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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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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
Jan 6, 2017	2016_295126_0030	013480-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF CORNWALL
1900 Montreal Rd. CORNWALL ON K6H 7L1

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

GLEN-STOR-DUN LODGE
1900 MONTREAL ROAD CORNWALL ON K6H 7L1

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

LINDA HARKINS (126), GILLIAN CHAMBERLIN (593), LISA KLUKE (547), MELANIE SARRAZIN (592), MICHELLE JONES (655)

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): December 5, 6, 7, 12, 13,14,15,16,19 and 20, 2016

During this inspection the following several inspection were conducted, including a follow up to an order, four Critical Incidents and one complaint were inspected.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Director of Care(DOC), the Director of Nutrition Care, the Dietitian, the Supervisor of Continuous Quality, the Staff Development/Health and Safety/ Infection Control Officer, the Nurse Practionner (NP)Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW), Registered Dietitian (RD), Food Service Assistant (FSA), Recreation Assistants (RA), the President of the Resident's Council, the President of the Family council, residents and family members.

In addition the inspection team, reviewed resident's health care records, plan menus and resident daily food and fluids intake sheets and resident and family councils minutes, Policies and Procedures related to Infection Control and Prevention of Abuse were reviewed. The inspection team observed aspects of resident's care and interactions with staff, along with medication administration, several meal services and staffing schedules .

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_200148_0020	592

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. 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. (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 has failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to resident #015 related to the use of side rails.

On December 07, 2016, resident #015 was observed by Inspector #592 with two quarter rails engaged while resident was in bed.

On December 13, 2016, resident #015 was observed resting in bed by Inspector #592 with one quarter rail engaged on the side of the wall.

A review of the resident #015's health care record indicated that resident #015 was admitted in 2016 with several diagnosis and decline in mobility function/flexibility.

A review of resident #015 Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment dated a specific day in October 2016 indicated under devices and restraints that two rails are in used for the resident.

A review of resident #015 current plan of care found multiple entries related to the use of side rails:
Under Sleep/Rest Pattern it is indicated that side rail by the wall is engaged.
Under risk for falls characterized by history of falls/injury it is indicated to have side rails

as ordered.

A review of resident #015's physician orders was completed. The inspector was unable to locate an order related to side rails.

During an interview with inspector # 592, on December 13, 2016, resident #015 replied that "one side rail is engaged on the side of the wall to hold the cord of the call bell in place" when asked if resident new about the side rail status.

During an interview with Inspector #592, December 13, 2016, PSW #102 reported that resident #015 had one quarter rail engaged on the side of the wall to keep the calling bell within reach when resident was in bed.

During an interview with Inspector #592, December 14, 2016, RN #101 indicated to Inspector #592 that resident #015 had two quarter rails in place for safety.

Upon reviewing the current plan of care of resident #015 in the presence of RN #101, she indicated to Inspector #592 that the directions for the use of side rails were not clear as there was no orders for side rails found in the resident health care records and that the resident should have two rails in place and not one as opposed to the care plan instructions. RN #101 further indicated to Inspector #592 that the plan of care does not provide clear direction and should be reviewed. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was reviewed when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #048 was admitted to the home in 2008 with several diagnoses. Prior to a specific date in July 2016, it is documented in the plan of care that Resident #048 was on a Regular Texture diet, was requiring limited feeding assistance, was requiring assistance with toileting and was mobilizing independently for short distance while sitting in the wheel chair.

Resident # 048's health care record was reviewed by Inspector #126 and the following were documented in the progress notes:

On a specific day of July 2016, it was documented that the Sensor pad alarmed was heard in resident #048's room in the early morning. Resident #048 was found on the floor of the bathroom. Resident #048 was conscious upon the arrival of staff. Resident # 048

was bleeding and was sent to the Emergency Room (ER) for assessment and treatment.

Later that day , it was documented that resident #048 returned to the home from the ER. The ER Physician discussed the level of care for resident #048 with the Substitute Decision Maker (SDM)) and it was determined that comfort measures would be implemented.

The following day, it was documented that resident #048 did not take anything by mouth. An dressing was applied to the injured area and was monitored closely.

Three days after the fall, it was documented that resident #048 had a slight increase in alertness. Resident #048 remained in bed throughout shift. Resident was repositioned every two hours and analgesics were administered for pain with good effect. Resident #048 had not voided on the day shift. Comfort measures maintained will continue to monitor.

Ten days after the fall, it was documented that resident #048 was restless and was attempting to climb out of bed,was pulling at the dressing and was moaning. Resident #048 was medicated and a bed bath was given. Resident voided a large amount of foul concentrated urine while receiving the bed bath.Resident was repositioned every two hours.

Two weeks after the fall ,it was documented that resident # 048 was restless before and during breakfast. Resident was pushing staff away, was calling out and was attempting to get out of bed. Resident's condition continued to deteriorate for several days and resident passed away on a specific day of August 2016.

During an interview with Inspector # 126 on December 19, 2016, RN #120 indicated that prior to resident #048 falls in July, 2016, resident #048 was able to move around the unit while sitting in the WC and was receiving limited assistance in some of his/her care needs. After the fall, resident #048's condition changed and resident became total care for every aspect of his/her care needs. RN #120 indicated that the plan of care was not updated to reflect the resident comfort measures interventions implemented. [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 resident # 015 set out cleat directions to staff related to the use of bed rails, to ensure when the resident's care needs change the plan of care is reviewed and revised, 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 licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

According to O.Reg.79/10, s.2.(1) " physical abuse is defined as the use of force by anyone other than a resident that causes physical injury or pain.

On December 07, 2016, while conducting an interview with resident #015, indicated to Inspector #592 that several weeks ago, was handle roughly by a PSW, grabbing both of

his/her wrist while being repositioned in bed. Resident # 048 further indicated to Inspector #592 that during the repositioning he/she felt acute pain to the neck, left shoulder and both wrists. The resident further indicated that he/she had reported the incident to a PSW. Resident #015 further told Inspector that he/she had spoken to RN #101 but did not hear anything after reporting the incident.

A review of the resident #015's health care record by Inspector # 592 indicated that resident #015 was admitted in July 2016 with several diagnoses. Resident #015 cognitive function was mildly impaired; short term memory loss with independent decision making and psychosocial strength; establishes own goals and make decision.

On December 13 2016, during an interview with PSW #102, who is the main caregiver for the resident, indicated to Inspector #592 that he/she does recall around a month or two ago shortly after resident #015 was moved to another floor that it was reported to him that a specific staff member had grabbed both wrist very hard during a repositioning which caused pain. PSW #102 further indicated to Inspector #592 that he had reported the incident immediately to RN #101 who was in charge that day. PSW #102 further indicated that as per the education provided by the home, he was instructed to report any complaint of alleged physical abuse made by a resident.

On December 14, 2016, during an interview with RN #101, she indicated to Inspector #592 that she does remember a PSW reporting that resident #015 had experience pain during a repositioning when a PSW grabbed both wrists. She further indicated to Inspector #592 that she does not recall which day but that she went to assess the resident and that both wrist was sensitive to touch but no marks were observed. RN #101 further indicated to Inspector #592 that she did not report the incident to her supervisor because the resident's pain did not exacerbate and that there was no worsening of pain, therefore did not considered the incident as a red flag and felt it was mild. She further told Inspector #592 that she had not document the incident and the follow-up of the resident on that specific day in the resident health care records.

A review of the licensee's policy titled "Resident Non Abuse" revised in March 2015 was done in the presence of RN #101. The licensee's policy under physical abuse indicates:

Any act of violence causing injury or physical discomfort:

The use of physical force by anyone other than a resident that causes physical injury or pain;

Furthermore the policy indicates that:

Physical abuse includes but is not limited to: Rough handling

Following the review of the definition of physical abuse with RN #101, she indicated to Inspector #592 that the licensee definition of physical abuse does identify the description of the resident's incident by having the resident describing pain and being handle roughly by staff member but at that time she though it was only an educational need for the PSW involved. She further told Inspector #592 that as per the Policy she should have reported the incident to her supervisor. Therefore, the information pertaining to an alleged physical abuse was not reported immediately. [s. 24. (1)]

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by a staff member occurred or may have occurred, immediately report the suspicion and the information upon which it was based to the Director.

Emotional abuse is defined in O.Reg 79/10 s.2 (1) a.as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Resident #021 was admitted to the home in April 2016 with several medical diagnoses. Upon review of the resident care units communication book from the resident's admission date in April 2016, resident #021 began to have concerns and complaints beginning in September 2016. On a specific day in September, 2016 during the 1400-2200 hours shift, it was documented that resident phoned family members to tell them to get him/her out of here. On a specific day in October 2016 during the 1400-2200 hours shift resident #021 was crying after supper, and RPN was made aware. Few days later in October 2016 during the 1400-2200 hours shift it was documented that the resident phoned family after supper, crying at times and asking if he/she could check himself/herself out of this home, Resident then raised his/her voice and yelled " because I am afraid to go to bed at night" to his/her family over the phone. Resident's progress notes indicated that the DOC interviewed the resident the next day, 2016 whereby the resident indicated that he/she was uneasy with a woman who works nights but could not name her.

On December 5, 2016 resident #021 indicated to Inspector #547 that he/she was afraid

of the some night shift staff members, but was not able to recall any names. Resident # 021, recalled that this staff member had been in the home for a long time and that other staff were upset with him/her as he/she complained about this staff member. Resident #021 indicated this staff member was caring for him/her one night and then when she left the resident's room, resident # 021 overheard this staff member say she will never come back in there. Resident #021 was embarrassed and found this upsetting.

Resident #021 also indicated to Inspector #592 that he/she reported to a nurse that gives out the pills on the floor the next day that staff on nights are loud and he/she cannot sleep which is not respectful to the residents in the home. Resident #021 then indicated on another occasion that nurses on the floor liked to write things down about me and then they both entered resident #021's room and laughed at him/her. They said nothing, but they just stood there and laughed. Resident indicated this was upsetting.

On December 15, 2016 the Director of Care indicated to Inspector #547 that as soon as she found out about these allegations, she went to investigate the situation as per the licensee's policy related to these types of complaints. She spoke to staff, and determined that there was no abuse, but rather a deterioration in the resident's medical condition.

The licensee's Resident Non Abuse policy #MM-0704-08 identifies "Psychological/Emotional Abuse as any action or comment that may cause emotional anguish, fear or diminish the self esteem or dignity of an individual". This policy further states that "mandatory staff reporting-investigation procedure that in any case of suspected resident abuse, the Administrator/Department Supervisor must be notified and in turn will notify the Director (Ministry of Health and Long Term Care) by way of critical incident report within ten days of the licensee becoming aware of the alleged, suspected or witnessed incident, or at a time required by the Director (in accordance with Section 24 of the Act)."

The Director of Care indicated that she did not report this alleged emotional staff to resident abuse to the Director of the Ministry of Health as required. [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 the there is reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall be immediately reported to the Director, to be implemented voluntarily.

WN #3: 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,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002, who is unable to toilet independently all of the time, receive assistance from staff to manage and maintain continence.

On December 14, 2016 during the supper meal observation, Inspector #547 heard resident #002 inform PSW #104, #103 and #106 that he/she needed to go to the bathroom at 1740 hours. PSW #106 brought the resident back to the room as he/she had completed his meal, and PSW #104 indicated to the resident that they would take him/her to the bathroom as soon as the dinner meal was completed. Inspector #547 returned to see resident #002 at the bedside at 1830 hours and the resident indicated that he/she no longer needed to go to the bathroom, as it was too late, and he/she already went in the brief. The resident further indicated that this happened all the time.

Resident #002 was admitted to the home in October 2015 with several medical diagnoses. The resident's current plan of care related to bowel routine indicated the resident requires assistance for potential to restore function to maximum self-sufficiency for the physical process of toileting. Resident #002 is to be toileted as per his/her needs,

and to be brought to the toilet at 1800 and 2000 hours to help prevent self-transferring.

On December 14, 2016 resident #047's family member reported to Inspector #547 that PSW's on the unit have indicated to her that they do not have enough staff on the unit to toilet residents around meal time, and that resident's will have to wait until meals are completed.

On December 14, 2016 PSW #104 indicated to Inspector #547 that he had not taken the resident to the bathroom yet, but was aware over fifty minutes had passed since the resident originally requested it. PSW #104 indicated that at meal time, with only two PSW's on the unit they do not have enough time to toilet residents.

On December 19, 2016 PSW #103 indicated to Inspector #547 that they are unable to follow all residents needs for toileting when requested if they request this during meals or staff break times, as these residents require two staff members to assist them, and only one PSW is on the unit. PSW #103 indicated that registered nursing staff are not asked to assist, and they tell the residents that they unfortunately have to wait.

On December 19, 2016 the Director of Care indicated that staff should be toileting residents when requested, and that it is not appropriate to leave them waiting to be toileted or soiled and this program will need to be reviewed with PSW staff in the home. [s. 51. (2) (c)]

2. . [s. 51. (2) (c)]

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 resident # 002, who is unable to toilet independently all of the time, receives assistance from staff to manage and maintain continence, 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who required assistance.

PSW #103 was observed by Inspector #547 during the dinner meal service in the dining room, to feed residents #049, #050, and #051. PSW #103 was observed by Inspector #547 to be standing while feeding the seated residents.

PSW's #103 indicated to Inspector #547 that he did not have time to sit with residents to feed them their meals as he also assisted many other residents that required redirection to the dining room and cueing assistance with their meals.

A review of resident #049, #050 and #051 care plans indicated these residents required extensive/total assistance by one staff as they were unable to feed themselves.

On December 15, 2016 the Director of Nutrition Care (DNC) indicated to Inspector #547 that nursing staff are aware that they are not supposed to feed residents while standing as part of the pleasurable dining experience.

On December 19, 2016 the DNC indicated to Inspector #547 that nursing staff are educated regarding feeding assistance expectations at their initial orientation and that the home's educator keeps nursing staff informed about current best practices required at meal times. The Director of Care (DOC) indicated that she would have to review with nursing staff that they cannot feed residents while standing. [s. 73. (1) 10.]

2. The licensee has failed to ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking.

On December 14, 2016 Inspector #547 observed the dinner meal service. PSW #106 and #112 were each seated at u-shaped tables that PSW #104 identified as feeding tables where residents are placed that require total assistance with eating or drinking. During this meal service, it was noted that PSW #112 provided assistance to the four residents seated at this table. PSW #106 was seated at the other feeding table where three residents were seated that she indicated required total assistance with eating and drinking. PSW #106 assisted these three residents at the same time during this meal service.

Inspector #547 interviewed PSW's #103, #104 and #106 at the end of this meal service, and they indicated that they were all aware that they are not supposed to assist more than two residents at a time for total feeding assistance, however due to staffing in the dining rooms at dinner time, they have no choice. PSW #104 indicated that usually they do not have PSW #112 assisting them and it is a lot busier than it was this evening. PSW #104 indicated that it is even harder when they are short staffed on the floor.

On December 15, 2016 the DNC indicated to Inspector #547 that they were aware of the staffing issues on the second floor and the feeding of multiple residents at the same time. The DNC said the home was aware that staff cannot feed more than two residents at a time.

On December 19, 2016 the DNC indicated to Inspector #547 that she will have to review the meal routines and feeding requirements for the second floor with the DNC to ensure that no more than two residents are provided total assistance for eating and drinking at one time. [s. 73. (2) (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 ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking and that proper techniques to assist these residents with eating is implemented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The license failed to ensure that there at least one Registered Nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times in the home.

As part of the Resident Quality Inspection, Inspector # 126 reviewed staffing related to 24/7 Registered Nurses (RN) coverage. It was noted that one shift was not assigned to any RN. Inspector # 126 requested the last 3 months schedule for 24/7 RN coverage.

The following shifts were noted not to be covered by a Registered Nurse (RN):

Wednesday September 7, 2016-no RN on site 1800-0600
Tuesday September 13, 2016-no RN on site 1800-0600
Sunday September 18, 2016-no RN on site 1800-0600
Monday September 19, 2016-no RN on site 1800-0600
Tuesday September 27, 2016-no RN on site 1800-0600
Wednesday September 28, 2016-no RN on site 2200-0600

Sunday October 2, 2016-no RN on site 1800-0600
Monday October 3, 2016- no RN on site 1800-0600
Saturday October 8, 2016, no RN on site 1800-0600
Wednesday October 12, 2016, no RN on site 2200-0600
Monday October 17, 2016, no RN on site 1800-0600

November 30, 2016, no RN on site 1800-0600

On December 12, 2016, via email, the Administrator confirmed that since September 2016, the home hired 6 RNs, one of which will be starting in January 2017. Since October 17, 2015 all the RN 24/7 shifts were covered as per schedule for the exception that on November 30, 2016, the RN called in sick and no replacement was available. The Administrator also indicated that the following was the process for replacing the RN "Our call out goes to RNs, then RNs in OT, then RPNs, then RPNs in OT. When an extra RPN is called in, the last RN is on call as well as the DOC. We are also fortunate that the Doctor and our Nurse Practitioner are always willing to help out in difficult situations."

An Order was not issued as the 24/7 RN coverage was corrected at the time of the Resident Quality Inspection was conducted. [s. 8. (3)]

WN #6: 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 has failed to ensure that as per O. Reg 79/10 s. 8 (1) (b), that any required plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

As per O. Reg 79/10 s. 48 (1), every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

A review of the licensee's policy titled "Fall Prevention Policy, Procedure, Post-Fall and Evaluation", DM3-0501-78, last revised June, 2015, indicated that the resident will be monitored for 72 hours after a fall.

A review of the resident health care record by Inspector # 593 indicated in the progress notes that resident #018 sustained an unwitnessed fall on a specific day in May, 2016, in the morning and no documentation was found related to 72 hour monitoring of the resident post-fall.

During an interview with Inspector #593, December 15, 2016, RPN #119 indicated that if a resident has an unwitnessed fall, the post falls monitoring includes regular monitoring of vital signs for 72 hours and that any post-falls monitoring of a resident is documented in the progress notes by a member of the registered nursing staff.

During an Interview with Inspector #593, December 19, 2016, the DOC confirmed that there was no documentation to support that 72 hour monitoring of the resident May 31, 2016 fall was completed and indicated that this is to be documented in the progress notes. [s. 8. (1) (a),s. 8. (1) (b)]

WN #7: 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. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

As per the LTCH Act, 2007 s. 20 (2) (e), at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

A review of the licensee's policy titled "Resident Non Abuse", MM-0704-08, last revised March, 2015, found that the individual to whom the incident has been reported will conduct an inquiry and complete a preliminary report before going off duty. The preliminary report shall contain the following: who were involved including witnesses to the event, why did it happen and was there anything that could have been done to prevent it from happening and written statements from witnesses.

A Critical Incident (CI) was submitted to the Director related to an incident of alleged resident to resident sexual abuse occurring a specific day in September, 2016. It was reported that resident #043 indicated that resident #002 touched her/him in a sexual way, without permission and he/she had to ask resident #002 to stop.

A review of resident #002 and #043's progress notes by Inspector # 593 found an entry completed by RPN #111 dated the day of the incident in September, 2016, in relation to the incident of alleged sexual abuse of resident #043 by resident #002. The entry documented that resident #043 alleged that resident #002 touched him/her in a sexual way without permission. PSW staff responding to the incident were not identified. The RPN documented in the progress note that the incident was reported to the charge RN and the DOC.

During an interview with Inspector #593, December 20, 2016, RPN #111 reported that the two PSW's working on the floor reported the incident to her. RPN #111 further added

that she reported the incident to both the charge RN and the DOC. In response to the incident, RPN #111reported that the two residents were separated and resident #002 was monitored for the rest of the night however it was the management of the home who were responsible for completing the investigation and as per the licensee's policy, the RPN reported the incident to the DOC and the charge nurse shortly after the incident occurred.

During an interview with Inspector #593, December 20, 2016, the DOC reported that she was responsible for the investigation into abuse allegations. The DOC indicated that she does not always document the investigation undertaken and was unsure of who was interviewed as part of the investigation into the alleged sexual abuse of resident #043 by resident #002. The DOC was unable to provide any documentation related to interviewing of possible witnesses, the residents involved or staff responding to the incident. [s. 20. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items are offered and available at each meal for residents.

On December 5, 2016 Inspector #547 observed the lunch meal service on the second floor. The planned puree menu for the resident's desert was identified as the following: Butter tarts or Apricots in all food textures.

PSW #127 indicated that the kitchen only made three pureed tarts, but all residents liked this choice and said there is not enough. Two residents were observed to not be offered a choice of desert and provided the apricots that PSW #127 indicated to them as the only choice for desert that day as they ran out of butter tarts for them. PSW #127 indicated the kitchen can often call to another unit, but that it can take a long time and they don't

have the time.

On December 14, 2016 Inspector #547 observed the dinner meal service on the second floor. Resident # 049 ate less than three quarters of the main course. PSW #104 asked the resident if he/she wanted a desert and the resident responded yes. PSW #104 gave jello without offering the other choices of deserts to resident # 049.

PSW #104 indicated to Inspector #547 that they had enough food choices to offer each resident for desert, but that he chose this desert for the resident hoping that he would prefer the sweet option. PSW #104 indicated that the pineapple was also available, and was not sure what the resident would have chosen if offered. PSW #104 indicated the kitchen on the second floor did run out of bread rolls tonight, as he had to inform resident #001 when he asked for a bread roll, that there was none left in the kitchen so the resident could not have any more bread. PSW #104 further indicated that the unit kitchen often runs out of the favoured items such as pies and cakes in any texture. Resident choices are often not an option, especially the pureed options but they have also been known to run out of regular texture items as well.

On December 15, 2016 Inspector #547 interviewed the Director of Nutrition Care for the home and she indicated that they began a new menu and that they would need to review the production from the kitchen to ensure that sufficient pureed/minced texture options are made available on each floor to support resident choices at meals as identified on the planned menu. The Director of Nutrition Care indicated that choices should always be offered to each resident. If the resident cannot or will not respond, the staff should make an attempt to offer choices to the resident, and then they can try one or the other food choices to see if the resident will enjoy it. [s. 71. (4)]

WN #9: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital was reported no later that one business day after the occurrence of the incident.

On a specific day in July, 2916, Resident #048 fell in the room's which resulted in an injury. Resident # 048 was sent to the hospital and was returned to the home the same day. In the ER, the physician discussed the treatment plan for the injury with the SDM and comfort measures were to be implemented. The resident condition deteriorated after the fall and resident #048 became totally dependent for all aspects of his/her care needs when the resident required limited assistance in some areas of his/her care needs prior to the fall.

During an interview with Inspector #126, December 20, 2016,RN #120 indicated that a Critical Incident should have been completed and was not aware if a Critical Incident was submitted.

During an interview with Inspector #126, December 19, 2016, the DOC indicated that a Critical Incident related to resident #048"s fall was not sent to the Director.

To this date, December 21. 2016, the home has not submit a critical incident involving resident # 048's fall which resulted in significant change in her condition. [s. 107. (3)]

WN #10: 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 or a medication cart that is secure and locked.

On December 14, 2016, the medication cart was found by Inspector #547 to be unlocked and unsupervised on the second floor in the central "reminiscing area". The second floor units are considered to be the home's dementia units that are secured for resident safety. This "reminiscing area" had five resident's seated with two independently ambulatory residents. Resident #045 and resident #046 were talking to each other and noticed Inspector #547 opening and closing the drawers in this medication cart. Resident #046 approached Inspector #547 asking if I was going to be administering medications and I indicated that I was looking at how the drawers functioned on this cart and redirected the resident to the rocking chair away from this cart. No registered nursing staff was observed in the area for approximately three minute period of time. RN # 109 returned from the hallway and went to the nursing station and shut the door. RN #109 then returned to the "reminiscing area" and went directly to the medication cart and pushed in the locking mechanism attached to the medication cart.

Inspector #547 interviewed RN #109 regarding the home's expectations for unattended medication carts, and indicated that they were suppose to always be kept locked. RN #109 indicated that she left the medication cart to take a phone call and look if there was any more apple sauce in the kitchen and forgot to lock the medication cart before she walked away. [s. 129. (1) (a)]

WN #11: 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 has failed to ensure that all areas when where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On December 19, 2016, RN #101 and Inspector #126 were reviewing the area where the Government supplies/medications were stored. In discussion with RN #101 , she indicated that the supplies and medication were ordered by the Supervisor of Continues Quality(SCQ) and the SCQ was the one that was ordering and bringing the supplies/medications to the room where the drugs are stored.

During an interview with Inspector #126, December 19, 2016, the SCQ indicated that she had a key to the area were the supplies/medications were kept and that she was not a registered nursing staff. The SQC was informed that as per legislation, only specific staff, such as RN, RPN, Pharmacist and the Administrator should have access to this restricted area. [s. 130. 2.]

Issued on this 9th day of January, 2017

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

Original report signed by the inspector.