Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 24, 2014	2014_369153_0015	T-031-14	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26 Midhurst ON L0L 1X0

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

GEORGIAN MANOR HOME FOR THE AGED
~~7 HARRIET STREET~~ PENETANGUISHENE ON L9M 1K8
101 Thompsons Road

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

LYNN PARSONS (153), ANN HENDERSON (559), BARBARA PARISOTTO (558)

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): October 20, 21, 24, 27, 28, 29, 30, 31, November 3, 4, 2014.

The following complaint logs were inspected: T-853-14, T-861-14.
The following Critical incident logs were inspected: T-561-14, T-907-14.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), nurse manager (NM), program services supervisor (PSS), environmental services manager (ESM), rood services supervisor (FSS), registered dietitians (RD), physiotherapist (PT), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), cooks. dietary aides (DA), residents and families.

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

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

16 WN(s)
10 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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe environment for its residents.

On October 29, 2014, at 11:50 a.m., the inspector observed a PSW exit a staff washroom on an identified home area and struck another inspector with the door. There were several residents either sitting in wheelchairs or walking in the hallway near the area where the door opened.
The incident was reported to the administrator who indicated a further review would be completed by the ESM.
During an interview with the administrator and ESM it was revealed that there are 12 doors in the home that open into the hallway on resident home areas. In the interim the home locked some of the doors opening into the resident home areas.
An interview with the administrator confirmed doors opening into the hallway where residents are ambulating is a safety issue. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home is a safe environment for residents in relation to doors opening into hallways of resident home areas, 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that that there is a written plan of care for each resident that sets out the planned care for the resident.

On October 21, 2014, one bed rail was observed to be in the up position for resident #01 at 2:10 p.m. Staff interviews revealed the home uses high-low beds and that two bed rails are in the up position unless otherwise indicated, and in that circumstance one rail would be in the up position and the other one is not in use. The staff confirmed resident #01 has two bed rails in the up position at bed time.

An interview with the DOC revealed that all beds in the home are high-low beds and that in most circumstances one rail is in the up position. The DOC indicated that two bed rails are in the up position when a resident is cognitively impaired and likely to move around in bed. In the circumstance that two bed rails are in the up position it would be documented in the written plan of care.

The DOC confirmed that two bed rails are in use at bed time for resident #01 to prevent the resident from rolling out of bed and that the use of bed rails was not documented in the written plan of care. The DOC indicated the written plan of care has been updated to reflect resident #01's bed be set in the lowest position with one rail in use and a fall mat placed down. [s. 6. (1) (a)]

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

A lunch dining observation on October 28, 2014, revealed resident #04 did not attend the dining room for the meal. A review of the dining servery report directed staff to send pudding to the resident's room if the resident refuses to go to the dining room. An observation revealed the resident received a fruit cup at lunch and no pudding was observed.
A staff interview revealed that resident #04 is to receive a fruit cup at lunch and that the resident's snacks were recently changed by the RD.
An interview with the FSS identified the changes made by the RD included sending a fruit cup at lunch and the FSS was unclear as to whether the pudding was to be offered in addition to the fruit cup or discontinued.

An interview with the RD revealed that the fruit cup is to be offered at lunch and not the pudding. [s. 6. (1) (c)]

3. A review of the diet servery report on October 28, 2014, identified half portions at all meals for resident #01. The report identified the serving size as the following: Breakfast – ½ Lunch – entrée ½ Dinner – entrée ½.
An interview with DAs revealed the resident is served half portions of all meal items including cereal, soup and dessert. An interview with the RD revealed the resident should be served a half portion entrée, with a full protein at breakfast, a full portion of soup and dessert at lunch and a full dessert at dinner.

An interview with the RD confirmed the plans of care for residents #01 and #04 did not

set out clear directions to staff. [s. 6. (1) (c)]

4. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A review of weights for resident #08 revealed significant weight loss of 7.5 per cent over three months between July and October 2014. A review of the resident's electronic health records did not locate a weight loss referral to the RD. A review of the policy weight management program DM G-35 dated February 2011, identified the registered staff shall review significant weight changes, complete and document the nursing assessment; then complete a dietary referral to the RD.

Interviews conducted on October 30, 2014, with a registered staff and RD confirmed a referral had not been generated for resident #08 related to weight loss. An interview with the DOC on October 31, 2014, confirmed a referral should be generated for weight loss of 7.5% over three months. A referral was initiated after the issue was raised by the inspector. [s. 6. (4) (a)]

5. The plan of care for resident #10 identifies the resident can brush own teeth with set up assistance and cueing. A PSW revealed the resident is resistive, requires repeated cueing and does not brush own teeth regularly in the morning and evening. In July 2014, a dental hygienist indicated the resident's oral hygiene needed improvement and the resident required staff assistance to brush teeth and gums twice daily. The hygienist's recommendations were not reflected in resident #10's plan of care.
A RPN confirmed awareness of the recommendations from the dental hygienist and that they were not incorporated into the plan of care. [s. 6. (4) (a)]

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

A review of health records for resident #08 revealed a physician's order received in June 2014, for a nutritional supplement to be given three times daily at meals for weight loss and wound healing. A medication review authorized by the physician in August 2014, revealed this nutritional supplement order was renewed. A review of the medication administration records (MARs) for June, July and August 2014, failed to reveal documentation for the administration of this nutritional supplement.
A record review and staff interviews confirmed that the nutritional supplement was not

provided until September 16, 2014, as the order was not transcribed to the MARs. Resident #08 experienced 4.1kg weight loss between the months of July and September 2014.

An RPN confirmed the care set out in the plan of care in reference to the nutritional supplement was not provided as specified in the plan. [s. 6. (7)]

7. A review of the plan of care for resident #01 identified the resident uses a pull up during the day and an incontinent brief at night. Staff interviews revealed the resident wears an incontinent brief during the day and at night. A review of the Tena admission and products change form dated September 10, 2014, identified the resident uses incontinent briefs only and not pull ups.

The PSW and RPN confirmed that the resident's plan of care was not revised when the resident's continence product needs changed. [s. 6. (10) (b)]

8. A review of the plan of care for resident #01 directs staff to reinforce the use of a walker. Observations revealed the resident uses a wheelchair for locomotion. A record review and interviews with a PSW and PT revealed the resident uses a wheelchair for locomotion and no longer uses a walker.

The PSW confirmed that the resident's plan of care was not revised when the resident's mobility needs changed. [s. 6. (10) (b)]

9. An interview with resident #07 revealed the resident sleeps through the breakfast meal.
Staff interviews revealed resident #07 remains awake late into the night and wakes up at 11:30 a.m.
A review of the plan of care indicates the resident prefers to get up at 7:00 a.m. and prefers to go to bed at 10:00 p.m. This preference was initiated on October 30, 2013.
A staff interview confirmed the plan of care was not accurate. The plan of care was not revised when the resident's sleep patterns and preferences changed. [s. 6. (10) (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;
- there is a written plan of care for each resident that sets out the planned care for the resident
- there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident
- staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other
- the care set out in the plan of care is provided to the resident as specified in the plan
- the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, 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 failed to ensure that the resident-staff communication and response system can be used by residents at all times.

On October 27, 28 and 30, 2014, the inspector observed the call bell cords to be wrapped around the fold down grab bars and unable to be activated in the bathroom of the identified resident rooms.

During a tour with the ESM on October 30, 2014, it was confirmed the call bells were unable to be activated. The ESM indicated the plastic hooks to hold the call bells in place were no longer affixed to the grab bars.
The ESM removed the call bell cords from the grab bars immediately and they were able to activated. [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 to ensure that the resident-staff communication and response system can be used by residents at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident is exhibiting altered skin integrity, including pressure ulcers or wounds is assessed by a registered dietitian who is a member of the home.

A review of resident #06's clinical health record revealed a pressure ulcer.
A record review failed to locate a referral to the RD for an assessment of the pressure ulcer.
Interviews with RPNs confirmed a referral was not completed for the RD to assess the resident related to the pressure ulcer.
An interview with the DOC confirmed a referral to the RD should have been completed for resident #06. [s. 50. (2) (b) (iii)]

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 when a resident is exhibiting altered skin integrity, including pressure ulcers or wounds is assessed by a registered dietitian who is a member of the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with a change of 7.5 per cent of body weight over three months, are assessed using an interdisciplinary approach and that actions are taken and outcomes are evaluated.

A review of the weights for resident #08 revealed significant weight loss of 7.5 per cent over three months between July and October 2014.
A review of the resident's health record identified the most recent RD assessment occurred on September 16, 2014. This referral was related to significant weight loss over one month. At that time the RD identified that the resident was not receiving a nutritional supplement as ordered on June 17, 2014, and indicated this may have contributed to the resident's weight loss in September. The supplement was scheduled on the MARs and administered to the resident commencing September 16, 2014.
An interview with the RD confirmed a nutritional assessment for resident #08 was not completed in October.

The RD failed to assess resident #08 for a 7.5 per cent weight loss in October and failed to evaluate the outcome of the actions taken in September related to previous weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 residents with a change of 7.5 per cent of body weight over three months, are assessed using an interdisciplinary approach and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #6: 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 an individualized menu is developed for the resident if his/her needs cannot be met through the home's menu cycle.

An interview with resident #07 revealed the resident sleeps through the breakfast meal, eats lunch in the dining room every other day, and is usually out with the family for dinner. The resident does not typically eat the snacks provided by the home and has a personal supply in the resident's bedroom. The resident described the home's food as okay, overcooked and has a preference for sandwiches. The resident has met with an RD and states the home usually does not or cannot do anything regarding the food.

A review of the resident's plan of care identifies the resident regularly skips lunch and an individualized meal plan was created with the resident and is provided by the kitchen according to the resident's likes and dislikes e.g. the resident is provided with a deli sandwich at lunch.

An interview with the FSS revealed resident #07 does not like the food served at the home and prefers to eat what the family provides. Interviews with the FSS and RD revealed that at one point in time a copy of the menu cycle was provided to the resident and it was discussed that an alternative would be sent if the resident did not prefer either menu option. The resident did not complete meal selections with the menus provided and requested a deli sandwich. The FSS confirmed the resident is provided a deli sandwich prepared to the resident's specifications, at lunch, three times per week since June of this year. The FSS confirmed the previous food service manager was in the process of developing a menu with the resident before the food service manager vacated the position.

The RD identified resident #07 is not eating a healthy diet based on food group servings, which puts the resident at higher nutritional risk. The RD confirmed there is no individualized menu developed for this resident. [s. 71. (5)]

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 an individualized menu is developed for the resident if their needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities.

Resident and staff interviews revealed the home has been without a nutrition manager over the past few months.
An interview with the FSS revealed the minimum number of hours per week for an on-site nutrition manager is 46.4 hours.
An interview with the administrator revealed that there are currently 30 hours of on-site nutrition management and the home is in the process of hiring a nutrition manager. [s. 75. (3)]

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 nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee failed to ensure that no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs.

A review of resident #37's quarterly reassessment completed October 28, 2014, for the period of November 1 to February 1, 2015, revealed an entry for medical directives with a line drawn through the renew box.
There was no documentation on the quarterly reassessment to indicate what medical directives were being renewed.
A review of the clinical record failed to locate a document outlining resident #37's medical directives.
An interview with the DOC revealed individualized medical directives are documented on a form titled, admission and symptom relief orders.
A review of resident #37's clinical record revealed an admission and symptom relief orders form authorized by the physician on February 7, 2014, but the individual sections on the form had not been completed for resident #37. There were no signatures to indicate the form was reviewed by registered staff.
An interview with the DOC confirmed the form had not been completed and resident #37 did not have individualized medical directives in place. [s. 117. (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 no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs, to be implemented voluntarily.

WN #9: 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 complies with manufacturer's instructions for the storage of the drugs.

An observation of the drug fridge on an identified home area revealed a supply of insulin for different residents. The fridge temperatures for the month of October were noted to be above the recommended maximum temperature of 8 degrees Celsius on the following dates:
October 1-5, 7-11, 13-27, 2014.
A charge nurse confirmed the fridge should be between 2 and 8 degrees Celsius to maintain the integrity and efficacy of the insulin supply. The charge nurse confirmed that the insulin was not stored as per the manufacturer's instructions. [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 complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #10: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the Infection Prevention and Control program was evaluated and updated at least annually.

An interview with the NM confirmed the Infection Prevention and Control program was not evaluated and updated at least annually. [s. 229. (2) (d)]

2. The licensee failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission.

A review of resident #03's immunization record revealed the following mantoux screening:
Step #1 May 19, 2014, – negative
Step #2,June 2, 2014, – negative.
Resident #03 was admitted to the home on April 22, 2014, and the mantoux screening should have been completed by May 6, 2014.

A review of resident #13's immunization record revealed the following mantoux screening:
Step #1 August 1, 2008- historical- negative
Step #2 December 9, 2013 – positive.
Resident #13 was admitted to the home on October 21, 2013, and the mantoux screening should have been completed by November 4, 2013.

A review of resident #37's immunization record revealed the following mantoux screening:
Step #1 December 21, 2008 – negative
Step #2 January 1, 2009 – negative.
Resident #37 was admitted to the home on December 11, 2008, and the mantoux screening should have been completed by December 25, 2008.

An interview with the DOC confirmed the above residents were not screened for tuberculosis within 14 days of admission. [s. 229. (10) 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 the Infection Prevention and Control program was evaluated and updated at least annually, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and the SDM within six weeks of the admission.

During the inspection it was identified resident #04 was admitted in April 2014. The six week multidisciplinary care conference was held in July 2014, thirteen weeks after admission. An interview with the DOC confirmed that the multidisciplinary care conference was not held within six weeks of the resident's admission to the home. [s. 27. (1)]

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 has failed to ensure that there is a written response within 10 days of receiving Family Council advice related to concerns or recommendations.

A review of the previous three Family Council meeting minutes for May 15, June 19 and September 25, 2014, revealed there were no written responses related to the following concerns or recommendations raised at the meetings and written in the minutes:
May 15, 2014, a Family Council member asked why the paper blinds have been removed in the resident's room,
June 19, 2014, a Family Council member asked about having the benches around the outside walking trail,
September 25, 2014, further concerns were raised that the benches are not yet around the village on the outside walkway.
The Family Council assistant confirmed in an interview that the responses are made verbally at the meeting or at the next meeting. The administrator confirmed that the home did not respond in writing in 10 days. [s. 60. (2)]

WN #13: 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 failed to ensure that there is a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter.

A review of health records for resident #08 revealed no documented height or body mass index at admission. A review of the policy weight management program DM G-35 dated February 2011, identified heights will be measured on admission and annually and recorded in the weights and vitals section of point click care.

Interviews with the RD and the DOC confirmed height and body mass index were not documented at admission. [s. 68. (2) (e) (ii)]

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the daily and weekly menus are communicated to residents.

During a lunch observation on October 20, 2014, on an identified home area, the weekly menu could not be located. The following day the weekly menu was posted. On October 29, 2014, on the same home area, the weekly menu posted was dated the week of October 20-26, 2014. An interview with a dietary aide revealed the identified home area was not supplied the updated weekly menu to post.

On October 28, 2014, the daily posted menu on two other home areas identified a shaved ham croissant would be offered at lunch. A review of the weekly menu and a dining observation revealed a shaved ham sandwich was being served.

On October 29, 2014, on an identified home area, the daily menu identified egg salad sandwich and meat pie would be offered at lunch. An interview with the dietary aide revealed pepper basil frittata and roast beef sandwich were being served.

Staff interviews revealed that the home does not currently have a food service manager and that the weekly and daily menus to post were printed by an external FSS. The home's internal FSS confirmed that the daily posted menus prepared by the external FSS were printed with errors. On October 30, 2014, the correct daily menus were re-printed and would be distributed to the home areas for posting. [s. 73. (1) 1.]

WN #15: 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. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure the Family Council's advice was sought in developing and carrying out the satisfaction survey, and in acting on its results.

The Family Council were shown the results of 2013 survey at the November 21, 2013, Family Council meeting. The Family Council were asked if there was any feedback for the 2014 survey. The Family Council assistant and administrator were unable to confirm if the Family Council's advice had been sought in the developing and carrying out of the 2013 satisfaction survey. [s. 85. (3)]

2. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey and in acting on its results.

A record review and resident interview did not reveal that the Residents' Council's advice was sought in the development and carrying out of the satisfaction survey and in acting on its results. An interview with the administrator could not locate evidence to support consultation with the Residents' Council. [s. 85. (3)]

3. The licensee has failed to ensure that the results of the satisfaction survey were made available to the Residents' Council.

A record review and resident interview did not reveal that the results of the satisfaction survey were made available to the Residents' Council. An interview with the Residents' Council assistant confirmed that the results of the survey had not been reviewed with the Residents' Council. [s. 85. (4) (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

An interview with resident #08 revealed an identified piece of missing personal property was reported to a nursing staff member approximately one month ago and has not been found. The identified PSW confirmed the resident reported the missing property and the PSW subsequently reported it to an unidentified RPN. The PSW further revealed that he/she did not document the missing item. A record review of resident #08's health records could not locate documentation regarding the missing property.
An interview with the charge nurse revealed when missing items are reported to a PSW, the PSW would in turn report to the RPN and the RPN report to the charge nurse. It was further revealed that the missing item would be documented in the resident's electronic health records and management would be informed. The DOC and the administrator confirmed that the expectation is that the missing item is documented in the resident's progress notes. The DOC confirmed that the identified missing item for resident #08 was not documented and that the DOC was just informed of the missing item that day. [s. 101. (2)]

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

Issued on this 28th day of November, 2014

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

L. Parsons.

Original report signed by the inspector.