Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 8, 19, 20, 21, 22, 24, 25, 26, 27, 28, 29, Jul 11, 2012	2012_074171_0007	Resident Quality Inspection

Licensee/Titulaire de permis

THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA
155 PANIN ROAD, BURLINGTON, ON, L7P-5A6

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

CAMA WOODLANDS NURSING HOME
159 PANIN ROAD, BURLINGTON, ON, L7P-5A6

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

ELISA WILSON (171), GILLIAN HUNTER (130), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN) Registered Practical Nurses (RPN), Registered Dietitian (RD), Food Services Manager (FSM), Physiotherapist, Building Services Manager, Personal Support Workers (PSW), Dietary Workers, Business Manager, residents and family members of residents.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage areas and care provided to residents, reviewed medical records and plans of care for identified residents, reviewed policies and procedures of the home, and observed the general maintenance, cleaning and condition of the home.

H-001042-12

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Quality Improvement

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

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
(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 that was instituted or otherwise put in place was complied with. [O.Reg. 79/10, s.8(1)(b)]

a) The home did not comply with their policy and procedure "Falls Prevention and Management - 08-14-01".

i) The procedure indicated that "The Registered Staff will complete the Risk of Falls Assessment - with quarterly documentation". During a review of the clinical records of two residents (#542, #562) it was identified that fall risk assessments were not completed or documented on a quarterly basis. Interview with the RN confirmed that prior to the implementation of Minimum Data Set (MDS), fall risk assessments were conducted on a quarterly basis. Currently the home conducts fall risk assessments on an "as needed basis", for example when a resident has multiple falls.
ii) The procedure indicated that "The DOC will complete a post fall investigation report". During an interview with the DOC it was confirmed that the DOC does not complete a post falls investigation report after each fall and that an identified RPN is the lead for falls management and chairs the monthly falls prevention committee. The RPN confirmed that "Post Fall Investigation" reports are not completed following each fall - that reports are completed on a few residents each month, for example high risk fallers. (168)

b) The licensee did not ensure that policies regarding weight monitoring were complied with.

The home Policy - Changes in Weight 05-02-07 indicated the food services manager would request a reweigh of the resident if the weight appears questionable. The food services manager confirmed this practice indicating a difference of 2.5kg in one month would be flagged for a reweigh. The policy also indicated the registered staff would record a significant weight change in the residents' progress notes.

Resident #619 had a significant weight change of 8.5% in one month. There were no reweighs recorded of the weight which was more than 2.5kg different from the previous month. There were no progress notes by registered staff regarding the significant weight change.

The food service manager confirmed a reweigh would be indicated in the weights section of point click care and there was not one completed for this resident. (171)

c) According to the home's policy "Processing Physician Medication Reviews 2.6", it is the expectation for the Nurse preparing the review: (a) The review was compared to the last review/admission orders in the resident's chart, (b) Every order, including non drug orders, written after the last review/admission up to the day the physician signs the review are present on the current review.

Registered staff obtained a verbal order from the physician for a restraint to be applied for resident #204. The verbal order was not recorded on the quarterly medication review which was signed by the physician after the verbal order was given. Registered staff confirmed there was no current physician's order for the device and that staff did not process the order on the quarterly medication review, in accordance with policy. (130)

d) According to the "Skin Care Program 05-07-21" , The skin integrity of all residents was to be monitored each time care was provided. Assessment of change was to be completed and documented by a Registered Staff in progress notes, on "Weekly Wound/Skin Assessment Summary, and on 24-hour report. Reassessment of area(s) was to occur at least weekly by Registered Staff or Skin Care Coordinator, (Nurse Practitioner or Physician prn) until healed and is to be summarized on "Weekly/Skin Assessment Summary". Registered Staff and the Director of Care confirmed that staff did not consistently record assessment findings for resident #548, in the progress notes and/or the Weekly/Skin Assessment record.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the homes polices regarding medication reviews, skin care program, falls management and weight monitoring are complied with, to be implemented voluntarily.

WN #2: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change. [LTCHA, 2007 S.O. 2007, c.8, s.6(10)(b)]

According to the minimum data set assessment (MDS) resident #548 had two skin integrity issues. The same assessment indicated one issue was healed but the other was present. The "skin/wounds" notes identified one issue was healed. The "skin integrity" report indicated the resident had a different skin condition develop later. The plans of care had not been revised when the status of the resident's skin condition changed and only indicated dry skin as a focus for skin integrity throughout the time period.

2. The licensee had not ensured that there was a written plan of care that sets out the planned care for all residents. [LTCHA, 2007 S.O. 2007, c.8, s.6(1)(a)]

Resident #615 indicated in an interview a preference for a specific time to go to bed which had been communicated at admission. The written plan of care does not include the resident's current bedtime request.

Two registered staff confirmed the plan of care does not include resident bedtime preferences and this information was not available to the PSWs who assist the residents with bedtime care.

3. The licensee had not ensured the written plan of care provided clear direction to staff who provide direct care to the resident. [LTCHA, 2007 S.O. 2007, c.8, s.6(1)(c)]

a) The plan of care found in point click care for resident #562 identified that the resident is to use specific devices for safety. Posted sign of safety devices for this resident indicated different directions from what was in point click care. Interviews with staff indicated that some are following the plan and others are not. The information available in the plan of care and other signage for staff regarding the needs of the resident is not clear. (168)

b) The plan of care reviewed on June 25, 2012 for resident #579 indicated "Report any redness, inflammation, or drainage at ostomy site". Two registered staff confirmed the resident does not have an ostomy. This statement does not provide clear direction to the staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the written plan of care sets out the planned care for the resident and clear directions to staff who provide care and that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee had not ensured that an individualized menu was developed for each resident whose needs could not be met through the home's menu cycle.

Resident #616 was on a specific therapeutic diet. The resident expressed a number of concerns about the choices offered on the diet.

The diet provided to this resident was restricted in certain nutrients, however the resident was receiving these nutrients in a supplement daily.

An individualized menu to reflect nutrient requirements and the resident's likes/dislikes was not developed. This was confirmed by the registered dietitian and the food services manager.

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 individualized menus are developed for each resident whose needs can not be met through the home's menu cycle, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following subsections:

s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The food production system did not provide for the preparation of all menu items according to the planned menu. [O.Reg. 79/10, s.72(2)(d)]

Breakfast meal service was observed on June 26, 2012. It was noted that the planned and posted menu included a choice of scrambled eggs and raisin bread. These two choices were not prepared and available to the residents at this meal. Muffins were served in place of raisin bread however there were no substitutions for the scrambled eggs. The missing items were confirmed by the staff person serving the meals.

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 all menu items are prepared according to the planned menu, to be implemented voluntarily.

WN #5: 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 subsections:

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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has not ensured that all areas of the home are kept clean. [LTCHA, 2007 S.O. 2007, c.8, s.15(2)(a)]

During a tour of the home on June 19, 2012, it was identified that some of the wall surfaces in the main dining room were soiled with food debris. This soiling was still present on June 22, 2012, when observed by the Building Services Manager. It was also observed that the flooring in the main dining room and Cama Cafe had a build up of debris, especially in the corners and where the floor meets the wall.

2. The licensee has not ensured that the furnishings and equipment are maintained in a good state of repair. [LTCHA, 2007 S.O. 2007, c.8, s.15(2)(c)]

a) It was observed that many of the wooden table legs and wooden chair surfaces in the dining room and Cama Cafe had the finish worn off. The condition of the wooden surfaces makes it difficult for staff to clean the area and the surfaces were not smooth to touch. Interview with the Building Services Manager confirmed the condition of the surfaces and indicated that in the past the home has touched up these surfaces to correct this situation.

b) It was observed that a chair in a resident room was not sturdy, as it wobbled when touched. The condition of this chair was confirmed by the Building Services Manager.

c) It was observed that the bed rail padding in another resident room was cracked and the inside lining was visible in some areas. It was identified in the laundry room that there were two other bed rail pads in storage which also demonstrated wear. The Building Services Manager confirmed that the home has a new supply of these pads in storage and that the worn items would be discarded immediately.

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 all areas of the home are kept clean and all home furnishings and equipment are maintained in a good state of repair, to be implemented voluntarily.

WN #6: 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 are kept inaccessible to residents at all times. [O.Reg. 79/10, s.91]

On June 19, 2012, during a tour of the home a number of hazardous substances were accessible to residents in the following locations:
1. In the unlocked and unattended spa area on the "B" wing
a) a 4 liter bottle of "Arjo" disinfectant cleanser which contains a warning of poison and corrosive
b) a bottle of "Total 10R" cleanser which contains a warning of highly irritating and corrosive

2. In the unlocked and unattended Cama Cafe
a) a bottle of "Total 10R" cleanser which contains a warning of highly irritating and corrosive
b) three bottles of silver polish which identifies avoid eye and skin contact and do not ingest
c) a spray can of "Rust-oleum" clear spray paint which contains a warning of poison

3. In the unlocked and unattended spa area on the "A" wing
a) a 4 liter bottle of "Arjo" disinfectant cleanser which contains a warning of poison and corrosive
b) a bottle of "Total 10R" cleanser which contains a warning of highly irritating and corrosive.

The accessibility of these products was communicated with the DOC who confirmed they are hazardous and should be in a locked area. The hazardous substances identified were removed from resident accessible locations.

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee did not ensure that all of the requirements were met with respect to the restraining of residents by a physical device under section 31 of the Act. [O.Reg. 79/10, s.110(1)]

Residents #002, #588, #204, #019 and #1092 did not have staff apply their restraints in accordance with manufacturer's instructions.

The identified residents were observed with their restraints applied incorrectly. The home policy "Guidelines for Restraint Use 08-09-01" directs staff that "all physical restraints must be used in accordance with manufacturer's instructions". No hard copy of manufacturer's instructions was available for staff.

Interview with the DOC confirmed that staff had been informed regarding the correct application of the restraints. Interviews with two RPN staff on June 22, 2012, confirmed the incorrect application of the devices that day.

2. Staff did not apply a physical device as ordered by the physician. [O.Reg. 79/10, s.110(2)1]

Resident #562 had a current physician's order, on the Quarterly Medication Review for a specific restraint for safety. According to the record, following a trial, staff deemed that the restraint was no longer needed and the device had not been used since that date.

Interview with the RN confirmed that the resident had a current restraint order in place and that the device is not being applied as ordered.

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 all of the requirements are met with respect to the restraining of residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee did not ensure that restraining by a physical device was in accordance with the LTCHA s. 31 (2) 2, 3, 4. [LTCHA, 2007 S.O. 2007, c.8, s.30(1)3]

a) Resident #204 was observed with a restraint applied. Staff verified that the device was being used as a restraint. Staff also confirmed there was no physician's order for the restraint, there was no restraint assessment completed, and no reference for the need of the device in the plan of care.

b) Resident #559 was observed on two occasions with a potential restraint in place. Staff interviewed confirmed the device was being used as a restraint. The plan of care indicated the resident was to have this restraint in place, however, there was no physician's order, consent, assessment, nor restraint monitoring flow sheet in place. The DOC confirmed that staff are required to obtain consent, an order and complete all other applicable restraint documentation whenever this particular restraint is being used.

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 restraining by a physical device is in accordance with the Act, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions. [O.Reg. 79/10, s.26(3)15]

Resident #619 returned to the home and a skin assessment identified altered skin integrity. According to skin/wound notes the resident had two specific skin integrity issues at that time. The plan of care did not include the resident's risk of skin breakdown, goals, strategies to minimize risk nor did the plan identify areas of existing breakdown and interventions to promote healing. This information was verified by staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the plan of care is based on interdisciplinary assessments of resident's skin condition, altered skin integrity and foot conditions, to be implemented voluntarily.

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 subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(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;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home and any changes made to the resident's plan of care relating to nutrition and hydration were implemented. [O.Reg. 79/10, s.50(2)(b)(iii)]

According to an assessment completed by the Registered Dietitian (RD) , resident # 548 was to receive a specific supplement at nourishment to increase protein and calories. According to the RD's next quarterly assessment, the supplement previously ordered had not been implemented. The RD confirmed that the resident had not been receiving the supplement.

2. The licensee did not ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed weekly by a member of the registered nursing staff, if clinically indicated. [O.Reg. 79/10, s.50(2)(b)(iv)]

a) The minimum data set (MDS) assessments for two quarters, indicated resident #548 had skin integrity issues. Clinical records reviewed showed the resident did not have a weekly skin assessment completed consistently for four months. This was confirmed by registered staff and the DOC.

b) Resident #619 returned to the home with two skin integrity issues. Registered staff did not complete a weekly assessment of these areas. Registered staff and the DOC confirmed this lack of assessment.

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 residents exhibiting altered skin integrity are assessed weekly by a member of the registered nursing staff and that changes made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provide direct care to residents, receive training in specific areas, at the times or intervals as provided for in the regulations: how to minimize the restraining of residents and where restraining is necessary, how to do so in accordance with the Act and the regulations. [LTCHA, 2007 S.O. 2007, c.8, s.76(7)4]

It was observed that not all restraints were applied according to manufacturers specifications. Two RPN staff interviewed regarding the application of the devices indicated that they were not aware of the manufacturers specifications for use. During an interview with the DOC it was confirmed that the staff received training regarding how to restrain residents in accordance with the Act and regulations during their orientation, however not yearly as required in regulation 221 of Ontario Regulation 79/10.

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 who provide direct care to residents receive training in the intervals provided for in the regulations, to be implemented voluntarily.

WN #12: 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 subsections:

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 respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. [LTCHA, 2007 S.O. 2007, c.8, s.57(2)]

The President of the Council stated when the Council raised concerns or made suggestions, the home responded in writing however the response was not presented to the Council until the next scheduled monthly meeting. The Administrator and the Council Assistant confirmed the home did not respond to concerns or suggestions in writing within 10 days.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following subsections:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. [LTCHA, 2007 S.O. 2007, c.8, s.85(3)]

The President of the Residents' Council stated the Residents' Council had not participated in developing and carrying out the satisfaction survey. This information was verified by the Administrator.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee did not ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. [O.Reg. 79/10, s.124]

The medication storage room contained, 110 dimenhydrinate 50 mg suppositories, 20 bottles of alugel, 400 dulcolax suppositories, 600 tabs aspirin 325 mg, 600 capsules of potassium . The DOC confirmed the amount exceeded the home's three month usage.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.TABLEHomes to which the 2009 design manual appliesLocation - LuxEnclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughoutAll corridors - Minimum levels of 322.92 lux continuous consistent lighting throughoutIn all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 luxAll other homesLocation - LuxStairways - Minimum levels of 322.92 lux continuous consistent lighting throughoutAll corridors - Minimum levels of 215.28 lux continuous consistent lighting throughoutIn all other areas of the home - Minimum levels of 215.84 luxEach drug cabinet - Minimum levels of 1,076.39 luxAt the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 luxO. Reg. 79/10, r. 18, Table.

Findings/Faits saillants :

1. The lighting requirements as set out in the table are not consistently maintained for the corridors and in all other areas of the home. [O.Reg. 79/10, s.18]

Lighting levels were measured with a light meter on June 25, 2012, in the presence of the Building Services Manager. It was confirmed that lighting levels in the "B" wing corridor were not at a minimum level of 215.28 lux continuous consistent lighting. Levels registered as high as 324 lux in some areas of the corridor and dropped to below 60 lux in other areas between fixtures. The lighting level in the small lounge was recorded at 190 lux which is below the requirement of 215.28 lux.