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

Division des foyers de soins de longue durée
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
Feb 23, 2017	2017_622521_0001	033868-16	Resident Quality Inspection

Licensee/Titulaire de permis

HANOVER NURSING HOME LIMITED
700 19TH AVENUE HANOVER ON N4N 3S6

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

HANOVER CARE CENTRE
700-19TH AVENUE HANOVER ON N4N 3S6

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

REBECCA DEWITTE (521), AMIE GIBBS-WARD (630), NUZHAT UDDIN (532)

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 16, 18, 19, 20, 25, 26, 27 and 30, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator, the Activation Manager, the Food Services Supervisor (FSS), the Housekeeping Aide, three Registered Nurses, One Registered Practical Nurse, One Cook, One Dietary Aide, One Maintenance Worker and four Personal Support Workers.

During the course of the inspection the inspector(s) toured all resident home areas, observed provision of resident care, a medication pass, staff to resident interactions, infection prevention and control practices, reviewed resident clinical records, posting of required information and reviewed minutes pertaining to Resident and Family Council meetings.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **7 VPC(s)**
- **4 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. 59. Family Council

Specifically failed to comply with the following:

s. 59. (3) The licensee shall assist in the establishment of a Family Council within 30 days of receiving a request from a person mentioned in subsection (2). 2007, c. 8, s. 59. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee assisted in the establishment of a Family Council within 30 days of receiving a request from a family member or person of importance to a resident.

A family council signup sheet was posted in the home asking "if you are interested in forming a family council, please sign below".

A review of the signup sheet had several families had expressed interest in forming a family council.

Contact with expressions of interest shared the family council had not been established.

An interview with the Administrator and Director of Care acknowledged the licensee had failed to ensure that the licensee assisted in the establishment of a Family Council within 30 days of receiving a request from a family member.

The scope of the non-compliance was widespread, the severity of the non-compliance was a minimum risk and the compliance history was one or more related non-compliance in the last three years of s.59(7)(a) VPC issued August 12, 2015. [s. 59. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The policy called Least Restraint #60-10 revised dated September 2015 stated under bullet 4. "The restraint of a resident shall be carried out only if there was an imminent risk of harm to the resident or another person and only if the physician has ordered the use of the restraint or has confirmed the use of the restraint within 12 hours of it being applied by charge staff".

The physician's order must include:
the type of restraint
the reason for its application
the duration of its use.

Record review of physician's order. The order did not include the reason of the restraint, and the duration of its use.

The Administrator acknowledged that the order should have included the reason for its application and the duration of its use in the policy and it did not. [s. 8. (1) (b)]

2. The policy called Documentation # 30-115 dated December 24, 1998, stated under bullet 9. "Errors in charting are to be bracketed and lined through once with the word "error" and signature of writer above the error".

Record review of a resident assessment - no date. Had scribbled out writing with pen. No signature or error noted.

Another assessment record was also scribbled out with pen. No signature, no error note.

Interview with DOC acknowledged the scribbled out documents were not acceptable and did not comply with documentation policy and standards. [s. 8. (1) (b)]

3. The policy called Code of Ethics #10-10 revised July 25, 2014 stated under bullet c)"Employees shall not solicit or accept any gift, present or favour".

Record review of Resident's Council meeting minutes stated "residents would like to purchase a gift card and a card on behalf of all residents and resident council. This will come out of residents council funds. $25.00 gift card".
"residents were reminded of the gift card purchase".

An interview with the Administrator acknowledged the staff did accept the gift cards. The Administrator #100 further verified the policy was not complied with and it was the homes expectation that staff were not to accept gifts from residents. [s. 8. (1) (b)]

4. A staff was observed completing a pass. It was noted that the staff identified the residents through a photograph, the staff then took the drugs for administration, referred to the Medication Administration Record (MAR) and signed for the administration prior to giving the medication to the residents.

Policy called Medication Pass #90-15 dated November 14, 2006, stated under bullet 7. d) "Having checked that all medications have been poured including liquids, government stock and narcotics and that the resident has been properly identified, administer medication. e) Observe the resident to ensure the drugs was ingested. f) Initial MAR sheets for all medications that were administered to that resident."

In an interview staff acknowledged that they signed the MAR prior to administering the drugs to the resident and stated that the policy on medication pass was not complied with when they signed the MAR prior to administering the medications. [s. 8. (1) (b)]

5. A review of policy Catheter Care Regulation and Standards dated December 1998, demonstrated it was the homes expectation that the residents care plan would indicate:

a) When the drainage bag was to be emptied
b) Frequency of changing and irrigation of the catheter
c) Frequency of changing the tubing and drainage bag

d) Type of drainage bag to be used
e) The perineal care to be provided, by whom, at what times with what solution
f) Nursing actions to deal with the residents emotional responses to the need for a catheter

Record review of 3 residents plans of care failed to note catheter care goals and interventions listed.

An interview with staff acknowledged the plans of care failed to indicate:

a) When the drainage bag was to be emptied
b) Frequency of changing and irrigation of the catheter
c) Frequency of changing the tubing and drainage bag
d) Type of drainage bag to be used
e) The perineal care to be provided, by whom, at what times with what solution
f) Nursing actions to deal with the residents emotional responses to the need for a catheter

An interview with the DOC verified it was the homes expectation that the policy Catheter Care Regulation and Standards dated December 1998, should have been complied with.

The scope of the non-compliance was widespread, the severity of the non-compliance had potential for actual harm and the compliance history was one or more related non-compliance in the last three years of r.8(1)(b) was issued as a VPC January 20, 2016. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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,
(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 has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A record review of progress notes identified a resident had altered skin integrity. A review of the resident skin assessments identified there were no initial assessments.

In an interview with staff it was verified the assessment was not completed for resident.

In an interview with the Director of Care it was acknowledged that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, should have received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian who was a member of the staff of the home.

A record review of progress notes indicated a resident exhibited altered skin integrity. A further review failed to identify an assessment by a registered dietitian following the identified altered skin integrity.

An interview with staff acknowledged there were no referrals to the dietitian pertaining to the residents altered skin integrity. [s. 50. (2) (b) (iii)]

3. A record review of a resident skin sheets identified a resident exhibited altered skin integrity.

The dietitians quarterly review identified the resident’s skin was intact.

A review of notes indicated a dietitian referral was frequently made for the resident’s other concerns but made no reference of the resident's altered skin integrity.

An interview with staff acknowledged there were no referrals to the dietitian pertaining to the resident’s altered skin integrity. [s. 50. (2) (b) (iii)]

4. A record review of progress notes completed by the a specialist identified a resident's skin concerns had resolved. A further review of progress notes completed by another staff identified a resident had altered skin integrity.

An interview with management acknowledged there were no completed referrals to the dietitian pertaining to the resident's altered skin integrity.

In an interview with the Director of Care it was verified that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds should have been assessed by a registered dietitian who was a member of the staff of the home. [s. 50. (2) (b) (iii)]

5. The licensee has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff.

A review of a resident tracking sheet identified a resident had altered skin integrity. The review of the assessment record identified there were no completed assessments recorded.

An interview with the DOC agreed the altered skin integrity had got progressively worse over time. [s. 50. (2) (b) (iv)]

6. A record review of notes identified a resident had altered skin integrity. A review of the resident's assessments identified there were no weekly assessment records for the altered skin integrity.

In an interview with staff it was verified the weekly assessments were not completed for the two resident's.

In an interview with the Director of Care it was acknowledged that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds should have been reassessed at least weekly by a member of the registered nursing staff.

The scope of the non-compliance was a isolated, the severity of the non-compliance was actual harm and the compliance history was one or more related non-compliance in the last three years of s.48(1) no skin and wound program compliance order issued May 13, 2014. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that where a drug that was to be destroyed was not a controlled substance, it was done by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing.

In an interview staff shared that the drug that was not a controlled substance was placed inside a white container in the medication room by the staff acting alone. The staff acknowledged that it was not done in a team acting together, composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing.
Observations of the white bin were made.

The policy # 90-85 called Disposal of Discontinued/Expired Non-Narcotic Medication dated July 17, 2015, stated 4. "For non-narcotic medication waste the registered staff disposing of the medication will do so by opening the container in which the medication is sealed in and place medication that is to be denatured in the sealed container that is provided to us by Stericycle for destruction".

The Administrator and DOC were unaware of the regulation that non-narcotic drug that were to be destroyed was to be completed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing as per

Ontario Regulation 79/10 r.136(3)(b) [s. 136. (3) (b)]

2. The licensee has failed to ensure that when a drug was destroyed, the drug was altered or denatured to such an extent that its consumption was rendered impossible or improbable.

Observation with staff identified that drugs that were not a controlled substances were being placed inside a white container provided by Stericycle. The drugs were inside the individual plastic packaging and placed in the container as a whole, the drugs were not denatured. The white container from Stericycle was observed and noted to be three quarters full.

The policy # 90-85 called Disposal of Discontinued/Expired Non-Narcotic Medication dated July 17, 2015, stated 4. "For non-narcotic medication waste the registered staff disposing of the medication will do so by opening the container in which the medication is sealed in and place medication that is to be denatured in the sealed container that is provided to us by Stericycle for destruction. 5. When the Stricycle sealed container is full it will be taken from use and placed in the locked area in the building which only registered staff and the Administrator will have access to and a new container with a sealed lid will be brought forth and placed in the medication room and used for disposal of non-narcotic medication."

The staff shared that the drugs were not altered or denatured to such an extent that its consumption was rendered impossible or improbable. The regulation was reviewed with the staff who shared that they did not denature the drugs, they put them as whole inside the white bin and that drugs were picked up and taken away by a third party arranged by the pharmacy provider.

This practice was acknowledged with the DOC that the drugs were picked up by a third party contractor arranged by the pharmacy. The DOC acknowledged that drugs were not destroyed or denatured in the home to such an extent that its consumption was rendered impossible or improbable.

The scope of the non-compliance was widespread, the severity of the non-compliance had potential for actual harm and the compliance history was one or more related non-compliance in the last three years of s.136(2)1 issued a VPC August 12, 2015. [s. 136. (6)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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 has failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respects the resident's dignity.

A record review of resident council meeting minutes stated the Administrator attended the meeting to address the shopping allowances for residents attending the local Walmart.

Residents were told they were allowed to buy up to one bag of groceries each and those who would not comply with this would not be able to go shopping.

An interview with a resident shared the meeting did take place and the residents were told the rules regarding the grocery allowance.

In an interview with the Administrator they acknowledged they did attend the meeting to tell the residents they were only allowed one bag of groceries, and if the residents were

not to comply with this they would not be allowed to go shopping. The Administrator demonstrated that they understood the breach and that resident's have 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. [s. 3. (1) 1.]

2. The licensee failed to ensure residents’ have the right to be afforded privacy in treatment and in caring for his or her personal needs.

Inspector #532 was walking down the hall and witnessed that the door to a room was wide open. There were people present in the room. The curtains to all of the beds were wide open. The observation further identified that there were three staff members assisting and exposing a resident.

Inspector #532 reported the incident and raised immediate concerns with the Administrator.

The Administrator walked over to learn why the door was not closed.

The Administrator asked why the door and the curtain was not closed when providing care to the resident.

Administrator gave directions to staff ensure that doors were closed and curtains were pulled when giving personal care to the residents.

The Administrator acknowledged that the staff members did not respect residents right be afforded privacy in treatment and in caring for his or her personal needs.

The scope of the non-compliance was widespread, the severity of the non-compliance had potential for actual harm and the compliance history was one or more related non-compliance in the last three years of s.3(1)11 iv lack of privacy was issued as a VPC May 13, 2014. [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' bill of rights are fully respected and promoted, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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 plan of care set out clear directions to staff and others who provide direct care to the resident.

Loud yelling noise was heard from the tub room.

Inspector #532 walked over to the tub room to inquire about the loud yelling noise.

The Administrator shared that a resident often yells during care.

The plan of care for the resident under care was reviewed and under interventions tab it said that "often yells during". However, there were no new or custom interventions to address the "yelling".

Another staff was interviewed and shared that they had been involved with assessing the resident for a while and had implemented interventions to address behaviours which were documented in the plan of care under behaviours. However, the staff acknowledged that different methods of personal care had not been tried with the resident.

It was agreed that care set out in the plan of care did not provide clear directions to staff and others who provide direct care to the resident. [s. 6. (7)]

2. The license has failed to ensure that the resident was 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 was no longer necessary.

A resident was observed with an intervention in place.

The resident was observed again with the intervention in place and the resident was able to remove the intervention when asked.

In an interview the resident shared that they did not like the intervention.

Record review of progress note stated that resident was to use the intervention as a reminder.

Plan of care was reviewed and under mobility it documented that the resident was dependent in the wheelchair with foot rests.

In an interview staff were asked about the resident's intervention. Staff shared that the intervention was applied to prevent resident from self-transferring. The staff further shared that the intervention was reassessed a week after the application and it was noted that the resident was able to undo the intervention and the decision was made by the staff to keep the intervention off. In the interview it was shared that the staff had made a note in the communication book for the Personal Support Staff (PSW) and crossed the intervention off from the PSW work sheet.

Review of the communication book documented trialing the intervention however, there was no note documenting that intervention was to remain off and this was acknowledged with the staff.

The staff acknowledged that when the plan of care was reviewed, it continued to state

that the resident had the intervention and agreed that the plan of care was not revised when the resident's care needs changed and the care set out in the plan of care was no longer necessary.

The scope of the non-compliance was isolated, the severity of the non-compliance had potential for actual harm and the compliance history was one or more related non-compliance in the last three years of s.6(1)(c) and s.6(9)1 relating to plan of care was issued as a VPC May 13, 2014. [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 the plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care was based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.

A review of a resident tracking sheet identified a resident had altered skin integrity.

An interview with Own Sound Hospital staff identified the resident was transferred with no altered skin integrity. The interview further identified resident had actual altered skin integrity. The skin integrity was described as “deep tissue injuries”.

2. A review of a resident progress notes identified a resident had altered skin integrity.

A review of the resident plan of care failed to mention the altered skin integrity.

In an interview with the staff it was acknowledged the plans of cares were very generic and therefore would not be based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity.

An interview with the Director of Care (DOC) acknowledged the resident's plans of care failed to identify the altered skin integrity and it was the homes expectation that the residents’ plan of care should be based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions. [s. 26. (3) 15.]

3. The licensee failed to ensure the plan of care was based on an interdisciplinary assessment with respect to the resident's special treatments and intervention.

A record review demonstrated resident's plans of care failed to reference an interdisciplinary assessment with respect to the resident’s special treatments and interventions.

An interview with staff shared the plan of care was not based on an interdisciplinary assessment with respect to the resident's special treatments and intervention.

An interview with the Director of Nursing (DOC) said it was the homes expectation that the plan of care was to be based on an interdisciplinary assessment with respect to the resident's special treatments and interventions.

The scope of the non-compliance was a isolated, the severity of the non compliance was potential for actual harm and the compliance history was one or more unrelated non-compliance in the last three years. [s. 26. (3) 18.]

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 plan of care was based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A review of policy #100-95 wrote the Director of Care was to ensure that the overall approach to resident continence and incontinence management was reviewed annually.

A review of the Bladder and Bowel Continence Management Program binder indicated there was no annual evaluations completed.

A review of policy #100-381A wrote the program would be evaluated annually and updated appropriately.

A review of the Skin Care and Wound Management Program binder shared there was no annual evaluations completed.

An interview with the Director of Care verified the Bladder and Bowel Continence Management Program and the Skin Care and Wound Management Program was not annually evaluated in accordance with best practices and it was the homes expectation that the Programs were to be evaluated and updated at least annually.

The scope of the non-compliance was a pattern, the severity of the non compliance was minimum risk and the compliance history was one or more unrelated non-compliance in the last three years. [s. 30. (1) 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 the program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee has failed to ensure that no prohibited restraint devices were used on a resident.

Record review documented that a resident was admitted in the home.

During Resident Quality Inspection (RQI) the resident was observed in a restraint.

The Administrator was accompanied to the resident while the resident was restrained. The Administrator was not able to immediately release the restraint.

Policy called Least Restraint #60-10 revised date September 26, 2015, wrote under that any device that cannot be immediately released by staff were prohibited. The regulations were reviewed with the DOC and the Administrator who were unaware the restraint was prohibited and it was acknowledged that the policy did not include sheets, wraps, tensors, or other types of strips or bandages that were also considered prohibited.

The Administrator acknowledged that the device was not immediately released and shared that wraps and strips should not be used in the home.

The scope of the non-compliance was a pattern, the severity of the non-compliance was potential for actual harm and the compliance history was one or more unrelated non-compliance in the last three years. [s. 35. (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 no prohibited restraint devices are used on a resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the most recent notes identified the resident was at "high nutritional risk".

The plan of care for the resident asked for staff to provide interventions.

Review of the Medication Administration Record showed the interventions were not provided.

Review of the Food and Fluid Intake Record for the resident showed no documented evidence that the interventions were provided.

Review of the notes found no documentation by nursing regarding refusal of the intervention.

Review of the home's policy called "Dietary Intake Charting for PSW/Nursing Staff" and "revised August 27, 2012" found it did not provide direction to staff regarding documentation of the interventions. The policy did state "PSW/Nursing staff will report to Charge Nurse when a resident refuses interventions.

Staff reported to Inspector that there was no place on the intake record where they record the intake of interventions.

Staff said that the resident in general had deteriorated.

Management acknowledged that the current policy and practices in the home did not include the monitoring of the interventions. [s. 68. (2) (d)]

2. Review of the most recent assessment completed by staff for a resident identified the resident was at "high nutritional risk".

The plan of care for the resident stated to provide interventions.

Review of the Medication Administration Record (MAR) for the resident had no completed documentation for the required intervention.

Review of the home's policy titled "Dietary Intake Charting for PSW/Nursing Staff" and "revised August 27, 2012" found it did not provide direction to staff regarding documentation for the interventions.

Resident reported to Inspector that they consume interventions from their own supply.

Management acknowledged that the current policy and practices in the home did not include the monitoring of the interventions provided to the resident from their own supply.

The scope of the non-compliance was isolated, the severity of the non-compliance was potential for actual harm and the compliance history was one or more unrelated non-compliance in the last three years. [s. 68. (2) (d)]

Additional Required Actions:

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

WN #11: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, has a response been made to the person who made the complaint, indicating what the licensee has done to resolve the complaint.

A review of resident council meeting minutes identified Residents' Council had concerns on three meetings that the dessert squares were a little frozen or too cold when they were served to the residents.

A review of the responses sent to the Residents Council identified “Staff are trying to remember to remove the squares from the fridge earlier. Sometimes they forgot”. “Unable to explain – perhaps the squares have been forgotten to be taken out ahead of time”.

An interview with a manager identified the staff were not taking the squares out of the fridge in adequate time during the meal serving process and that resulted in the squares being served too cold. The interview further acknowledged there were no checks made on the removal of dessert from the fridge included in the audit procedure.

An interview with a staff said that the dessert cart remains in the fridge until it was time to serve the dessert.

An interview with another staff said that the dessert cart remains in the fridge until it was time to serve the dessert unless there were squares on the dessert cart, then it was to be removed earlier.

An interview with the Administrator verified the response to the resident’s council should have included what the manager had done to resolve the complaint.

The scope of the non-compliance was a pattern, the severity of the non-compliance was minimum risk and the compliance history was one or more unrelated non-compliance in the last three years. [s. 101. (1) 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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, has a response been made to the person who made the complaint, indicating what the licensee has done to resolve the complaint, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping that procedures were developed and implemented for supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

An Inspector observed that the wheelchair being used by a resident was unclean and had a stain on the cushion.

Review of the plan of care for the resident identified this resident did not include direction to staff regarding frequency of cleaning of the wheelchair.

During an interview with staff it was reported that the resident wheelchairs were to be cleaned weekly by the night shift based on the PSW assignment sheets. They reported that the night shift used the steamer to clean the chairs.

Review of the home's policy titled "Wheelchair and Geriatric Chairs – Cleaning and Servicing" and "Revised December 10, 2013" documented that "all wheelchairs will be washed weekly with cleaning disinfectant solution".

DOC told Inspector that wheelchairs were to be cleaned weekly as stated in the policy. DOC reported that the night staff used to initial a form indicating that the chair had been cleaned but that sheet could not be located at the time of the inspection and may no longer have been implemented in the home.

During observations of the wheelchair with DOC it was acknowledged that the chair was dirty. DOC reported that there was no documentation to show when the last time this wheelchair had been cleaned. DOC shared it was the expectation in the home that the procedures for weekly cleaning of the wheelchair were implemented.

The scope of the non-compliance was isolated, the severity of the non-compliance was minimum risk and the compliance history was one or more unrelated non-compliance in the last three years. [s. 87. (2) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy addressed alternatives to the use of physical devices, including how these alternatives were planned, developed and implemented, using an interdisciplinary approach.

Policy called Least Restraint #60-10 revised dated September 2015, listed the alternatives to restraints which included bed alarm, pinning of call bell to night clothes, uncluttered environment, exercise, music, medication review, pain management, companion, increased supervision, reduced environmental noise, increase and decreased stimulation, physical assessment i.e. Urinary Tract Infection (UTI), bowel impaction, massage relaxation, improved communication between staff and resident and positioning devices.

In an interview with the Administrator it was verified the policy did not address how these alternatives were planned, developed and implemented, using an interdisciplinary approach.

The scope of the non-compliance was isolated, the severity of the non-compliance was minimum risk and the compliance history was one or more unrelated non-compliance in the last three years. [s. 109. (f)]

Issued on this 27th day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	REBECCA DEWITTE (521), AMIE GIBBS-WARD (630), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2017_622521_0001
Log No. / Registre no:	033868-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 23, 2017
Licensee / Titulaire de permis :	HANOVER NURSING HOME LIMITED 700 19TH AVENUE, HANOVER, ON, N4N-3S6
LTC Home / Foyer de SLD :	HANOVER CARE CENTRE 700-19TH AVENUE, HANOVER, ON, N4N-3S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brenda Weppler

To HANOVER NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 59. (3) The licensee shall assist in the establishment of a Family Council within 30 days of receiving a request from a person mentioned in subsection (2). 2007, c. 8, s. 59. (3).

Order / Ordre :

The licensee must achieve compliance to ensure that the home assists in the establishment of a Family Council within 30 days of receiving a request from a family member or person of importance to a resident.

Specifically, the licensee will:

1) Educate all staff on the powers of the Family Council, the duty to respond to the Family Council and the duties of the Family Council Assistant

2) Provide a Family Council Assistant

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the licensee assisted in the establishment of a Family Council within 30 days of receiving a request from a family member or person of importance to a resident.

A family council signup sheet was posted in the home asking "if you are interested in forming a family council, please sign below".

A review of the signup sheet had several families had expressed interest in forming a family council.

Contact with expressions of interest shared the family council had not been established.

An interview with the Administrator and Director of Care acknowledged the licensee had failed to ensure that the licensee assisted in the establishment of a Family Council within 30 days of receiving a request from a family member.

The scope of the non-compliance was widespread, the severity of the non-compliance was a minimum risk and the compliance history was one or more related non-compliance in the last three years of s.59(7)(a) VPC issued August 12, 2015. [s. 59. (3)] (521)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2017

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must achieve compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Specifically, the licensee will:

a) Educate all appropriate staff on the written policies including Restraints, Continence and Bowels, Skin and Wound, Ethics, Documentation and Medication.

b) Develop and implement a process for tracking staff education to ensure completion.

Grounds / Motifs :

1.

(521)

2. On January 27, 2017, Registered Nurse #117 at 1230 hours was observed completing a medication pass. It was noted that Registered Nurse #117 identified the residents through a photograph, the Registered Nurse #117 then took the drugs for administration, referred to the Medication Administration Record (MAR) and signed for the administration prior to giving the medication to

the residents.

Policy called Medication Pass #90-15 dated November 14, 2006, stated under bullet 7. d) "Having checked that all medications have been poured including liquids, government stock and narcotics and that the resident has been properly identified, administer medication. e) Observe the resident to ensure the drugs was ingested. f) Initial MAR sheets for all medications that were administered to that resident."

On January 27, 2017 RN #117 in an interview acknowledged that they signed the MAR prior to administering the drugs to the resident and stated that the policy on medication pass was not complied with when they signed the MAR prior to administering the medications. (532)

3. The policy called Code of Ethics #10-10 revised July 25, 2014 stated under bullet c)"Employees shall not solicit or accept any gift, present or favour".

Record review of Resident's Council meeting minutes on January 26, 2017, revealed on April 25, 2016, "Upcoming baby shower – residents would like to purchase a gift card and a card on behalf of all residents and resident council. This will come out of residents council funds. $25.00 gift card".
On October 24, 2016 "residents were reminded of the gift card purchase for baby Levi and Dawnyca's baby shower".

An interview with the Administrator #100 on January 26, 2017, acknowledged the staff did accept the gift cards.
The Administrator #100 further verified the policy was not complied with and it was the homes expectation that staff were not to accept gifts from residents. (521)

4. 1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The policy called Least Restraint #60-10 revised dated September 2015 stated under bullet 4. "The restraint of a resident shall be carried out only if there was an imminent risk of harm to the resident or another person and only if the physician has ordered the use of the restraint or has confirmed the use of the restraint within 12 hours of it being applied by charge staff".

The physician's order must include:
the type of restraint
the reason for its application
the duration of its use.

Record review of physician's order. The order did not include the reason of the restraint, and the duration of its use.

The Administrator acknowledged that the order should have included the reason for its application and the duration of its use in the policy and it did not. [s. 8. (1) (b)]

2. The policy called Documentation # 30-115 dated December 24, 1998, stated under bullet 9. "Errors in charting are to be bracketed and lined through once with the word "error" and signature of writer above the error".

Record review of a resident assessment - no date. Had scribbled out writing with pen. No signature or error noted.
Another assessment record was also scribbled out with pen. No signature, no error note.

Interview with DOC acknowledged the scribbled out documents were not acceptable and did not comply with documentation policy and standards. [s. 8. (1) (b)]

3. The policy called Code of Ethics #10-10 revised July 25, 2014 stated under bullet c)"Employees shall not solicit or accept any gift, present or favour".

Record review of Resident's Council meeting minutes stated "residents would like to purchase a gift card and a card on behalf of all residents and resident council. This will come out of residents council funds. $25.00 gift card".
"residents were reminded of the gift card purchase".

An interview with the Administrator acknowledged the staff did accept the gift cards.
The Administrator #100 further verified the policy was not complied with and it was the homes expectation that staff were not to accept gifts from residents. [s. 8. (1) (b)]

4. A staff was observed completing a pass. It was noted that the staff identified the residents through a photograph, the staff then took the drugs for administration, referred to the Medication Administration Record (MAR) and signed for the administration prior to giving the medication to the residents.

Policy called Medication Pass #90-15 dated November 14, 2006, stated under bullet 7. d) "Having checked that all medications have been poured including liquids, government stock and narcotics and that the resident has been properly identified, administer medication. e) Observe the resident to ensure the drugs was ingested. f) Initial MAR sheets for all medications that were administered to that resident."

In an interview staff acknowledged that they signed the MAR prior to administering the drugs to the resident and stated that the policy on medication pass was not complied with when they signed the MAR prior to administering the medications. [s. 8. (1) (b)]

5. A review of policy Catheter Care Regulation and Standards dated December 1998, demonstrated it was the homes expectation that the residents care plan would indicate:

a) When the drainage bag was to be emptied
b) Frequency of changing and irrigation of the catheter
c) Frequency of changing the tubing and drainage bag
d) Type of drainage bag to be used
e) The perineal care to be provided, by whom, at what times with what solution
f) Nursing actions to deal with the residents emotional responses to the need for a catheter

Record review of 3 residents plans of care failed to note catheter care goals and interventions listed.

An interview with staff acknowledged the plans of care failed to indicate:

a) When the drainage bag was to be emptied
b) Frequency of changing and irrigation of the catheter
c) Frequency of changing the tubing and drainage bag
d) Type of drainage bag to be used
e) The perineal care to be provided, by whom, at what times with what solution

f) Nursing actions to deal with the residents emotional responses to the need for a catheter

An interview with the DOC verified it was the homes expectation that the policy Catheter Care Regulation and Standards dated December 1998, should have been complied with.

The scope of the non-compliance was widespread, the severity of the non-compliance had potential for actual harm and the compliance history was one or more related non-compliance in the last three years of r.8(1)(b) was issued as a VPC January 20, 2016. [s. 8. (1) (b)] (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2017

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must achieve compliance to 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).

Specifically, the home will:

a) Develop and implement a process for completing skin assessments,
b) Develop and implement a tracking and auditing system for all altered skin integrity in the home, assessments, documentation and strategies;
c) Educate all nursing staff related to the types of altered skin integrity ("altered skin integrity" means potential or actual disruption of epidermal or dermal tissue), roles and responsibilities related to recognition, reporting, documentation, assessments and appropriate strategies;
d) Educate all registered staff related to the process for completing a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and the process for completing a skin assessment when the home's software for skin assessments is inaccessible; and
e) Develop and implement a process for tracking staff education to ensure completion.

Grounds / Motifs :

1. 1. The licensee has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A record review of progress notes identified a resident had altered skin integrity.

A review of the resident skin assessments identified there were no initial assessments.

In an interview with staff it was verified the assessment was not completed for resident.

In an interview with the Director of Care it was acknowledged that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, should have received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian who was a member of the staff of the home.

A record review of progress notes indicated a resident exhibited altered skin integrity. A further review failed to identify an assessment by a registered dietitian following the identified altered skin integrity.

An interview with staff acknowledged there were no referrals to the dietitian pertaining to the residents altered skin integrity. [s. 50. (2) (b) (iii)]

3. A record review of a resident skin sheets identified a resident exhibited altered skin integrity.

The dietitians quarterly review identified the resident's skin was intact.

A review of notes indicated a dietitian referral was frequently made for the resident's other concerns but made no reference of the resident's altered skin integrity.

An interview with staff acknowledged there were no referrals to the dietitian pertaining to the resident's altered skin integrity. [s. 50. (2) (b) (iii)]

4. A record review of progress notes completed by the a specialist identified a resident's skin concerns had resolved. A further review of progress notes completed by another staff identified a resident had altered skin integrity.

An interview with management acknowledged there were no completed referrals to the dietitian pertaining to the resident's altered skin integrity.

In an interview with the Director of Care it was verified that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds should have been assessed by a registered dietitian who was a member of the staff of the home. [s. 50. (2) (b) (iii)]

5. The licensee has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff.

A review of a resident tracking sheet identified a resident had altered skin integrity. The review of the assessment record identified there were no completed assessments recorded.

An interview with the DOC agreed the altered skin integrity had got progressively worse over time. [s. 50. (2) (b) (iv)]

6. A record review of notes identified a resident had altered skin integrity. A review of the resident's assessments identified there were no weekly assessment records for the altered skin integrity.

In an interview with staff it was verified the weekly assessments were not completed for the two resident's.

In an interview with the Director of Care it was acknowledged that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds should have been reassessed at least weekly by a member of the registered nursing staff.

The scope of the non-compliance was a isolated, the severity of the non-compliance was actual harm and the compliance history was one or more related non-compliance in the last three years of s.48(1) no skin and wound program compliance order issued May 13, 2014. [s. 50. (2) (b) (iv)] (521)

2.
(521)

3.
(521)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2017

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Order / Ordre :

The licensee must achieve compliance to ensure that:

1)The drugs for destruction and disposal must be destroyed by a team acting together and composed of, (b) in every other case, (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) one other staff member appointed by the Director of Nursing and Personal Care and

2)That when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that where a drug that was to be destroyed was not a controlled substance, it was done by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing.

In an interview staff shared that the drug that was not a controlled substance was placed inside a white container in the medication room by the staff acting alone. The staff acknowledged that it was not done in a team acting together, composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing.
Observations of the white bin were made.

The policy # 90-85 called Disposal of Discontinued/Expired Non-Narcotic Medication dated July 17, 2015, stated 4. "For non-narcotic medication waste the registered staff disposing of the medication will do so by opening the container in which the medication is sealed in and place medication that is to be denatured in the sealed container that is provided to us by Stericycle for destruction".

The Administrator and DOC were unaware of the regulation that non-narcotic drug that were to be destroyed was to be completed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing as per Ontario Regulation 79/10 r.136(3)(b) [s. 136. (3) (b)]

2. The licensee has failed to ensure that when a drug was destroyed, the drug was altered or denatured to such an extent that its consumption was rendered impossible or improbable.

Observation with staff identified that drugs that were not a controlled substances were being placed inside a white container provided by Stericycle. The drugs were inside the individual plastic packaging and placed in the container as a whole, the drugs were not denatured. (532)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23rd day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Rebecca Dewitte

Service Area Office /
Bureau régional de services : London Service Area Office