Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 6, 2014	2014_275536_0022	H-001171-14	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF DUFFERIN
151 Centre St, SHELBURNE, ON, L0N-1S4

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

DUFFERIN OAKS
151 CENTRE STREET, SHELBURNE, ON, L0N-1S4

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

CATHIE ROBITAILLE (536), KATHLEEN MILLAR (527), LEAH CURLE (585)

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): September 2, 3, 4, 5, 9, 10, 11, 2014

This RQI inspection was conducted simultaneously with Log #H-000654-14, H-000671-14 and H-000716-14.

During the course of the inspection, the inspector(s) spoke with residents, family members,regulated and unregulated workers, dietary staff, Dietary Manager, Dietitian, Social Worker, Program and Services Co-Ordinator, Maintenance Manager, Registered Staff, Physiotherapist, Resident Assessment Instrument-Material Data Set Co-Ordinator(RAI-MDS), Assistant Director of Care (ADOC), Director of Care (DOC)and the Administrator.

During the course of the inspection, the inspector(s) Toured the home, observed care and services, interviewed staff, residents and families, reviewed clinical records, business files and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Trust Accounts

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family

and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident has the right to be afforded privacy during treatment and in caring for his or her personal needs.[3(1)8]

A)On an identified date in 2014 at approximately 1600 hours (hrs), on an identified floor, the Registered Practical Nurse (RPN) was observed testing resident #201's blood glucose in a common area, with other residents present. The RPN told the resident their blood glucose value at a volume audible to other residents in the area. The RPN was then observed administering insulin in the resident's arm, once again in front of other residents. (585)

B)On an identified date in 2014, at approximately 1620 hrs, on an identified floor, the previously identified RPN was observed administering insulin to resident #202 in the lounge in front of other residents. The Director of Care verified that resident should be offered privacy during any type of treatment or invasive procedure.(536) [s. 3. (1)]

2. The licensee failed to ensure that every resident has the right not to be neglected by staff.[3(1)3]

On an identified date in 2014, at approximately 0700 hours (hrs), resident #200 who had been declared palliative care, was moaning, and the Personal Support Worker (PSW) on duty twice requested that the Registered Practical Nurse (RPN) on duty observe the resident who was exhibiting signs of pain. The RPN did not go to the resident's room to assess or give the ordered pain medication. Resident #200 had received a recent order for pain analgesic, every two hour as needed (Q2hPRN). When the RPN refused the second time to assess the resident, the PSW called the Registered Nurse/Unit Co-Ordinator (RN/UC)on duty who could hear the resident moaning while speaking with the staff on the phone. The RN/UC then approached the RPN who verified that they had been advised twice by the PSW that the resident was moaning and appeared in pain, and that they would get there when they got there. The RN/UC offered to administer the analgesic at that time and the RPN agreed. The investigation notes identified that the resident had waited over three hours for the pain medication to be given. The Director of Care(DOC)verified that following the home's investigation, it was considered incompetent treatment/neglect and failure to provide appropriate analgesic for adequate pain control to a resident. The RPN was disciplined.(536) [s. 3. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the resident has the right to be afforded privacy and the right not to be neglected, 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:

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

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

Findings/Faits saillants :

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

A) Resident #008 had an Material Data Set(MDS)and Resident Assessment Protocol's (RAPs) assessment conducted on an identified date in 2014. It identified that the resident is on a scheduled toileting plan for continence. The bladder and bowel assessment from the identified date in 2014 stated the method for continence restoring is prompted voiding and urinal. The documents which the RPN's and PSW's use to direct care called the care plan and kardex identified that the resident is on an incontinent program. This intervention included toilet before and after meals and at bedtime and wears an identified size brief. The assessments and the documents which directed the care of the resident did not set out clear directions to staff and others who provide direct care to the residents. The staff and the Assistant Director of Care (ADOC) confirmed the plan of care did not provide clear direction to staff and

others who provide direct care to the resident.(527)

B) Resident #022 had an MDS and RAPs assessment conducted on an identified date in 2014. It identified that the resident was on a scheduled toileting plan for continence. The bladder and bowel assessment from an identified date in 2014, identified the resident was on a toileting routine for both bladder and bowels, and the method for continence restoring was prompted voiding. The documents which the RPN's and PSW's used to direct care called the care plan and kardex identified interventions for bladder function was to note any changes in amount, frequency, colour or odour and quantity; wears a pull up during the day. For bowel function it identified changes in bowel function. In addition, the care plan under the "Transferring" section, which was initiated and created on an identified date in 2013, stated the resident was on a Restorative program to establish a toileting schedule to suit the resident's needs. The bladder and bowel assessment, the MDS quarterly assessment and the documents used to direct the care of the resident, had different programs and interventions for the resident. The assessments and the documents which directed the care of the resident did not set out clear directions to staff and others who provided direct care to the residents. The staff and the Assistant Director of Care (ADOC) confirmed the plan of care did not provide clear direction to staff and others who provide direct care to the resident. (527)

C) Resident #031 had an MDS and RAPs assessment conducted on an identified date in 2014. It identified that the resident was using briefs for dribbling; however, the resident knew when they needed to go to the bathroom. The bladder and bowel assessment from identified dates in 2014 confirmed the resident used briefs for dribbling during the day and needed a pull up at night. The documents, which the RPNs and PSWs use to direct care called the care plan and kardex did not identify bladder and bowel needs of the resident based on the assessments. RPN's and PSW's confirmed the interventions on the care plan were confusing as it did not reflect the care the resident was being provided. The assessments and the documents which directed the care of the resident did not set out clear directions to staff and others who provided direct care to the residents. The staff and the ADOC confirmed the plan of care did not provide clear direction to staff and others who provided direct care to the resident.(527)

D) Resident #100 was identified through a falls risk assessment as being high risk for falls. On identified dates in 2014 resident #100 sustained two falls. The fall on an identified date in 2014 required the resident to be transferred to the hospital.

Subsequently, the resident had an additional eight falls. On an identified date in 2014 the physiotherapist made recommendations based on the falls assessment and the plan of care was not updated. The following interventions were not on the care plan related to the bed and chair alarm; and that the resident's bed should be kept at the lowest position and to keep crash mat close to bed. All of the interventions on the resident's care plan dated back to an identified date in 2013 and did not reflect the resident's current needs to prevent and/or minimize resident's falling and degree of injury. On an identified date in 2014, the resident was observed with the bed in high position. The registered staff and the PSW's confirmed that the care plan does not set out clear directions to staff and others who provide direct care to the resident.(527)

E) Resident #022 had a Fall Risk Assessment completed on an identified date in 2014 which identified resident as being low to moderate risk for falls with a score of 28. On identified dates in 2014 resident had a fall. The assessments identified continence as a contributing factor and the care plan identified that resident #022 was on a toileting schedule. The assessments also identified that the resident was to have a bed or chair alarm and the bed kept in the lowest position. There was no documentation on the care plan related to a bed or chair alarm being used to alert staff; and that the resident's bed should be kept at the lowest position. All of the interventions on the resident's care plan dated back to an identified date in 2011, except for the request by family on an identified date in 2013 to keep one bed rail up at night for the resident. On identified dates in 2014, the resident's bed was observed in the high position. The registered staff and the PSW's confirmed that the care plan did not set out clear directions to staff and others who provide direct care to the resident.(527) [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The plan of care for managing falls for Resident #100 was based on the interdisciplinary assessments. The recommendations were that a bed alarm be used, and that the resident's bed was to be kept in the lowest position. When observed on September 10 and 11, 2014, the bed alarm was not being used by the staff. The resident's bed was in the high position and not the lowest position. The RPN and PSW's confirmed that these safety strategies to mitigate the resident from falling or minimize the resident's injuries were not in place and should have been implemented. (527) [s. 6. (7)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system be easily seen, accessed and used by residents, staff and visitors at all times.

The resident-staff communication and response system in the ten tub rooms in the home was not easily accessible for staff to use when they need assistance with resident care or in an emergency situation. The resident-staff communication and response system was secured along the wall, with the pull station located on the wall at the bottom end of the bath tub. The PSW's identified that if they need assistance from another PSW or had an emergency situation, they would "scream" for help or use their telephones in their uniform pocket. PSW's confirmed that the resident-staff communication and response system in the ten tub rooms in the home was not easily accessible for staff to use when assistance was required for resident care.(527) [s. 17. (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 and ensuring that resident-staff communication and response system can be easily accessed by residents, staff and visitors, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions.

Inspection was conducted on the Alenti (Model # CDB80XX) bath tub chair lifts in all ten tub rooms in the home. Nine out of the ten tub chair lifts had no safety belts and eight of the ten tub rooms had no safety belts accessible for the Alenti bath tub chair lifts. Interviews were conducted with PSW's and the RPN's on each unit. The PSW's on nine out of the ten units confirmed they did not use the safety belts in accordance with the manufacturers' instructions. Interviews with the Unit Coordinator's and Director of Care confirmed that staff were expected to follow the manufacturers' instructions for the Alenti bath tub chair lift. Once this concern was brought to the attention of the home management, safety belts were made available and staff were re-instructed to use as per the manufacturers' instructions.(527)[s. 23.]

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 and ensuring that manufacturers' instructions are followed, to be implemented voluntarily.

WN #5: 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 failed to ensure that any actions with respect to resident #300 under their nutrition care program, including reassessments, interventions and the resident's responses to interventions were documented.

A) Resident #300 was classified as high nutrition risk during nutrition quarterly assessments completed on identified dates in 2014. The home's policy titled

[Nutritional Care Assessment & Screening Program]identified as 3-060 last revised November 2012, stated "follow-up is required by the Registered Dietitian as follows for each risk level: High Nutrition Risk: Regular follow-up is required at least monthly." Clinical documentation from the RD showed that only nutrition quarterly assessments were completed, and no monthly follow-ups were documented on identified dates in 2014. The RD reported that follow-ups did occur however, confirmed that follow ups were not documented.(585)[s. 30. (2)]

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

A)The plan of care for resident #031 identified that an evaluation of the resident's bladder control pattern was to be conducted, and to note any changes in amount, frequency, colour or odour. The PSW's and the Unit Coordinator confirmed staff would document this information on a voiding and monitoring tool. This information would then be used in conjunction with the bladder and bowel assessment to establish the individualized interventions for the resident. There was no documentation of the voiding and monitoring tool on the resident's clinical record. There was no documentation on the care plan or kardex used by the home to direct care of the interventions related to frequency of toileting and brief changes.(527)

B)The bladder assessments conducted for resident #008 on an identified date in 2014, identified that the resident had potential to restore urinary function and the method to be implemented was prompted voiding and a voiding container at night. There was no documentation in the clinical record of the interventions being implemented or their effectiveness. There was no documentation on the care plan or kardex used by the home to direct care of the interventions related to restoring urinary function. The ADOC, RPN and PSW's confirmed there was no documentation of the actions taken with respect to the urinary continence assesssment's and the responses of the resident to the interventions.(527)

C)The bladder and bowel assessment conducted for resident #022 on an identified date in 2014, identified that the resident has potential to restore urinary function and the method to be implemented was prompted voiding. There was no documentation in the clinical record of the interventions being implemented or their effectiveness. There was no documentation on the care plan or kardex used by the home to direct care of the interventions related to restoring urinary function. The ADOC, RPN and PSW's

confirmed there was no documentation of the actions taken with respect to the urinary continence assessments and the responses of the resident to the interventions.(527) [s. 30. (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 and ensuring reassessments, interventions and resident's response to interventions are documented, to be implemented voluntarily.

WN #6: 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 resident #015 was assessed post-fall using a clinically appropriate assessment instrument that was specifically designed for falls.

On an identified date in 2014, resident #015 had two falls on the day shift. The RPN did not complete the post-fall assessment using a clinically appropriate instrument specifically designed for falls. The DOC confirmed that the RPN did not conduct a post-fall assessment using an appropriate assessment instrument, and the RPN was subsequently disciplined by the home.(527)[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 and ensuring use of clinically appropriate assessment instruments, to be implemented voluntarily.

WN #7: 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,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident's who are incontinent had an individualized plan of care to promote and manage bladder continence based on the assessment.

A)Resident #008 was identified in the continence assessment conducted on an identified date in 2014 as having the ability to restore urinary function. The care plan had interventions that were dating back to identified dates in 2011 and in 2014. The interventions identified that staff were to note any changes in the amount, frequency, colour and odour of urine; the resident was on an incontinent program to toilet before, after meals and at bedtime; and the resident wore a brief. These interventions were outdated and did not reflect the individualized care needs of the resident based on the quarterly assessments. The bladder assessment conducted on an identified date in 2014 indicated that the method to restore urinary function for the resident was prompted voiding and use of an identified voiding container at night. These restorative strategies were not noted on the care plan. The PSW's and the RPN confirmed that they were not aware of these interventions and had not implemented them. The resident was interviewed and they stated that they do not use the identified voiding container, and that during the day the staff assist them to the bathroom and at night they uses a brief. The PSWs confirmed they not use an identified voiding container at night. The current interventions from the identified dates in 2014 urinary assessments

were not included in the document used by staff to direct care, therefore the resident's plan of care was not individualized to restore urinary continence. The ADOC and the PSW's confirmed the plan of care was not individualized to the resident.(527)

B)Resident #022 was identified in the bladder and bowel assessment conducted on an identified date in 2014 as having the ability to restore urinary function. The care plan had interventions that were dating back to an identified date in 2011. The interventions identified that staff were to note any changes in the amount, frequency, quantity of urine; note changes in urinary function; and resident wears a pull up during the day, and a brief overnight. These interventions were outdated and did not reflect the individualized care needs of the resident based on the quarterly assessments. The bladder assessment conducted on an identified date in 2014 identified that the method to restore urinary function for the resident was prompted voiding. These restorative strategies were not noted on the care plan which the staff use to direct care. The PSW's and the RPN confirmed that they were not aware of these interventions and had not implemented them. The current interventions from the identified date in 2014 bladder and bowel assessment, were not included in the document used by staff to direct care, therefore the resident's plan of care was not individualized to restore urinary continence. The ADOC and the PSW's confirmed the plan of care was not individualized to the resident.(527) [s. 51. (2) (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 and ensuring individualized plan of care, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

A)Staff were observed on an identified dates in 2014 in the dining room. Hand hygiene was not being performed prior to feeding residents; when cleaning off dishes and then touching other residents.(585)

B) On an identified in 2014 staff did not perform hand hygiene when going between resident rooms to provide direct care. (527)

C) On an identified date in 2014 an RPN was observed performing an aseptic dressing in a resident's room, while talking on a portable telephone. Staff interviewed confirmed they were aware of the home's policy and procedures for infection prevention and control; however, forgot to perform hand hygiene before care, and in between providing direct care to residents.(527)

D) On an identified date in 2014, on first floor, an RPN was observed administering insulin and testing resident #201 blood glucose. The RPN proceeded with their medication pass, and administered medication to resident #303, without washing their hands in between residents.(585)

Staff interviewed and confirmed they were aware of the home's policy and procedures for infection prevention and control; however, forget to perform hand hygiene before care, and in between providing direct care to residents. Interviewed the ADOC and she confirmed that staff were expected to perform hand hygiene before initial resident contact, before aseptic procedure(s), after body fluid exposure risk, and after resident or environment contact. The ADOC confirmed that staff were expected to perform hand hygiene before initial resident contact, before aseptic procedure(s), after body fluid exposure risk, and after resident or environment contact. (527) [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring staff participate in the infection prevention and control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the Falls Prevention and Management policy was complied with.

The homes policy titled [Fall Prevention and Management policy] identified as NS 9-010 last revised November 2013, identified that the physiotherapist evaluates and reassesses the resident status on admission, re-admission, if applicable, and with each fall. Review of the clinical records for residents' #100, #015, # 001, #022 and #031, identified there were no post-fall assessments by the Physiotherapist (PT). The Fall Prevention and Management program lead and the DOC confirmed that the PT only conducts post-fall assessments by referral, as well as the PT will conduct a Fall assessment on a quarterly basis.(527)[s. 8. (1) (b)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that at a minimum the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of duty under section 24 to make mandatory reports.

The home's policy titled [Abuse Policy] identified as GN 3-020 last revised November 2012, does not contain an explanation of the following information included in Section 24. (536)

A)The policy did not contain a correct explanation of reporting immediately to the Director any suspicion of abuse. The policy stated that all individuals who have reasonable grounds to suspect that any abuse or neglect of a resident by the home or staff that resulted in harm or a risk of harm to the resident, should be reported immediately. The policy then states to report it to the Ministry of Health and Long Term Care by way of a phone call to an inspector. The policy then directed the staff to submit a Critical Incident Report within 10 business days of determining abuse has occurred. (536)

B)The policy did not contain an explanation of the consequences of providing false information to the director. (536)

C)The policy did not contain an explanation of the exceptions for residents reporting abuse.(536)

This was verified by the Administrator on an identified date in 2014. (536) [s. 20. (2)]

WN #11: 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 failed to respond in writing within 10 days of receiving advice from Resident's Council, when Resident's Council advised the licensee of concerns or recommendations under paragraph 6 of subsection (1).

A) During a Resident Council interview, one member was unable to confirm whether the licensee provided written responses to concerns or recommendations from Council. Council meeting minutes identified that on an identified date in 2014, residents were concerned about one smoking outside too close to the building. The minutes stated that the concern would be brought to the attention of the Director of Care (DOC). The DOC confirmed they were aware of the issue, and a response in writing to the concern was not provided to Council in 10 days. (585) [s. 57. (2)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving advice from Family Council, when Family Council advised the licensee of concerns or recommendations under paragraph 9 of subsection (1).

During a Family Council interview, a member stated they were unaware of the Council receiving written responses within 10 days from the licensee regarding concerns or recommendations about the operations of the home. Council meeting minutes indicated that on multiple occasions, concerns and/or recommendations were raised to the attention of the licensee.

A) On an identified date in 2014, Council inquired about having adjustable sinks in the hair salon as some wheelchairs did not fit under the sink. The Administrator confirmed they were aware of Council's inquiry, and a response in writing was not provided to Council in 10 days. (585)

B) On an identified date in 2014, Family Council raised concerns about management of snow on the walkway of the main entrance to the home. The Administrator confirmed they were aware of the concern, and a response in writing was not provided to Council in 10 days.(585) [s. 60. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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 failed to ensure that resident #300 had an individualized menu developed when their needs could not be met through the home's menu cycle.

A) On an identified date in 2014, at breakfast on an identified floor, resident #300 stated that they were unable to eat scrambled eggs, they had a milk allergy, and milk was in the eggs. The resident reported that approximately six months ago, they requested to have a boiled egg for breakfast daily and they were told it was not possible. The resident's plan of care, diet list, and medical alert bracelet indicated they had an allergy/intolerance to beef and milk. The Dietary Manager confirmed they were aware that the resident had a self-reported milk and beef allergy, and that the home did not have an individualized breakfast menu developed for the resident. Items were removed from the regular menu for resident #300 without planning an appropriate substitution, which affected the nutritional quality and appeal of the menu for the resident.(585) [s. 71. (5)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was communication of the breakfast daily menu to residents.

A) On an identified date in 2014, on the identified floors, seven-day menus for breakfast, lunch and supper were posted; however, there was no posted daily menu for breakfast.(585)

B) On an identified date in 2014, on the identified floors, seven-day menus for breakfast, lunch and supper were posted; however, there was no posted daily menu for breakfast. The Food Service Manager confirmed no daily breakfast menus were posted.(585) [s. 73. (1) 1.]

2. The licensee failed to ensure that foods and fluids were served to residents at a temperature that was safe and palatable to residents.

A) On an identified date n 2014, on an identified floor, drinks were observed placed on dining tables at 1100 hours. The lunch meal was scheduled to start at 1200 hours.

Two dietary staff reported that drinks were regularly poured prior to residents arriving to the dining room. The Dietary Manager confirmed it was unsafe to place drinks 50 minutes in advance.(585)

B) During resident interviews, resident #8, #26 and #31 stated that hot foods were served cold.(585)

C) On an identified date in 2014, hot food temperatures were taken midway through supper meal service on third floor. Regular chicken was probed at 56.9 degrees Celcius. The dietary staff serving probed the regular chicken at 128 degrees Fahrenheit (53 degrees Celcius). The staff continued to serve the chicken to two residents. A total of four residents were served chicken below 60 degrees Celcius. One resident who received the regular chicken reported that it was not hot enough. The dietary staff stated hot food were to be served and held during service at 140 degrees Farenheit (60 degrees Celcius) or higher. A cook confirmed that hot food was to be held through meal service at 140 degrees Farenheit (60 degrees Celcius) or higher.(585)

D) Daily Food Temperature Records from September 7 – 10, 2014 on first, second, and third floor serveries were reviewed.
i) On the identified floor, 4 out of 12 meal temperature records were incomplete.
ii) On the identified floor, 1 out of 12 meal temperature records were incomplete.

The Dietary Manager confirmed that the Daily Food Temperature Records were expected to be completed for all meals.(585) [s. 73. (1) 6.]

3. The licensee failed to ensure residents were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

On September 2, 2014, during lunch meal service, on second floor, a dietary staff served dessert to resident #301 and #302 while they were eating their main course. The dietary staff confirmed that both residents were served their dessert before they finished their main course and that they had no instruction directing them to serve both courses together. Resident #301 and #302's plans of care were reviewed and neither indicated an assessed need to receive both courses together.(585) [s. 73. (1) 8.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4)4. An injury in respect of which a person was taken to the hospital.

Resident #100 experienced two falls, one on an identified date in 2014 and the other on an identified date in 2014. The resident's injuries required a transfer to the hospital. The home did not inform the Director of the incident that caused an injury to Resident #100 until an identified date in 2014, therefore nine days after the incidents. The DOC confirmed the home did not report the incident, which sent the resident to the hospital until nine days after the incident, and it should have been reported within one business day. (527)[s. 107. (3) 4.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs are stored was kept locked at all times, when not in use.

On an identified date in 2014 at approximately 2:15 pm the medication room door, on an identified floor, was propped open and one of the two medication carts in the room where noted to be unlocked. The cupboards that held the government stock medication did not have a lock, allowing anyone entering the room access to the unlocked medications in both the medication cart and the cupboards. On another identified date in 2014 at approximately 10:00 am the medication room door, on an identified floor, was propped open and the medication cart in the room was noted to be unlocked. The cupboards that held the government stock medication did not have a lock, once again allowing anyone entering the room access to the unlocked medications in both the medication cart and the cupboards. The Director of Care (DOC) verified that the medication room doors should be closed and locked when not in use. (536) [s. 130. 1.]

Issued on this 3rd day of November, 2014

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