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

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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
Mar 10, 2015	2015_363591_0001	T-1650-15	Resident Quality Inspection

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

COLEMAN CARE CENTRE
140 CUNDLES ROAD WEST BARRIE ON L4N 9X8

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

NATASHA JONES (591), ANN HENDERSON (559), JANET GROUX (606)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 12, 13, 14, 15, 16, 18, 19, 20, 21, 23, 26, 27, 2015.

This inspection was conducted concurrently with critical incident inspection T-1306-14.

During the course of the inspection, the inspector(s) spoke with the general manager (GM), director of nursing (DON), director of recreation services (DRS),director of food services (DFS), maintenance staff, recreation aide (RA), registered nursing staff, housekeeping staff, personal support worker (PSW), and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

12 WN(s)
5 VPC(s)
0 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system that is required by the act or regulation to be put in place is complied with.

Record review and registered staff interviews identified resident #8 as requiring a weekly pain assessment to be completed. The home's policy titled Pain Management Program states when a resident is receiving regularly prescribed medication for the relief of pain, the resident will be assessed weekly by the registered staff using the Weekly Pain Assessment tool to determine the effectiveness of the medication.

Documentation of the Weekly Pain Assessment tool revealed resident #8 did not receive an assessment on an identified date.

An interview with the DON confirmed registered staff did not complete a weekly pain assessment and confirmed the policy had not been complied with. [s. 8. (1)]

2. Record review of the policy titled Nutrition and Hydration, reviewed April 2014 revealed commercial supplementation or alcoholic beverages will be documented on the medication administration record (MAR) and the Daily Additional Fluids charts. This will be completed by registered team members. The ingested supplementation will be part of the resident's fluid monitoring and documentation.

Interviews with PSW's revealed they do sign for total fluid intake including commercial supplements and protein powders on the Nutrition and Hydration flow sheets.

Interview with an identified registered staff revealed the registered staff do not sign the MAR for commercial supplements or protein powders and the PSW's sign for total fluid intake including commercial supplements and protein powders on the Nutrition and Hydration flow sheets.

An interview with the DFS confirmed the registered staff sign the MAR for an identified commercial supplement but not for other identified commercial supplements or protein powder supplements, and further confirmed all supplements should be monitored and signed for in the MAR by registered staff. [s. 8. (1) (b)]

3. Record review identified resident #6 as a moderate falls risk. The home's policy titled Fall Prevention and Management [LTC] directs staff in all cases to notify the family or power of attorney (POA) by the registered team member on the neighbourhood where the fall occurred.

On an identified date, resident #6 fell and the 2 identified registered staff failed to notify the family. This was confirmed in interviews with both registered staff.

The DON confirmed registered staff failed to follow the policy. [s. 8. (1) (b)]

4. Record review of the policy titled "College of Nurses of Ontario Standards re Delegation of Duties", reviewed on January 10, 2014, revealed the physician or registered team member must teach the RN, RPN, or PSW how to perform the skill and it must involve an oral discussion as well as a visual demonstration.

Record review of the delegation of duties binder revealed the identified PSW had not had been delegated by a registered staff to perform the controlled act.

Interview with an identified PSW revealed he/she had administered an identified topical medication to resident #4, but had not had been delegated by a registered staff to administer it.

Interview with the DON revealed PSW's must be delegated by a registered staff to administer topical medication and confirmed the policy had not been complied with. [s. 8. (1) (b)]

5. Record review identified resident #7 as a low falls risk. The home's policy titled Fall

Prevention and Management [LTC] directs staff in all cases:

1- to notify the family or power of attorney (POA) by the registered team member on the neighbourhood where the fall occurred.
2- if there were no witnesses to the fall a head injury routine is followed.
3- the registered team member is required to complete the remainder of the form.

On an identified date, resident #7 had an unwitnessed fall. An identified registered staff failed to contact the family, commence a head injury routine and complete the remainder of the form. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system that is required by the act or regulation to be put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure where bed rails are used steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Record review of the document titled Bed Entrapment Inspection completed on an identified date, confirmed resident #9's bed failed the inspection in zones 2, 3, and 4 and was missing mattress corners to prevent the mattress from sliding, moving and creating gaps.

An interview with the GM on January 21, 2015, confirmed the bed entrapment inspection was completed on an identified date, and no action had been taken to correct resident #9's bed. [s. 15. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure where bed rails are used steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Observations of resident #36 revealed the resident was provided with and ingested 1 bottle of supplement in the dining room during the lunch meal.

Record review of resident #36's MAR revealed there is a physician's order for the above mentioned supplement to be given twice daily (lunch and dinner), however, there was no corresponding signature to confirm the supplement had been given to the resident.

Record review of resident #36's current care plan revealed the resident had been identified by the registered dietician as high risk.

Record review of resident #36's Nutrition and Hydration Flow sheet revealed the PSW's record the daily total fluid intake which includes the supplement in the total.

Interview with the DFS revealed resident #36's supplement intake is not being monitored and confirmed that supplements require monitoring, and should be signed for by registered staff in the MAR. [s. 68. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area that is used exclusively for drugs and drug-related supplies, and that the area is secure and locked.

Observations of the clean utility rooms in the home revealed that topical medications are kept in bins on the treatment carts. The clean utility room is used for storage of linen, personal hygiene care products and supplies. The clean utility room is kept locked at all times, but the key is hanging on the front of the door.

Interviews with identified PSWs and registered staff revealed the topical medications are kept in the clean utility room and the room key is kept hanging on the outside of the door.

Interview with the DON confirmed the clean utility room is not an area used exclusively for drugs and is not secure. [s. 129. (1) (a)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

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

Record review and staff interviews revealed resident #8 as having pain related to medical conditions. An interview with the resident and staff revealed the resident informs staff when he/she is having pain and registered staff administer pain medications. An identified registered staff confirmed the resident's response and effectiveness are to be documented on the MAR.

Record review of the MAR for resident #8 revealed that an identified analgesic medication was given to the resident on 3 identified dates for pain and the effectiveness was not documented on the MAR.

The DON confirmed the resident's response and effectiveness to the medications were not documented on the MAR. [s. 134. (a)]

2. Record review and staff interviews reveal resident #9 as having pain related to medical conditions.

An interview with the resident and staff identified the resident informs staff when he/she is having pain and registered staff administer pain medications. An identified registered staff confirmed the resident's response and effectiveness are to be documented on MAR.

Record review of the MAR for resident #9 revealed that an identified medication was given to the resident on an identified date and time, for a temperature of 38.2 celsius. On an identified date and time, an identified medication was given also given for left sided pain and the effectiveness and outcomes were not documented.

The DON confirmed the resident's response and effectiveness to the medications were not documented on the MAR [s. 134. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for the resident taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

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

Findings/Faits saillants :

1. Record review and staff interviews reveals resident #8 has pain identified as a concern in the plan of care. The resident requires regular medication for pain and will request breakthrough medication on an as needed basis. The resident uses hot packs, physiotherapy interventions and rest for pain management. The registered staff are to complete a weekly pain assessment tool and document results in progress notes.

Review of the weekly pain assessment tool and progress notes reveal the weekly pain assessment for an identified date, was not completed and this was confirmed by an identified registered staff.

The DON confirmed the weekly pain assessment set out in the plan of care was not provided to the resident. [s. 6. (7)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to minimize restraining of residents is complied with.

Record review of resident #9's written plan of care indicates 2 full side rail restraints are to be up when the resident is in bed.

Interviews with registered staff and PSWs confirmed that the full side rails are restraints.

Record review of the home's restraint policy reveals that for all restraints in use, the following will be completed and documented: the restraint will be examined at least every hour by the PSWs to ensure that the restraint is intact and the resident is comfortable (safety check), the resident will be released and repositioned at least every two hours or more frequently as required.

Record review of the Restraint Monitoring Chart identified missing documentation on 6 identified dates between September 2014 and January 2015.

An interview with the DON confirmed the PSWs failed to follow the home's policy to minimize the restraining of residents. [s. 29. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review of resident #9's written plan of care reveals staff are to document nutritional and fluid intake on the Nutrition and Hydration Flow sheet.
Review of the Nutrition and Hydration Flow sheet identifies missing documentation on identified dates between September and December 2014.

An interview with the DON confirmed the PSWs failed to document the resident's nutritional and fluid intake on the identified dates. [s. 30. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home responds in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review and an interview with the GM and president of Residents' Council revealed some concerns or recommendations are responded to verbally.
Residents' Council minutes for an identified date, revealed two concerns:

1- wandering residents : the residents want to know what to do about this?
2- can we have the heat turned on in the family room for winter months?

The GM confirmed he/she had not responded in writing within 10 days to Residents' Council. [s. 57. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 58. Residents' Council assistant

Specifically failed to comply with the following:

s. 58. (1) Every licensee of a long-term care home shall appoint a Residents' Council assistant who is acceptable to that Council to assist the Residents' Council. 2007, c. 8, s. 58. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has appointed an assistant to the Residents' Council to assist the Council.

Record review and an interview with the GM and president of the Residents' Council revealed different staff attend and take minutes at the Residents' Council meetings.

The GM and DRS confirmed the home has not appointed an assistant to the Residents' Council to assist the Council. [s. 58. (1)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, established by the regulations, specifically copies of the inspection reports from the past two years for the long-term care home.

During the initial tour of the home, the following inspection reports were not posted: 2013_168202_0022, and 2013_168202_0023.

An interview with the GM confirmed the above mentioned inspection reports had not been posted. [s. 79. (3) (k)]

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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a member who is not otherwise permitted to administer a drug to a resident in the home has been trained by a member of the registered nursing staff in the administration of topicals.

Record review of resident #4's Treatment Administration Record (TAR) revealed an identified PSW documented the administration of an identified topical medication.

Record review of the delegation of duties binder revealed the identified PSW had not had been delegated by a registered nursing staff to administer topicals.

Interview with an identified PSW revealed he/she administered the topical to resident #4 and did not receive training to do so.

Interview with the DON confirmed the identified PSW had not been trained and delegated to administer topicals. [s. 131. (4)]

Issued on this 24th day of March, 2015

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

Original report signed by the inspector.