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
Sep 29, 2015	2015_332575_0015	018920-15	Resident Quality Inspection

Licensee/Titulaire de permis

ALGONQUIN NURSING HOME OF MATTAWA LIMITED
231 TENTH STREET P.O. BOX 270 MATTAWA ON P0H 1V0

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

ALGONQUIN NURSING HOME OF MATTAWA LIMITED
231 TENTH STREET P.O. BOX 270 MATTAWA ON P0H 1V0

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

LINDSAY DYRDA (575), GILLIAN CHAMBERLIN (593), MONIKA GRAY (594)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 10-14 and 17-20, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Dietary/Housekeeping/Laundry Manager, Resident and Family Services Coordinator, RAI-MDS Coordinator, Maintenance Coordinator, Behavioural Supports Ontario (BSO) Coordinator, Physiotherapy staff, Registered Dietitian (RD), Dietary Aides, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family Council President, Family Members, and Residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

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

13 WN(s)
6 VPC(s)
2 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written description of the Skin and Wound Care program that included its:
* goals and objectives
* relevant policies, procedures, protocols
* methods to reduce risk
* methods to monitor outcomes, and
* protocols for referral of resident to specialized resources where required.

Inspector #575 requested to review the home's skin and wound care program. The DOC indicated that the home did not have a skin and wound care program or policy in writing that met the requirements set out in the Regulations. The DOC indicated that staff follow

the CCAC wound care protocol for wound care guidance. The inspector reviewed the CCAC wound care protocol which provided wound descriptors used to select the appropriate dressing protocols and did not provide for the requirements as indicated in the Regulations. [s. 30. (1) 1.]

2. The licensee has failed to ensure that there was a written description of the Continence Care and Bowel Management program that included its:
* goals and objectives
* relevant policies, procedures, protocols
* methods to reduce risk
* methods to monitor outcomes, and
* protocols for referral of resident to specialized resources where required.

The DOC provided Inspector #575 the home's continence care and bowel management program binder. The inspector reviewed the contents of the binder which included the home's policy titled 'Continence Program' last reviewed May 2015, products, education, surveys, product assessment forms, and emergency sign out sheets. The inspector noted that the program policy did not include any methods to reduce risk, methods to monitor outcomes, nor any relevant procedures or protocols as required.

During an interview, the DOC confirmed to the inspector that the home's written program did not meet the requirements of the legislation. [s. 30. (1) 1.]

3. The licensee has failed to ensure that there was a written description of the Falls Prevention and Management program that included its:
* goals and objectives
* relevant policies, procedures, protocols
* methods to reduce risk
* methods to monitor outcomes, and
* protocols for referral of resident to specialized resources where required.

Inspector #594 requested the documented falls prevention and management program. The DOC provided the inspector with the 'Terms of Reference Falls Prevention Program' policy #MP-A-01 and 'Falls Prevention Program' policy #NM-E-05. The inspector reviewed the policies which failed to include relevant procedures, protocols, methods to reduce risk, methods to monitor outcomes and protocols for referral of the resident to specialized resources where required.

During an interview, the DOC indicated to the inspector how the licensee fulfills the falls prevention and management program requirements but validated that there was no written description as required by legislation. [s. 30. (1) 1.]

4. The licensee has failed to ensure that with respect of the interdisciplinary programs required under section 48 of the regulation, that the programs were evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Inspector #575 interviewed the DOC regarding program evaluations for the Continence Care and Bowel Management and Falls Prevention and Management programs. The DOC indicated that the current programs had not been evaluated or reviewed annually. [s. 30. (1) 3.]

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. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian (RD) who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

During the inspection, Inspector #593 asked the S #203 when S #201 was scheduled to be on site to speak with the inspector. S #203 reported that S #201 only visits once every three months.

During an interview, S #203 indicated that S #201 is on site at the home once every three months for three full days. In between visits, S #201 uses Skype and e-mail to communicate with the home and the they work a full day every Thursday remotely, as they have remote access to Point Click Care (PCC). S #203 further reported that S #201 regularly (weekly) speaks with staff in the home about the residents as part of their off site assessments. The off site hours are included in the S #201's total hours for the home each month.

The inspector interviewed the S #201 via telephone. S #201 reported that for a period of approximately six months, they completed a total of 267 hours which was equivalent to 38 hours per month. They confirmed that they are usually on site only once every three months and occasionally they are on site every two months. In an email correspondence, S #201 indicated that in 2015 they were on site for 24 hours in March and then not back on site until July for 24 hours. The inspector noted S #201 was only on site for two out of seven months.

The home has 73 residents, therefore the on site RD hours at a minimum are required to be 36.5 hours per month. [s. 74. (2)]

Additional Required Actions:

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

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

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 licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #013.

During this inspection, it was identified during an interview with the DOC that resident #013 had a fall.

During an interview with Inspector #594, S #103 indicated that direct care staff can access the kardex on Point of Care (POC) which provided a quick overview of the resident care required, and that they would also access the full care plan in the resident's health care record at the nursing station including another kardex (in hard copy).

The inspector reviewed the resident's current care plan which documented an intervention related to a risk for falls. Review of the POC kardex identified that the resident was a fall risk but failed to identify any further fall risk interventions. Review of the Minimum Data Set (MDS) kardex report in the resident's health care record failed to identify the interventions documented in the care plan.

The DOC and the inspector reviewed the POC kardex, resident record MDS kardex, and the current care plan in the resident's health care record. The DOC stated that the kardexs were missing information regarding the fall prevention interventions.

Given that the care plan stated specific fall prevention interventions, and that the POC kardex and resident record MDS kardex failed to identify the interventions, the plan of care failed to provide clear direction. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #003.

On three occasions, Inspector #575 noted resident #003 with an odour. The inspector interviewed several direct care staff (S #105, S #106, S#107, S#114) who all indicated that the resident was independent and continent. The inspector interviewed the DOC and S #111 who indicated that the resident was incontinent.

The inspector reviewed the resident's current care plan located in the resident's health care record. Under the toileting section, the care plan indicated that the resident required monitoring and that the resident would ask for and receive the necessary assistance. Under bladder function, the care plan indicated that the resident required monitoring and that staff were to use verbal reminders for the resident to use the washroom.

The inspector reviewed the MDS and Resident Assessment Protocol (RAP) assessments since the resident's admission. The two most recent assessments indicated the resident was incontinent. Both most recent RAPS indicated that the resident was incontinent and often had an odour.

The inspector reviewed the resident's most recent continence care assessment with the DOC and S #111. The DOC and S #111 indicated that during the MDS review period, staff are to enter the resident's continence assessment by entering if the resident has control of their bladder or bowels, if they use a product, and if the incontinence is new. Once the assessment period of 7 days is completed, S #111 stated that they review the information to discuss the plan for the resident, and then that information is written in the RAPS.

The inspector noted that during the assessment period, only one staff entered the required information during the 7 day period (on one occasion, however, it should be completed each shift) and indicated that the resident was continent, however, the RAPS

indicated the resident was incontinent.

The inspector noted that the assessment indicated that the resident was continent, the RAPS indicated that the resident was incontinent, the staff interviewed indicated that the resident was continent, and the resident's care plan indicated the resident should be monitored with no indication if they were continent or incontinent. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #007.

During an interview with S # 101, it was stated that resident #007 had two falls. In an interview with Inspector #594, S #103 stated that direct care staff can access the kardex on POC which provided a quick overview of the resident care required, and that they would also access the full care plan in the resident's health care record at the nursing station including another kardex (in hard copy).

The inspector reviewed the resident's current care plan which documented two interventions related to a risk of falls. Review of the POC kardex identified that the resident had falls and required a different intervention than indicated in the care plan. Review of the MDS kardex report in the resident record identified one of the interventions as described in the care plan.

Inspector #594 interviewed S #112 who stated that the interventions were as described in the current care plan. The inspector and S #112 reviewed the POC kardex which identified a different intervention. S #112 stated they were unsure what that meant.

During the inspection, Inspector #594 observed the resident on approximately two occasions with the intervention in place as described in the care plan, however, did not observe the intervention as described in the POC kardex.

The DOC and the inspector reviewed the POC kardex, resident record MDS kardex and the current care plan in the resident's health care record. The DOC confirmed that the resident's plan of care did not provide clear direction. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #010.

During an interview with the DOC, it was identified that resident #010 had a fall.

In an interview with Inspector #594, S #103 stated direct care staff can access the kardex on POC which provided a quick overview of the resident care required, and that they would also access the full care plan in the resident's health care record at the nursing station including another kardex (in hard copy).

The inspector reviewed the resident's current care plan which identified an intervention related to a risk of falls. According to the same care plan, an intervention for mobility/ambulation was also identified. Review of the POC kardex identified that the resident had falls but failed to identify any further interventions. Review of the MDS kardex report in the resident's record failed to identify one of the interventions as described in the care plan.

During the inspection, Inspector #594 observed the resident on approximately four occasions without staff implementing one of the interventions as described in the care plan.

The DOC and the inspector reviewed the POC kardex, resident record MDS kardex and the current care plan in the resident's health care record. The DOC confirmed the plan of care did not provide clear direction. [s. 6. (1) (c)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #006 as specified in the plan.

During this inspection, it was identified during an interview with S #101, that resident #006 had impaired skin integrity.

Inspector #575 reviewed the resident's health care record and noted the resident's current care plan indicated the resident had impaired skin integrity to certain areas of their body. The inspector reviewed the physician orders in the resident's health care record and noted the following:

-A CCAC wound care protocol that indicated where the impaired skin integrity was and provided certain wound care instructions;
-A note (in the physician orders section written by a staff member) that indicated resident #006 had no new orders and to continue with the same order;
-A previous (old) CCAC wound care protocol that indicated certain wound care instructions.

The resident's Treatment Administration Record (TAR) indicated that staff were following the wound care instructions from the previous (old) CCAC wound care protocol. S #101 confirmed that staff were currently following the previous wound care protocol.

The inspector reviewed the resident's TAR and current physician orders with the DOC. Upon review, the DOC indicated that the current wound care instructions were not the most recent ordered. The DOC indicated that it was an error and that staff must have assumed it was the same product. The DOC confirmed that the current wound care treatment administered by the staff was not reflective of the physician orders, therefore, the care was not provided as specified in the plan. [s. 6. (7)]

6. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #013 as specified in the plan.

During an interview with the DOC, it was identified that resident #013 recently had a fall.

Inspector #594 reviewed the resident's health care record which identified in the care plan an intervention related to a risk of falls.

During the inspection, for a period of approximately five hours (hrs) the inspector observed the resident with a device in place, however the device was not applied properly, making the device ineffective.

During an interview, S #103 stated that the resident had the device because of falls. The inspector and S #103 examined the device. Upon observation, S #103 stated that the device was to be connected and because the device was not applied properly, it would not perform its intended purpose. [s. 6. (7)]

7. The licensee has failed to ensure that resident #006's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During an interview with S #101, they indicated that resident #006 had impaired skin integrity to certain areas of their body.

Inspector #575 reviewed the resident's health care record and noted the resident's current care plan indicated that the resident had impaired skin integrity to certain areas of

their body. Interventions were described the care plan.

The resident's Treatment Administration Record (TAR) indicated that staff were implementing a different intervention than what was described in the care plan.

The physician orders in the resident's health care record indicated the following:
-A CCAC wound care protocol that indicated where the impaired skin integrity was and provided certain wound care instructions;
-A note (in the physician orders section written by a staff member) that indicated resident #006 had no new orders and to continue with the same order;
-A previous (old) CCAC wound care protocol that indicated certain wound care instructions.

The inspector reviewed the resident's current care plan, TAR and current physician orders with the DOC. The DOC confirmed that what the home was doing was not reflective of the current treatment orders and that the resident's plan of care was not updated to reflect the current orders and care needs of the resident. [s. 6. (10) (b)]

8. The licensee has failed to ensure that resident #013 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.

During an interview with the DOC, it was stated that resident #013 recently had a fall.

Inspector #594 reviewed the resident's health care record which identified that the resident had incurred numerous falls and had sustained serious injuries related to some of the falls.

During an interview, the DOC stated that the Fall Risk Assessment was considered the home's post fall assessment instrument and was required to be completed after each fall. The inspector and DOC reviewed the resident's falls and the DOC stated that a post fall assessment for resident #013 was not completed for all falls.

The inspector reviewed the resident's plan of care which identified risk of fall interventions. The inspector reviewed the resident's care plan which failed to document any resolved or cancelled fall interventions.

Review of the resident's RAPs triggered by falls dated documented that resident #013

remained at a potential risk for falls and that interventions have been implemented in the care plan and remain ongoing.

The inspector interviewed the DOC regarding what fall interventions had been attempted after each fall assessment for resident #013. The DOC stated that there was no documentation of what interventions had been tried aside from the fall interventions documented on the care plan. The DOC further stated that they review the risk management report to review which residents have fallen to establish a trend.

Given that resident #013 sustained serious injuries over the course of two years, that the RAP documented the same reasons after each of the assessments conduced over the course of a year and a half, that only one fall intervention was initiated in one year and the last fall intervention was introduced within the last several months, that not all post fall assessments were completed and that the resident continued to fall; the licensee has failed to ensure that the resident was reassessed and the plan of care reviewed when the care set out in the plan has not been effective. [s. 6. (10) (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 ensuring that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care is provided to residents as specified in the plan, that residents are reassessed and the plan of care reviewed and revised when the residents' care needs change or care set out in the plan is no longer necessary or when care set out in the plan has not been effective, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are provided with fluids that are safe.

Inspector #593 observed, during the lunch service, S #106 prepare thickened fluids for two residents. S #106 was observed to use a plastic teaspoon to scoop thickener from a container labelled thickener, into cups holding fluids. S #106 was then observed to serve the fluids to both residents. Two fluids were served to the first resident, the inspector observed one of the fluids to be nectar consistency and the other to be honey consistency. A soup was served to the resident at this time, which was nectar thick consistency.

On another day during the inspection, Inspector #593 observed during the lunch service, the second resident was served two fluids. Both fluids were observed to be thin consistency and were consumed by the resident.

On another day during the inspection, Inspector #593 observed during the lunch service, the first resident was served three beverages, none of these beverages were thickened. The thin fluids were consumed by the resident during the lunch service. The resident also consumed a soup which was nectar thick consistency. The inspector observed a carton of pre-thickened apple juice on the beverage cart which was honey thick consistency. This was not served to any residents during the meal lunch service.

On the same day, Inspector #593 observed during the lunch service, a staff member thicken a beverage for the second resident. The staff member was observed to scoop two teaspoons of the powdered thickener into a cup and stir. The staff member did not refer to a recipe or procedure while preparing this fluid. The inspector observed the fluid served to the resident and it was between nectar and honey consistency. No thickened fluid recipes or procedures were available on the beverage cart or in the dining room servery at this time.

On another day during the inspection, Inspector #593 observed during the lunch service,

the first resident with two beverages, both were observed to be thickened to between thin and nectar consistency. The inspector overheard a staff member ask another staff member, "does this resident receive thickened fluids", and the staff member replied "I don't think so". The staff member was then observed to prepare two thickened beverages for the second resident and the staff member did not refer to a recipe or procedure while preparing this fluid.

During an interview with Inspector #593, S #106 reported that when staff are preparing the thickened fluids, they are to add one scoop of thickener to one cup of fluid for nectar, two scoops of thickener to one cup of fluid for honey and three scoops of thickener to one cup of fluid for pudding thick consistency. They further added that sometimes at this ratio the pudding thick fluid is too thick and they will have to add extra fluid to thin it out. S #106 was not sure why this happens and stated that maybe the home is using different types of thickeners.

A review of the first resident's care plan, found that the resident was required to receive honey thick fluids. A review of the second resident's care plan, found that the resident was required to receive pudding thick fluids.

A review of the first resident's physician's orders found a diet order for honey thick fluids. A review of the second resident's physician's orders found a diet order for pudding thick fluids.

During an interview with Inspector #593, S #109 reported that the dietary binder located in the dining room is for nursing staff to refer to, and the dietary staff are to refer to the diet sheets posted in the servery. This information available to all staff included meal texture and fluid requirement. S# 109 further added that staff are responsible to know the residents' fluid requirements in their area as there are no diet sheets on the beverage carts, the staff are to refer to diet sheets located in the servery and the kitchen. Verbal updates are also communicated to dietary staff whenever changes are made. They further reported that most staff are full time so they get to know the residents' requirements quite well.

A review of the home's Nutrition Care and Hydration Policy: Dietary Roster and the Roster's Dining Card #01-02 dated January, 2013, documented that it is the responsibility of all staff members to refer to the dietary roster prior to serving any resident food or fluids.

A review of the diet roster by Inspector #593 posted in the servery, showed that the first resident required honey thick fluids and the second resident required pudding thick fluids. This information was consistent with the information observed in the dietary binder, also located in the dining room servery. However, this consistency of fluids was not provided to either resident as identified previously.

During an interview with Inspector #593, S #203 reported that they have had issues with the staff thickening fluids. They further added that the expectation is that two teaspoons of thickener per cup is for nectar thick, four teaspoons of thickener per cup is for honey thick and six teaspoons of thickener per cup is for pudding thick fluids. S #203 reported that in the past, they had a guide for staff to refer to when thickening fluids, however this is not currently available. They added that the concerns observed are legitimate and they know this is a problem and it has been a problem in the past. [s. 11. (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 ensuring that residents are provided with fluids that are safe, specifically related to the consistency of these fluids, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #013 had fallen, the resident had been assessed and a post-fall assessment had been conducted using a clinically

appropriate assessment instrument that was specifically designed for falls.

During this inspection, resident #013 was identified during an interview with the DOC as having had a fall. According to the resident's health care record, the resident had numerous falls over the course of approximately two years.

Inspector #594 interviewed S #102 and S #104 who stated that when a resident has fallen a Risk Management Incident form is completed and a Fall Risk Assessment is to be completed. During an interview, the DOC stated that the Fall Risk Assessment was considered the home's post fall assessment instrument and was required to be completed after each fall. The inspector and DOC reviewed the resident's Fall Risk Assessments on PCC and the DOC confirmed that a post fall assessment for resident #013 was not completed for all falls. [s. 49. (2)]

2. The licensee has failed to ensure that when resident #007 had fallen, the resident had been assessed and a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

During this inspection, resident #007 was identified during an interview with S #101 as having had two falls. Review of the resident's health care record by Inspector #594 identified that the resident had fallen on approximately three occasions within the last seven months.

Inspector #594 interviewed S #102 and S #104 who stated that when a resident has fallen a Risk Management Incident form is completed and a Fall Risk Assessment is to be completed.

During an interview, the DOC stated that the Fall Risk Assessment was considered the home's post fall assessment instrument and was required to be completed after each fall. The inspector reviewed the Fall Risk Assessment tool which assessed the resident risk for a fall but failed to assess the resident post fall. The inspector and DOC reviewed the resident's Fall Risk Assessments on PCC and the DOC confirmed that a post fall assessment for resident #007 was not completed for two of the falls.

Review of the home's Falls Prevention Program policy #NM-E-05 identified that registered staff were responsible to complete a fall assessment after each fall. [s. 49. (2)]

3. The licensee has failed to ensure that when resident #010 had fallen, the resident had

been assessed and a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

During this inspection, resident #010 was identified during an interview with the DOC as having had a fall. Review of the resident's health care record by Inspector #594 identified that the resident had fallen on two occasions.

Inspector #594 interviewed S #102 and S #104 who stated that when a resident has fallen a Risk Management Incident form is completed and a Fall Risk Assessment is to be completed.

During an interview, the DOC stated that the Fall Risk Assessment was considered the home's post fall assessment instrument and was required to be completed after each fall. The inspector reviewed the Fall Risk Assessment tool which assessed the resident risk for a fall but failed to assess the resident post fall. The inspector and DOC reviewed the resident's Fall Risk Assessment's on PCC and the DOC confirmed that post fall assessments for resident #010 were not completed after the falls as required.

Review of the home's Falls Prevention Program policy #NM-E-05 identified that registered staff were responsible to complete a fall assessment after each fall. [s. 49. (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 ensuring that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls is conducted, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003, who is incontinent, received an assessment that:

* included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and
* was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

On three occasions, Inspector #575 noted resident #003 with an odour. The inspector interviewed several direct care staff (S #105, S #106, S#107, S#114) who all indicated that the resident was independent and continent. The inspector interviewed the DOC and S #111 who indicated that the resident was incontinent.

During an interview, the DOC and S #111 indicated that the continence care assessment is located in POC and that it is the assessment instrument used by the home. During the MDS review period, staff are to enter the resident's continence assessment by entering if the resident has control of their bladder or bowels, if they use a product, and if the incontinence is new. Once the assessment period of 7 days is completed, S #111 stated that they review the information to discuss the plan for the resident, and then that information is written in the RAPS.

The inspector reviewed the MDS and Resident Assessment Protocol (RAP) assessments since the resident's admission. The two most recent assessments indicated the resident was incontinent. Both most recent RAPS indicated that the resident was incontinent.

The inspector reviewed the resident's most recent assessment with the DOC and S #111. The inspector noted that during the assessment period, only one staff entered the required information (on one occasion during the 7 day period, however, it should be completed each shift) and that the assessment indicated the resident was continent, however, the RAPS indicated the resident was incontinent. The inspector reviewed the resident's care plan and there was no indication if they were continent or incontinent.

The resident's assessment did not include the causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and it was not conducted using a clinically appropriate assessment instrument. [s. 51. (2) (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 ensuring that each resident who is incontinent receives an assessment that includes identification of casual factors, patters, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle included alternative choices of entrees and vegetables for residents requiring a pureed diet.

On August 10, 2015, Inspector #593 observed during the lunch meal service, a meal of pureed sausages and mashed potato being served to residents requiring a pureed diet.

During an interview with Inspector #593, S# 125 reported that the alternative option for the pureed meal was a tray puree however, this is offered to residents only if they do not like the first choice.

On August 13, 2015, Inspector #593 observed during the lunch meal service, a meal of pureed chicken, pureed carrot and mashed potato being served to residents requiring a pureed diet.

During an interview with Inspector #593, S# 124 reported that there was no alternative choice available for residents requiring a pureed diet.

On August 14, 2015, the inspector observed during the lunch meal service, a meal of pureed ribs, mashed potato and pureed carrot being served to residents requiring a pureed diet.

During an interview with the inspector, S# 124 reported that there was no alternative choice available for residents requiring a pureed diet.

On August 17, 2015, the inspector observed during the lunch meal service, a meal of pureed meat, pureed cauliflower and mashed potato being served to residents requiring a pureed diet. There was no alternative choice being offered to these residents.

During an interview with the inspector, S# 108 reported that the alternative option for the pureed meal was a tray puree, however this is offered to residents only if they do not like the first choice. The home's menu cycle did not include alternative choices for entrees and vegetables for residents requiring a pureed diet.

During an interview, S #203 reported that the expectation is that the pureed meals available should closely match what is on the regular menu, especially for the first choice. It is the cook or the dietary manager that makes the decision as to what the pureed meal should be for each meal service. S #203 added that the tray pureed meals are used once or twice per week and are usually just used as the second choice but they should have two pureed options available to offer to residents requiring a pureed diet. [s. 71. (1) (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 ensuring that the home's menu cycle includes alternative choices of entrees, vegetables and desserts at lunch and dinner for residents requiring a pureed diet, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(e) menu substitutions that are comparable to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's food production system included menu substitutions that are comparable to the planned menu.

On multiple occasions, Inspector #593 observed a single pureed meal option for residents requiring a pureed diet that was not comparable to the regular menu.

On August 10, 2015, Inspector #593 observed during the lunch meal service, a meal of pureed sausages and mashed potato being served to residents requiring a pureed diet. The standard menu posted and observed by the inspector to be served to most residents included: sausages, cucumber salad, cous cous salad OR egg salad sandwiches with green salad.

During an interview with Inspector #593, S# 125 reported that the second option for the pureed meal was a tray puree and that this was not comparable to the regular menu.

On August 14, 2015, Inspector #593 observed during the lunch meal service, a meal of pureed ribs, mashed potato and pureed carrot being served to residents requiring a pureed diet. The standard menu posted and observed by the inspector to be served to most residents included: barbeque ribs, broccoli and buttered bread or a beef burger with salad. S #124 confirmed these choices served to the residents during this meal service and that there was no comparable alternative option.

On August 17, 2015, the inspector observed during the lunch meal service, a meal of pureed meat, pureed cauliflower and mashed potato being served to residents requiring a pureed diet. The standard menu posted and observed by the inspector to be served to most residents included: egg salad with green salad and a bun or sub sandwich with green salad. S# 108 confirmed these choices served to the residents during this meal

service.

During an interview with the inspector, S# 108 reported that the second option for the pureed meal was a tray puree and that this was not comparable to the regular menu.

During an interview with the inspector, S #203 reported that the expectation is that the pureed meals available should closely match what is on the regular menu, especially for the first choice. It is the cook or the dietary manager that makes the decision as to what the pureed meal should be for each meal service. S #203 added that the tray pureed meals should only be used once or twice per week and are usually just used as the second choice however these are not comparable to the regular menu. [s. 72. (2) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the food production system includes menu substitutions that are comparable to the planned menu, to be implemented voluntarily.

WN #9: 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).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to 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.

On approximately six occasions throughout the inspection, Inspector #593 observed resident #001 with a PASD in use. A review of the resident's current plan of care found

no mention of the use of the PASD for this resident.

A review of the home's Policy: PASDs NM-E-11 dated April, 2015, documented that a PASD is a device used to assist a person with a routine activity of living. A PASD may limit or inhibit movement and may restrain a resident but is not considered a restraint if the intent is to provide assistance with activities of daily living. The resident's care plan must indicate how, when and why the device is to be used as a support to promote independence and quality of life. The care plan must include a description of the device that is being authorized and instructions relating to the order: purpose, when it will be used, how it will be used, how long it will be used, duration and frequency of use.

During an interview with the inspector, S# 104 reported that the PASD was used to prevent the resident from falling as well as to hold the resident's belongings. S# 104 further reported that there was nothing in the resident's plan of care about the PASD.

During an interview with the inspector, S# 111 reported that resident #001 used the device for positioning and activities. The device was used upon resident request. They further added that the device is considered a PASD and confirmed that there was nothing in the resident's plan of care related to the use of the device. They believed that the home's process for PASD use was missed for this resident which is why it was not been included in the plan of care. [s. 33. (3)]

2. The licensee has failed to ensure that a PASD under subsection (3) to assist a resident with a routine activity of living may be included in the resident's plan of care only if the use of the PASD has been approved by a physician, a registered nurse (RN), a registered practical nurse (RPN), a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.

On approximately six occasions throughout the inspection, Inspector #593 observed resident #001 with a PASD in use. A review of the resident's current plan of care found no mention of the use of the PASD for this resident including approval by a person as required for in the regulations.

A review of the home's Policy: PASDs NM-E-11 dated April, 2015, documented that a PASD is a device used to assist a person with a routine activity of living. A PASD may limit or inhibit movement and may restrain a resident but is not considered a restraint if the intent is to provide assistance with activities of daily living. The use of the PASD

must be approved by one of the following: a physician, an RN, an RPN, a member of the College of Occupational Therapists of Ontario or a member of the College of Physiotherapists of Ontario. Documentation of the PASD use must include authorization of the use of the device.

During an interview with the inspector, S# 104 reported that the PASD was used to prevent the resident from falling as well as to assist the resident in holding their belongings. S# 104 further reported that there was nothing in the resident's plan of care about the PASD.

During an interview with Inspector #593, S# 111 reported that resident #001 used the PASD for positioning and activities. The device was used upon resident request. They further added that the device is considered a PASD and confirmed that there was nothing in the resident's plan of care related to the use of the device including approval by a physician. S# 111 believed that the home's process for PASD use was missed for this resident which was why it had not been approved by a physician or as provided for in the regulations. As per the home's process, the PASD should have been originally approved by a physician and then the physician's order updated every three months when the resident's medication review was completed. [s. 33. (4) 3.]

3. The licensee has failed to ensure that a PASD under subsection (3) used to assist a resident with a routine activity of living may only be included in the resident's plan of care if the use of the PASD has been consented to by the resident, or if the resident is incapable, a substitute-decision maker (SDM) of the resident with authority to give that consent.

On approximately six occasions throughout the inspection, Inspector #593 observed resident #001 with a PASD in use. A review of the resident's current plan of care found no mention of the use of a PASD for this resident including consent by the resident's SDM.

A review of the home's Policy: PASDs NM-E-11 dated April, 2015, documented that a PASD is a device used to assist a person with a routine activity of living. A PASD may limit or inhibit movement and may restrain a resident but is not considered a restraint if the intent is to provide assistance with activities of daily living. The prescribing physician is required to obtain informed consent for the treatment from the resident and or the SDM.

During an interview with the inspector, S# 104 reported that the PASD was used to prevent the resident from falling as well as to hold the resident's belongings. S# 104 further reported that there was nothing documented in the resident's plan of care about the PASD.

During an interview with Inspector #593, S# 111 reported that resident #001 used the PASD for positioning and activities and it was used upon resident request. They further added that there was nothing in the resident's plan of care related to the use of the PASD including consent from the resident's SDM. They believed that the home's process for PASD use was missed for this resident which is why the consent from the SDM was not available. [s. 33. (4) 4.]

WN #10: 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 resident #006 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #006 exhibited altered skin integrity and had two wounds.

During an interview, the DOC indicated that the home's skin assessment instrument is within POC and is to be completed daily by staff and after any dressing change.

The inspector reviewed the resident's TAR and progress notes to determine the dates the resident received dressing changes between a two week time period. The inspector noted that the five completed wound assessments only identified the one area of altered skin integrity, however, the other area was not assessed.

The DOC confirmed that staff should be completing wound assessments for both wounds, and were only completing the wound assessment on one of the wounds. [s. 50. (2) (b) (iv)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been:

* investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and
* where the complaint alleges harm or risk of harm to one or more residents, the investigation commenced immediately.

According to a progress note, a complaint was made to a staff member regarding resident #007. The person informed the staff that they wanted to make a complaint and was then assured the issue would be investigated.

The inspector reviewed the resident's progress notes and noted after the person brought it forward, the next note regarding the complaint was 11 business days later and indicated that the person was contacted and the concern was discussed and resolved.

During an interview regarding the complaint, the DOC indicated they were away when the complaint was made, and upon their return, they were not made aware of the complaint immediately. The DOC indicated that they started an investigation and spoke to the complainant the next day with the findings from the investigation. Then, 15 business days later a response letter was mailed to the complainant regarding their findings and actions taken. [s. 101. (1) 1.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (6) Where a resident of the home is permitted to administer a drug to himself or herself under subsection (5), the licensee shall ensure that there are written policies to ensure that the residents who do so understand,
(a) the use of the drug; O. Reg. 79/10, s. 131 (6).
(b) the need for the drug; O. Reg. 79/10, s. 131 (6).
(c) the need for monitoring and documentation of the use of the drug; and O. Reg. 79/10, s. 131 (6).
(d) the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room under subsection (7). O. Reg. 79/10, s. 131 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that where a resident is permitted to administer a drug to himself or herself, the licensee ensures that there are written policies to ensure that the residents who do so understand:
(a) The use of the drug
(b) The need for the drug
(c) The need for monitoring and documentation of the use of the drug, and
(d) The necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room.

Inspector #575 was told by S #104 that resident #015 had a physician's order to self-administer a certain medication and keep the medication at their bedside. The inspector reviewed the resident's MAR and noted an order for the medication at the bedside.

The inspector interviewed resident #015 regarding their medication. The resident stated that they have the medication at their bedside because they know how to use it. The inspector asked if the resident advised the staff when they used the medication and they indicated that they use it once or twice per day but that they do not advise staff when they use it.

The inspector reviewed the resident's MAR for a period of approximately three months and noted no documentation of the use of the medication.

The inspector reviewed the home's 'Resident Self Medication' policy last revised May 2014 provided to the inspector by the DOC. The policy indicated that the physician would counsel the resident as to the proper time of administration, safe storage in a locked container or fridge and possible adverse effects. The policy did not outline the need to ensure that resident's understand the need for monitoring and documentation of the medication and what that would include. [s. 131. (6)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were provided training in falls prevention and management annually.

Inspector #594 interviewed S #123 and S #105 who stated that they were unsure if they received falls prevention and management training in 2014. S #105 demonstrated to the inspector their online staff education record and were unable to locate training documentation in falls prevention and management for 2014.

Inspector #575 requested the falls prevention and management training records from S #115 for 2014. S #115 told Inspector #575 that no falls prevention and management training had been provided to direct care staff in 2014. [s. 221. (1) 1.]

Issued on this 9th day of November, 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) :	LINDSAY DYRDA (575), GILLIAN CHAMBERLIN (593), MONIKA GRAY (594)
Inspection No. / No de l'inspection :	2015_332575_0015
Log No. / Registre no:	018920-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 29, 2015
Licensee / Titulaire de permis :	ALGONQUIN NURSING HOME OF MATTAWA LIMITED 231 TENTH STREET, P.O. BOX 270, MATTAWA, ON, P0H-1V0
LTC Home / Foyer de SLD :	ALGONQUIN NURSING HOME OF MATTAWA LIMITED 231 TENTH STREET, P.O. BOX 270, MATTAWA, ON, P0H-1V0
	Jeremy Stevenson

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

Name of Administrator /
Nom de l'administratrice ou de l'administrateur :

To ALGONQUIN NURSING HOME OF MATTAWA LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

The licensee shall ensure that for each of the following programs: Falls prevention and management; Skin and wound care; and Continence care and bowel management, that there is a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written description of the Falls Prevention and Management program that included its:
   * goals and objectives

* relevant policies, procedures, protocols
* methods to reduce risk
* methods to monitor outcomes, and
* protocols for referral of resident to specialized resources where required.

Inspector #594 requested the documented falls prevention and management program. The DOC provided the inspector with the 'Terms of Reference Falls Prevention Program' policy #MP-A-01 and 'Falls Prevention Program' policy #NM-E-05. The inspector reviewed the policies which failed to include relevant procedures, protocols, methods to reduce risk, methods to monitor outcomes and protocols for referral of the resident to specialized resources where required.

During an interview, the DOC indicated to the inspector how the licensee fulfills the falls prevention and management program requirements but validated that there was no written description as required by legislation. (594)

2. The licensee has failed to ensure that there was a written description of the Continence Care and Bowel Management program that included its:
* goals and objectives
* relevant policies, procedures, protocols
* methods to reduce risk
* methods to monitor outcomes, and
* protocols for referral of resident to specialized resources where required.

The DOC provided Inspector #575 the home's continence care and bowel management program binder. The inspector reviewed the contents of the binder which included the home's policy titled 'Continence Program' last reviewed May 2015, products, education, surveys, product assessment forms, and emergency sign out sheets. The inspector noted that the program policy did not include any methods to reduce risk, methods to monitor outcomes, nor any relevant procedures or protocols as required.

During an interview, the DOC confirmed to the inspector that the home's written program did not meet the requirements of the legislation. (575)

3. The licensee has failed to ensure that there was a written description of the Skin and Wound Care program that included its:
* goals and objectives

* relevant policies, procedures, protocols
* methods to reduce risk
* methods to monitor outcomes, and
* protocols for referral of resident to specialized resources where required.

Inspector #575 requested to review the home's skin and wound care program. The DOC indicated that the home did not have a skin and wound care program or policy in writing that met the requirements set out in the Regulations. The DOC indicated that staff follow the CCAC wound care protocol for wound care guidance. The inspector reviewed the CCAC wound care protocol which provided wound descriptors used to select the appropriate dressing protocols and did not provide for the requirements as indicated in the Regulations. (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 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. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan ensuring that a registered dietitian (RD) who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

This plan shall include how the licensee will ensure that the RD who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month.

This plan must also include a schedule identifying when the RD will be on site for October, November, and December 2015.

This plan may be submitted in writing to Lindsay Dyrda, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, by email: lindsay.dyrda@ontario.ca, or by fax: 705-564-3133.

This plan must be submitted by October 14, 2015, and fully implemented by November 30, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that a registered dietitian (RD) who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

During the inspection, Inspector #593 asked the S #203 when S #201 was scheduled to be on site to speak with the inspector. S #203 reported that S #201 only visits once every three months.

During an interview, S #203 indicated that S #201 is on site at the home once every three months for three full days. In between visits, S #201 uses Skype and e-mail to communicate with the home and the they work a full day every Thursday remotely, as they have remote access to Point Click Care (PCC). S #203 further reported that S #201 regularly (weekly) speaks with staff in the home about the residents as part of their off site assessments. The off site hours are included in the S #201's total hours for the home each month.

The inspector interviewed the S #201 via telephone. S #201 reported that for a period of approximately six months, they completed a total of 267 hours which was equivalent to 38 hours per month. They confirmed that they are usually on site only once every three months and occasionally they are on site every two months. In an email correspondence, S #201 indicated that in 2015 they were on site for 24 hours in March and then not back on site until July for 24 hours. The inspector noted S #201 was only on site for two out of seven months.

The home has 73 residents, therefore the on site RD hours at a minimum are required to be 36.5 hours per month. [s. 74. (2)] (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 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 29th day of September, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lindsay Dyrda

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