record review. (168)

C. Resident #17 had a progress note dated July 14, 2014, which indicated complaints about a skin tear being sore with tingling and numbness. This was the first entry in the clinical record reviewed, which identified the area of altered skin integrity. An assessment of the tear was completed on July 15, 2014, using a clinically appropriate tool and the area was assessed and treatment suggested by the Nurse Practitioner. The identified area of altered skin integrity was not assessed using a clinically appropriate assessment tool when first identified, which was confirmed by the registered staff during a record review. [s. 50. (2) (b) (i)]

2. The resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was not assessed by a RD who was a member of the staff of the home.

A. Resident #10 was identified in the progress to have an area of altered skin integrity in 2014, which continued to require treatment as of July 21, 2014. Interview with registered staff, during a clinical record review, confirmed that a referral was not initiated, nor an assessment completed by the RD related to the area of altered skin integrity. The resident was assessed by nutritional care staff on four occasions following the identification of the area of altered skin integrity, however each time the documentation noted the resident's skin to be intact. (168)

B. Resident #25 was observed to have a skin tear covered with a dressing. Review of the plan of care on July 19, 2014, did not include an assessment by the RD related to the altered skin integrity. Interview with registered staff confirmed that a referral was not sent to the RD related to the skin tear, and therefore the resident was not assessed by the RD. (528)

C. Resident #17 was identified to have three small stage II pressure areas in 2014. A review of the clinical record did not include a referral to or an assessment of the area

of altered skin integrity by the RD. Interview with the registered staff confirmed that a referral was not initiated nor an assessment conducted by the RD following the identification of the pressure areas, during a record review. [s. 50. (2) (b) (iii)]

3. The resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was not reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #10 had an area of altered skin integrity identified in 2014, which continued to require treatment as of July 21, 2104, according to the clinical record. The area was not assessed weekly by a member of the registered staff. The area was assessed on May 22, 2014. On June 1, 2014, a Skin Notes Assessment indicated that the resident's skin was intact. The area was assessed again on June 22, 2014, July 13, 2014, and July 17, 2014. Interview with registered staff, who reviewed the clinical record confirmed that the area of altered skin integrity was not assessed weekly as required. [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 the resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, is assessed by a registered dietitian who was a member of the staff of the home, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee did not consistently respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Family Council Meeting Minutes reviewed identified that not all concerns were responded to in writing within 10 days. Interview with the Administrator identified that concerns were responded to within 10 days of receipt of Meeting Minutes, not from the date of the meeting. The Council Assistant, an employee of the home, was responsible to record Meeting Minutes.
i. During the June 4, 2014, meeting a concern was identified regarding a servery fan, which was not responded to in writing until June 23, 2014.
ii. During the May 7, 2014, meeting concerns were identified regarding a piece of equipment, the location of hot beverages and patio doors, which were not responded to in writing until June 7, 2014. [s. 60. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #10: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. 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:
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 did not ensure that the dining and snack service included a review of the snack times by the Residents' Council.

Interview with the FSM confirmed a review of the meal times with the Residents' Council however did not include a review the snack times as part of the dining and snack service. A review of recent Residents' Council Meeting Minutes did not include a review of snack times by the Council. [s. 73. (1) 2.]

2. Not all food and fluids were served at a temperature that was both safe and palatable to the residents.

Some residents interviewed identified concerns that food was not consistently served at an appropriate temperature. The temperature range in which food-borne bacteria can grow, known as the danger zone is 4 degrees Celsius (°C) to 60 °C.

A. During the observed lunch meal on July 16, 2014, food temperatures were taken in the servery for Home Areas #1 and #2.
i. The mini sub was probed at 7.8 °C and the minced texture sub at 9.0 °C.
ii. The cucumber salad was probed at 6.7 °C, minced texture at 6.4 °C and pureed texture at 7.7 °C.
iii. The coleslaw was probed at 4.4 °C, minced texture at 6.2 °C and pureed texture at 7.7 °C.

B. During the observed lunch meal on July 17, 2014, food temperatures were taken in the servery for the Home Areas #3 and #4.
i. The barbecued hamburgers were probed at 47.2 °C and minced texture hamburgers were probed at 45.4 °C.

C. During the observed lunch meal on July 21, 2014, food temperatures were taken in the servery for Home Areas #3 and #4.
i. The chicken salad sandwiches were probed at 5.7 °C and pureed texture sandwiches at 8.4 °C.
ii. The minced texture four bean salad was probed at 11.5 °C and the pureed texture at 8.4 °C.
It was noted that the ice was found to be melted under the pan of salads and the sandwiches were on a thin ice pack which was partially melted. [s. 73. (1) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids are served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Procedures were developed but not fully implemented for addressing incidents of lingering offensive odours.

The home's policy "Indoor Air Quality" indicated that automatic air fresheners were to be used throughout the building for troublesome areas to maintain a pleasant environment. These were monitored to avoid any strong offensive odours or allergen irritations to staff and residents.

During multiple dates of the inspection, it was observed that the shower room on Home Area #3 was malodourous. The ESM, when in the shower room on two separate occasions confirmed the lingering and offensive odours. It was also noted that an air freshener was not available in this room. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #12: 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. Not all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

On July 14, 2014, at 1035 hours, janitor closet room #439, was not latched shut and the door could easily be opened. One large container of floor cleaner, a hazardous substance, was noted inside the unlocked room and accessible to residents. Interview with direct care and housekeeping confirmed that the door should have been closed completely for the automatic lock to work. [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 labelled properly and kept inaccessible to residents at all times, to be implemented voluntarily.

WN #13: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Not all staff participated in the implementation of the infection prevention and control program.

On July 14 and 15, 2014, several unlabelled personal care items were located in tub and shower rooms. On July 23, 2014, the following items were observed:
i. PSW staff confirmed that four used and unlabelled stick or roll-on deodorants and a pair of unlabelled and used nail clippers were in the shower room of Home Area #3.
ii. Registered staff on Home Area #1 confirmed that an unlabelled, used comb and a pair of used nail clippers were found in the tub room.
Staff interviewed confirmed that the items should have been labelled or in the case of the nail clippers returned to the foot care nurse. [s. 229. (4)]

2. Not every resident admitted to the home was screened for tuberculosis within 14 days of admission, unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee.

A. The following residents were not screened within 14 days of admission, and did not have results of previous screening completed in the 90 days prior.
i. Resident #30 was admitted to the home in the summer of 2013, and was not screened for tuberculosis (TB) until 21 days after admission.
ii. Resident #32 was admitted to the home in the fall of 2013, and was not screened for TB until approximately four months after admission.
Interview with registered staff confirmed that residents #30 and #32 were not screened for TB within 14 days of admission or 90 days prior to admission. [s. 229. (10) 1.]

3. Not all residents were offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

A. Resident #31 was admitted to the home in the fall of 2013. Review of the clinical record revealed that as of July 2014, consent for tetanus and diphtheria remained outstanding. Interview with registered staff confirmed that consent had not yet been obtained or discussed with the substitute decision maker (SDM), although flagged in the chart as required. [s. 229. (10) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program and that every resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening is available to the licensee, to be implemented voluntarily.

WN #14: 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident was cared for in a manner consistent with their needs.

In 2014, resident #60, who was known to demonstrate aggressive behaviours during care was not cared for in a manner consistent with their needs. Documents reviewed and staff interviewed confirmed that, during the night shift, a PSW who provided care did not greet the resident or explain the care to be provided, when the resident became startled and attempted to strike out, staff held the resident and continued to provide care. The Administrator confirmed the home's policy on responsive behaviours and the expectation that the PSW staff would greet the resident upon entering their room, announce they were there to provide care and stop and re-approach at a later time if they were aggressive. The Administrator confirmed that the resident was not cared for in a manner consistent with their needs. [s. 3. (1) 4.]

WN #15: 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 written policy to promote zero tolerance of abuse and neglect of residents was not complied with.

The home's policy "Abuse-Zero Tolerance, effective date September 2013", identified a Duty to Report. That a person who had reasonable grounds to suspect that, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, had occurred or may occur would immediately report the suspicion and the information upon which it was based to the Director.

In early 2014, resident #33 and #34 had an altercation which resulted in superficial injuries to resident #33. A review of the plan of care did not include a report to the Director. Interview with the Administrator confirmed that the resident to resident abuse was not reported to the Director as required in the home's abuse policy. (528) [s. 20. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The resident did not receive individualized personal care, including hygiene care and grooming on a daily basis.

The plan of care for resident #25 indicated they required limited assistance with hygiene and grooming, including shaving. On July 15, 18, and 19, 2014, they were observed to be unshaven. Interview with the resident on July 19, 2014, confirmed that they had not been shaved for two days, but was usually shaved daily. Interview with PSW staff confirmed that the resident's razor was not working and as a result, required staff to assist with shaving. PSW staff confirmed that the resident was not shaved on the morning of July 19, 2014, with morning care as routine and would provide assistance before lunch. [s. 32.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The resident did not receive fingernail care, including the cutting of fingernails.

Resident #19 required extensive assistance of one staff member for grooming and hygiene. It was observed on July 15, 16, and 17, 2014, that the resident's nails were untrimmed and nails on the left hand were unclean. The clinical record indicated that the resident was provided a shower on July 15, 2014. Interview with PSW staff confirmed that nails were typically done on bath day and appeared long, uneven, and unclean. The resident did not receive fingernail care as required. [s. 35. (2)]

WN #18: 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 did not consistently respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Residents' Council Meeting Minutes identified that not all concerns were responded to, in writing, within 10 days of receipt. Interview with the Administrator identified that responses to Council concerns were completed within 10 days of receipt of the Meeting minutes, not consistently within 10 days following the meeting, if the minutes were delayed.

i. A meeting was held on June 12, 2014, and concerns were identified related to dining room chairs, a sink and an ironing board. These concerns were not responded to in writing until June 23, 2014.

ii. A meeting was held on December 13, 2013, and concerns were identified related to staffing and power wheelchairs. These concerns were not responded to in writing until December 31, 2013.

iii. A meeting was held on October 10, 2013, and concerns were identified related to pleasurable dining. These concerns were not responded to in writing until October 21, 2013. [s. 57. (2)]

Issued on this 5th day of September, 2014

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