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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 21, 2014	2014_202165_0004	L-000095-14	Resident Quality Inspection

Licensee/Titulaire de permis

FAIRVIEW MENNONITE HOME
515 Langs Drive, CAMBRIDGE, ON, N3H-5E4

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

FAIRVIEW MENNONITE HOME
515 LANGS DRIVE, CAMBRIDGE, ON, N3H-5E4

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

TAMMY SZYMANOWSKI (165), REBECCA DEWITTE (521), ROCHELLE SPICER (516), SALLY ASHBY (520)

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 28, 29, 30, 31, February 4, 10, 11, 2014

During the course of the inspection, the inspector(s) spoke with The Clinical Co-ordinator, Recreation Co-ordinator, Pastor, Programs and Therapies Manager, Scheduling Clerk, Resident Assessment Instrument (RAI) Co-ordinator, Houskeeping Supervisor, Housekeeping staff, Personal Support Workers (PSW), Registered Nurses (RN), Registered Practical Nurses (RPN), Wound Care Team Lead, Maintenance Manager, Nutrition Manager, Dietary staff, Administrator, families and residents.

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

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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).

Findings/Faits saillants :

1. The licensee failed to fully respect and promote the residents right to be treated with courtesy and respect and in a way that fully recognizes their individuality and dignity.
A) On February 11, 2014, at approximately 0815 hours, two housekeeping staff were making beds in a resident's room when one staff member used offensive language. The inspector was in the hallway and a nearby resident heard the staff member. The language used did not promote courtesy and respect to residents. [s. 3. (1) 1.]

2. The licensee failed to respect and promote the residents rights to be afforded privacy in treatment and in caring for his or her personal care needs.
A) Observations during morning care on all four home areas on February 11, 2014, revealed that staff did not always provide privacy in treatment and caring for resident's personal care needs.
i)On one home area two residents were observed receiving care with the door to the hallway open and privacy curtains were not fully drawn.
ii) On one home area one resident was observed receiving care with the door to the hallway open.
iii) On one home area two residents were observed receiving care with doors to the hallway open, and one resident was receiving care with the tub door propped open and the privacy curtain was not fully drawn.
iv) On one home area two residents were observed receiving care with doors to the hallway open. [s. 3. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the residents right to be afforded privacy in treatment and caring for his or her personal needs are promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The long term care home did not ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director.
A) In January 2014, resident #007 reported to the Registered Practical Nurse that staff had treated them roughly and they wanted to move out. The Registered Practical Nurse confirmed that they did not report the allegation to the Registered Nurse or any Management of the home. The Registered Practical Nurse confirmed there was no documentation completed related to the allegation by the resident.
B) The home's Abuse policy reference number 4-5 indicated that the charge nurse would be notified immediately and all information would be recorded. The policy indicated that the Ministry of Health would be notified however, it was confirmed that the Registered Practical Nurse failed to report the allegation and the Director was not notified. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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;
O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the Registered Nursing staff within 24 hours of the resident's admission.
A) Resident #076 was admitted to the home in October 2012, however, a skin assessment was not completed by a member of the Registered Nursing staff until three days later. A member of the Registered Nursing staff confirmed that a skin assessment was not completed within 24 hours of the resident's admission. [s. 50. (2) (a) (i)]

2. The Licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown received immediate treatment and interventions to prevent infection.
A) Resident #076 had altered skin integrity including skin breakdown related to a medical skin condition. The resident required extensive hands on care including the application of topical medications. It was confirmed that the resident was residing in a shared bedroom with another resident that was identified as compromising the resident's risk of infection. The home's policy indicated that residents known to compromise other resident's risk of infections should be in a private room and residents should not share a room with other residents who required extensive hands-on care. The Clinical Care Co-ordinator verified that the home's policy was the current expectation for staff to follow. [s. 50. (2) (b) (ii)]

3. The Licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown was assessed by a Registered Dietitian.
A) Resident #076 had impaired skin integrity including skin breakdown related to a medical skin condition. A review of the clinical health record revealed that there was no nutritional assessment completed related to the skin integrity. This was confirmed by the Clinical Care Co-ordinator and Registered Nursing staff. [s. 50. (2) (b) (iii)]

4. The Licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown was reassessed at least weekly by a member of the registered nursing staff.
A) Resident #076 had impaired skin integrity including skin breakdown related to a medical skin condition. A review of the clinical health record revealed that weekly skin assessments for five weeks over a four month period from October 2013, to January 2014, were not completed. This was confirmed by a member of the Registered Nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required, to be implemented voluntarily.

WN #4: 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:
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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that the home had a dining and snack service that included food and fluids served at a temperature that was both safe and palatable to the residents.
A) The home's recipes for pork chops indicated serving temperatures should be maintained at a minimum of 150 degrees fahrenheit however; during the lunch meal service February 10, 2014, the regular texture pork chop was 136 degrees fahrenheit and the minced texture was 130 degrees fahrenheit. The home's recipe for chicken indicated serving temperatures should be maintained at a minimum of 140 degrees fahrenheit however; puree chicken was 130 degrees fahrenheit and the minced chicken was 117 degrees fahrenheit.
B) It was identified during resident interviews that food temperatures of textured menu items were not always maintained, compromising the palatability of food.
C) It was observed on February 11, 2014, that cold beverages including milk and juices were placed at residents tables prior to 0700 hours, greater than one hour prior to the commencing of meal service. The Nutrition Manager confirmed that beverages were not to be placed on the tables until 15 minutes prior to the commencing of meal service. [s. 73. (1) 6.]

2. The licensee of the long term care home failed to ensure that the home had a dining and snack service that included, proper techniques to assist residents with eating, including safe positioning of residents who required assistance.
A) Staff did not always use proper techniques to assist residents with eating.
On three occasions during the inspection staff members were observed standing to feed a resident.

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 food and fluids are served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #5: 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:

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. 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:
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.) O. Reg. 79/10, s. 110 (2).

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:
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).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that staff apply the physical device in accordance with any manufacturer's instructions.
A) Resident #052 was observed in February 2014, to have their physical device applied too loose. The inspector could fit a hand between the resident's pelvic crest and the physical device which was confirmed by a Personal Support Worker . The Personal Support Worker confirmed that the physical device was as tight as it could be applied and could not be adjusted tighter to meet the instruction of two fingers from the resident's pelvic crest to the physical device. [s. 110. (1) 1.]

2. The licensee did not ensure that the resident was released from the physical device and repositioned at least once every two hours.
A) Resident #052 was observed in February 2014, sitting in their wheel chair, with a physical device applied. The resident was observed for a three and a half hour period and the resident was not released from the physical device and repositioned during this time. Interview with Personal Support Workers confirmed that the resident had not had their physical device released and repositioned for a period greater than four hours. [s. 110. (2) 4.]

3. The licensee failed to ensure that the resident's condition was 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.
A) Resident #052 was not reassessed and the effectiveness of the restraining evaluated 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. A Registered Practical Nurse, the RAI Coordinator and Clinical Coordinator confirmed that a reassessment and the effectiveness of the restraining was not completed every eight hours. [s. 110. (2) 6.]

4. The licensee did not ensure that every use of a physical device to restrain a resident included documentation of every release of the device and all repositioning.
A) A review of resident #052's clinical health record revealed that there was no documentation that included the release of the resident's physical device and all repositioning. This was confirmed by the RAI Co-ordinator.
B) The DOC confirmed that electronic documentation for resident's with physical devices currently did not include every release of the devices and all repositioning. [s. 110. (7) 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 to ensure that staff apply the physical device in accordance with manufacturer's instructions, residents are released from the physical device and repositioned at least once every two hours, resident's conditions are reassessed and the effectiveness of the restraining evaluated 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 every use of a physical device to restrain a resident includes documentation of every release of the device and all repositioning, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provide direct care to residents received annual training related to Abuse, Falls Prevention and Management program, Physical Devices and Personal Assistance Service Devices.
A) The home was unable to provide confirmation that all staff received retraining in 2013 related to the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections. This was confirmed by the Clinical Coordinator and Director of Care.
B) The Director of Care confirmed that all staff who provided direct care to residents did not receive Fall Prevention and Management training for 2013.
C)The DOC confirmed that all staff who provide direct care to residents did not receive annual training in the application, use and potential dangers of physical devices and personal assistance service devices for 2013. [s. 221. (2) 1.]

Additional Required Actions:

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

WN #7: 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 failed to ensure that all staff participate in the implementation of the infection prevention and control program.
A) The infection prevention and control program identified that all residents at the home would receive their own pair of finger nail and toenail clippers except for residents diagnosed with diabetes who would receive foot care by an outside service provider. In January 2014, it was observed in every tub room that there was communal nail clippers. Staff confirmed the clippers were not identified for each resident. In February 2014, at approximately 1245 hours in Hespeler tub room a nail clipper in the communal clean container contained a dirty nail clipping in the ledge of the clippers. It was noted that there were three rusted nail clippers also in use. This was verified with the Infection Control and Prevention Nurse.
B) In the Galt Dining Room a Personal Support Worker student was observed alternating feeding between two resident. The Personal Support Worker student was observed assisting one resident wiping their nose in the clothing protector and then continued to feed the other resident without washing hands.
C) On January 30, 2014, a staff member was observed wiping oral secretions with resident's clothing protectors and continuing to assist all four residents sitting at the table without washing hands. The Infection Prevention and Control Nurse confirmed it was the homes expectation that hand hygiene washing would occur when staff were being exposed to any bodily fluid including saliva while assisting multiple residents during meals.
D) In February 2014, the Registered Practical Nurse administered insulin to an identified resident without washing hands before or after injecting resident with insulin.

E) In February 2014, a staff member was observed in the Hespeler and Preston dining room shaking hands with residents while they were eating. The staff member did not wash their hands.
F) On January 28, 2014, a pad pan and a dirty urinal were found on the back of resident's toilets. A wash basin was found on the floor in another resident's bathroom. These were confirmed by the Infection Prevention and Control Nurse who revealed this was not the proper storage expected in the home. [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 to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: 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).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
A) On two separate occasions in January 2014, resident #002 was observed sleeping in bed with no falls mat in place. On one occasion in January 2014, the resident was observed sleeping in bed with the falls mat in place. The Clinical Co-ordinator reported that the resident had movements and their safety fluctuated therefore, the strategy to place the fall mat was used at times. The resident's plan of care last dated July 21, 2012, did not include the use of the falls mat and directions for staff when to use this strategy. The Clinical Co-ordinator confirmed that the plan of care did not set out clear directions for staff.
B) Resident #007's plan of care related to Mobility indicated that the resident was dependent in a wheel chair with a physical device. The resident was observed throughout the inspection with no physical device applied. There was no physician's order for the use of the physical device. Staff interviewed confirmed the resident did not use a physical device when up in their wheel chair. The plan of care did not set out clear direction. [s. 6. (1) (c)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary. A) On February 11, 2014, at approximately 0745 hours the floor of the second floor dining room was significantly soiled with crushed crumbs, dried coffee and tea spills, a used tissue and a used medicine pot under the table. This was verified by the Personal Support Worker prior to residents entering the dining room for breakfast. [s. 15. (2) (a)]

WN #10: 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 of the long term care home failed to ensure that the home was equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times.
A) In February 2014, resident #007 was taken into their bedroom and sat facing the television in their wheelchair without access to the call bell. The resident was asked how they would alert staff for assistance and the resident shrugged their shoulders. The Personal Support Worker and Registered Practical Nurse confirmed that the call bell was to be placed within reach for this resident. [s. 17. (1) (a)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. A resident was restrained by a physical device as described in paragraph 3 of subsection 30(1) however; the restraining of the resident was not included in the resident's plan of care.
A) Resident #052 had a physical device and a tilt wheel chair in place throughout the inspection. Staff confirmed that the resident was not capable of releasing the devices and they had restraining effects on the resident. A review of the resident's plan of care revealed that the restraining of the resident was not included in the plan of care. A Registered Practical Nurse, the RAI Co-ordinator and Clinical Co-ordinator confirmed that the restraining of the resident was not included in the resident's plan of care. [s. 31. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee of the long-term care home failed to ensure that each resident of the home has his or her personal items, including personal aids labeled within 48 hours of admission and of acquiring, in the case of new items.
A) On January 28, 2014, unlabeled personal care items including treatment cream, body lotions and soaps were found in a shared bathroom in one home area.
B) On January 28, 2014, unlabeled personal care items including treatment cream and deodorant were found in the communal tub room in one home area.
C) On January 28, 2014, unlabeled opened treatment cream was found on the counter in the clean utility room.
It was confirmed by the Infection Prevention and Control Nurse that all personal care items were to be labeled. [s. 37. (1)]

WN #13: 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 of the long term care home did not ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.
A) Resident #002 sustained a fall in July 2013, however, a review of the clinical health record revealed that there was no post fall assessment completed. The resident had an annual Resident Assessment Instrument (RAI) Assessment completed in May 2013, however, there was no fall assessment completed despite a falls Resident Assessment Protocol (RAP) triggered. The home's fall prevention policy, reference No. 8-FP-01, indicated that staff were to complete an assessment with each falls RAP triggered during a quarterly or annual RAI Assessment and following each fall. The Clinical Co-ordinator confirmed that the resident did not have a falls assessment completed for the resident's annual RAI assessment in May 2013, and post fall in July 2013.
B) In August 2013, resident #002 sustained a fall. A clinical health record review revealed there was no post fall assessment completed after the fall in August 2013. The Clinical Co-ordinator verified there was no post fall assessment completed at this time even though the home's policy directed staff to complete an assessment following each fall. [s. 49. (2)]

WN #14: 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:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that, at least once in every year, a survey was taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.
A) The Administrator of the home confirmed that there was no survey completed for the year 2013. The last completed survey taken of the residents and their families was 2012. [s. 85. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis.
A) The DOC confirmed that the home did not complete an analysis of the restraining of residents by use of a physical device on a monthly basis. [s. 113. (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that the improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents were communicated to the Resident's Council, Family Council and the staff of the home on an ongoing basis.
A) The Administrator confirmed that the home did not communicate improvements made to the quality of the accommodation, care, services, programs and goods provided to the Resident's Council. [s. 228. 3.]

2. The licensee of the long term care home did not ensure that the quality improvement and utilization review system maintained a record setting out the names of the person who participated in evaluations, and the dates improvements were implemented.
A) The Administrator confirmed that records did not include the names of the persons who participated in evaluations and the dates the improvements were implemented. [s. 228. 4. ii.]

Issued on this 28th day of February, 2014

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