Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 25, 2016	2016_214146_0001	000181-16	Resident Quality Inspection

Licensee/Titulaire de permis

PLEASANT MANOR RETIREMENT VILLAGE
15 Elden Street Box 500 Virgil ON L0S 1T0

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

PLEASANT MANOR RETIREMENT VILLAGE
15 Elden Street Box 500 Virgil ON L0S 1T0

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

BARBARA NAYKALYK-HUNT (146), IRENE SCHMIDT (510a), KELLY CHUCKRY (611), ROBIN MACKIE (511)

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 6, 7, 8, 12, 13, 14, 15, 18, 19, 2016

Kerry Abbott shadowing this RQI inspection.
Complaint inspections #006656-15 and 015792-15 related to care issues, staffing and dietary issues completed during this RQI. Critical Incident inspections #009902 -15, 009967-15 and 011293-15 related to falls and elopement completed during this RQI. During the course of this inspection, the inspectors: toured the home; reviewed policies and procedures; observed care and dining areas; reviewed meeting minutes and health records.

During the course of the inspection, the inspector(s) spoke with the Administrator; Acting Director of Care; Registered Dietitian (RD); Food Service Manager (FSM); Environmental Services Manager (ESM); registered staff, dietary staff, Personal Support Workers (PSW's); residents and family members.

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

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

15 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident that exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

A review of the clinical record for an identified resident indicated that on a date in August 2015 impaired skin integrity had developed and deteriorated within several days. A referral form to the RD was not submitted and the resident did not receive a dietary assessment related to the impaired skin integrity until October 2015. The Acting DOC

confirmed that the licensee failed to ensure that when the resident exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident was assessed by a registered dietitian. [s. 50. (2) (a) (i)]

2. The licensee has failed to ensure that (b) a resident that exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) 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) An identified resident triggered during this inspection for having a worsening pressure ulcer. A review of the clinical record indicated that an assessment in May 2015 stated that the resident did not have any pressure ulcers. A review of the clinical record indicated that a skin and wound care progress note on a date in August 2015 identified a pressure ulcer with no description of the size of the wound or other assessment criteria as identified on the home's Pressure Ulcer /Wound assessment record. Interview with staff #105 and the Acting DOC confirmed that the identified skin and wound care note, located in the home's Point Click Care (PCC) progress notes was not a clinically appropriate assessment tool.

B) An identified resident triggered during this inspection for having new impaired skin integrity. Assessments in July and September 2015 indicated that the resident had one to two areas of impaired skin integrity but no description or measurements were documented. There was inconsistent description of the wound that did not include the assessment criteria as identified on the home's "Pressure Ulcer /Would assessment Record". Interview with staff #105 and the Acting DOC indicated that the identified skin and wound care note, located in the home's PCC electronic documentation record, was not a clinically appropriate assessment tool as provided for in the home's skin and wound program as Appendix D " Pressure Ulcer /Wound assessment record". [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,and (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Registered staff indicated that weekly wound assessments are documented in progress notes. A six month look back at the progress notes entitled "weekly skin/wound note" revealed the following: in July 2015 an identified resident's wound was assessed on 1 out of 5 weeks; in August the wound was assessed 3 out of 4 weeks; in

September the wound was assessed 3 out of 5 weeks; in October the wound was assessed 3 out of 4 weeks; in November the wound was assessed 3 out of 4 weeks and in December 2015, the wound was assessed 3 out of 5 weeks. Weekly wound assessments were not consistently completed every week as confirmed by the registered staff and the acting DOC. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that (b) a resident that exhibits 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 and (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated,, to be implemented voluntarily.

WN #2: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that the following rights of the resident were fully respected and promoted. 11. Every resident had the right to, ii. give or refuse consent to any treatment, care or services for which his or her consent was required by law and to be informed of the consequences of giving or refusing consent.

An identified cognitively alert resident's attempt to refuse a treatment was not respected nor promoted. The RN and the Acting DOC confirmed that the licensee failed to ensure that the resident rights were fully respected and promoted to give or refuse consent to any treatment, care or services for which his or her consent was required by law and to be informed of the consequences of giving or refusing consent. [s. 3. (1) 11. ii.]

WN #3: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A) On a date in January 2015, nursing documented in the progress notes that a resident had specific impaired skin integrity. Four days later, the dietitian documented an assessment in the progress notes and stated that the skin was intact. The two assessments were not collaborative and did not complement each other as confirmed by registered staff and the Acting DOC. (146)

B) On two dates in January 2016, an identified resident was observed to receive an altered portion of food at the noon meal. The food service aide (FSA) and food service manager (FSM) reported that the resident requested the altered portion. The FSA and FSM did not know if this information had been communicated to the dietitian. Review of the document the home refers to as the care plan did not include a plan for the resident to receive altered portions which decreased nutrients. The dietitian reported being unaware that the resident had requested and was receiving altered portions at meals. Staff involved in care of the resident did not collaborate so that assessments were

integrated, consistent with and complemented each other. (510) [s. 6. (4) (a)]

2. The licensee has failed to ensure that when a resident was reassessed and the plan of care reviewed and revised, (a) subsections (4) and (5) applied, with necessary modifications, with respect to the reassessment and revision; and (b) if the plan of care was being revised because care set out in the plan had not been effective, the licensee shall ensure that different approaches were considered in the revision of the plan of care.

A review of the clinical record indicated that an identified resident was identified as a wandering risk with going to exit doors. The substitute decision maker (SDM) agreed to a specific strategy. The resident continued to exit seek and was successful in exiting the home on six occasions between May and October 2015.

A review of the resident's plan of care during the date of the first incident in May 2015 and the last incident in October 2015, related to the focus of reducing the residents wandering risk, did not indicate any changes to the interventions or different approaches considered.
Interview with staff #103 confirmed that when the resident was reassessed and the plan of care reviewed and revised, the licensee failed to ensure that different approaches were considered in the revision of the plan of care related to the residents risk of elopement. [s. 6. (11) (b)]

WN #4: 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, where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) was in compliance with and was implemented in accordance with applicable requirements under the Act

A) Regulation 50(2)(b)(iii) requires that a registered dietitian (RD) assess a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds. The home's policy and procedure entitled "Skin and Wound Care-Program" stated that "the dietitian will be notified by the unit's registered staff and will complete the dietary referral/consult for all skin tears and Stage 2 or higher pressure ulcers and full thickness wounds". The Administrator and acting DOC confirmed that the policy as presently worded is not in accordance with the Act. (146) [s. 8. (1) (a),s. 8. (1) (b)]

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

A) A review of the most recent Skin and Wound Care program that was provided by the home, indicated a referral would be completed to the interdisciplinary team members (e.g. Dietitian) as required . Interview with registered staff #103, on the referral process to the RD stated that pressure ulcers would be required to be referred. Staff #103 indicated that the "Pleasant Manor Retirement Village-Heritage Place Dietary Screening and Requisition" form would have been completed for skin breakdown or delayed healing and would have been provided to the FSM. Interview with the FSM confirmed this process and indicated that the requisition would be shared with the RD, as indicated on the form, at the RD's next scheduled work day (within 7 days).

i) A review of the clinical record for an identified resident indicated that in July 2015, the resident developed impaired skin integrity. The RD confirmed that she had seen the resident when she was verbally notified of the wound by the staff when she was in the home. The RD confirmed that she had not received a completed written referral form for this wound.

ii) An identified resident had impaired skin integrity in August 2015. Interview with the RD confirmed that she was not aware of the impaired skin integrity until October 2015. The RD confirmed that she had not assessed the wound as she had not been verbally notified or received a documented referral.

The FSM and the Dietitian confirmed that the Skin and Wound care program referral process for pressure ulcers had not been complied with when the "Pleasant Manor Retirement Village-Heritage Place Dietary Screening and Requisition" referral forms for the two identified residents had not been submitted to the RD. (511)

B) On a date in January 2016, the tub room door was found open and the tub was full of water. There was a sign on the door that directed the tub room door was to be closed at all times. Two PSW's arrived after 5 minutes had passed and confirmed that:
1) the tub was full of water
2) the door should be closed at all times and,
3) there were ambulatory residents with cognitive impairment on the unit.
The Acting DOC and Administrator confirmed that the process for bathing included that the tub room door should be closed at all times.
The home's plan and process for bathing was not complied with. (510) [s. 8. (1) (a),s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

During Stage one an identified resident was observed to be in bed with two half bed rails, secured to the mid section of the bed, in the raised position. The resident was cognitively aware and stated preference for the rails down. A review of the clinical record indicated that there was no indication in the most recent plan of care that bed rails were used . The most recent MDS assessment indicated that side rails were not used. Interview with RN #103 confirmed that the resident used bed rails but the resident would not have been assessed for bed rail use as the home did not consider half or assist rails as bed rails. [s. 15. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

A review of the manufacturer's instructions provided by the home for the Alenti bath chair by ArjoHuntleigh dated April 2013, indicated that the safety seat belt must be used at all times and inspected to ensure it is in good condition without loose threads,tears or defects prior to each use. The purpose of the safety belt was to keep the resident secured and properly positioned while on the Alenti lift. In January 2015, during an observation of the tub and bathing room, staff #116 was noted to have just completed a bath on a resident. The resident had returned to their room. The Alenti bath chair was noted to be at the side of the tub with no safety belt attached to the chair. The safety belt was noted to be hanging on a hook in the shower area and was dry. Interview with the staff member confirmed that the safety belt was not routinely used with the Alenti bath chair including the most recent resident. [s. 23.]

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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences for the resident.

During Stage one of this inspection, an identified resident stated that the resident was put to bed in the evening three or four hours earlier than preferred. A review of the clinical record indicated a health status note on a date in December 2015 that was completed by RN#103 that confirmed the resident preferred to go to sleep late at night between 2300-2400 hours. Interview with PSW #107 and PSW #108 indicated they did not know what time the resident would go to sleep but this would be found in the resident's written plan of care or the kardex. A review of the resident's most recent plan of care and kardex did not indicate the resident's sleep patterns or preferences. Interview with RN #103 confirmed that the resident's sleep patterns and preferences were not included in the plan of care.

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 that the following was 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: The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A review of the home's most recent Skin and Wound Care program indicated that there would be a program evaluation that would track, analyze, trend and report internally, externally, worsening and Stage one-four pressure ulcers to an internal 'Best Practice' committee. A review of the monthly wound care reports did not indicate the collection of this data. There were no internal home reports that indicated any of the data was analyzed, trended or reported internally in an effort to evaluate the Skin and Wound Care program. Interview with the Acting DOC confirmed that the home's evaluation program for their Skin and Wound Care program was not implemented, nor updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. [s. 30. (1) 1.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition and hydration program included (ii) body mass index and height upon admission and annually thereafter.

The home documented current heights in Point Click Care (PCC). Nine residents' health records were reviewed; seven of those residents did not have a height measured and recorded within the last year.
An interview with staff #103 confirmed that the home measures and records heights on admission only, and height is not monitored annually.

Upon review of the homes policy, Weights-Measurement and Documentation indicated that heights are measured upon admission, and only as necessary thereafter.

An interview with the Acting DOC confirmed that heights are only measured and recorded upon admission. [s. 68. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. Every licensee shall ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the areas mentioned below: 11. Any other areas provided for in the regulations.

Training was required in regulation 79/10, section 230, Emergency Plans, specifically, subsection 4. 1 Dealing with: vii. situations involving a missing resident.
The home had submitted a report for a missing resident in May 2015. A clinical record review of the identified resident indicated that the resident had exited the resident home area on six separate occasions in 2015 without the home's knowledge. A review of the Operational Nursing Manual that was located at the nursing station and referred to by the front line staff, indicated a 2005 policy for "Wandering Residents" and a 2005 "Wandering Residents-Elopement" policy. Interview with the Acting DOC confirmed that a new policy, for 'Missing Resident Code Yellow' was located in the Peace Time Disaster and Emergency Safety Plan Response Manual. This document was provided to the LTC Inspector, with a Code Yellow Checklist (appendix 12), from the acting DOC at the time of the inspection. Another policy on 'Resident Safeguards-Wandering Resident-Elopement', dated May 2014 was also provided to the Inspector. These documents were not located at the nursing station or referred to from the front line staff. Interview with three staff members, RN#103, RPN#105 and a new RN employee #201 indicated that they had not received training on the above policies regarding situations involving a missing resident. A review of the home's risk management and clinical records did not indicate that the Code Yellow Checklist had been implemented in any of 6 elopements of resident #031. Interview with the Acting DOC confirmed that the home had not provided training as mentioned above with respect to the home's Missing resident and Code Yellow policy. [s. 76. (2) 11.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that they sought the advice of the Residents' Council in the development of the satisfaction survey.

A review of the minutes of Resident Council for 2014 and 2015 confirmed that the home does not seek the advice of residents council on the development of the questions associated with the Residents satisfaction survey. Interviews conducted with staff #110 and #111 and further discussion with the Administrator also confirmed that the home does not seek advice from Residents Council in the development of the satisfaction survey. [s. 85. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure as part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (a) procedures are developed and implemented to ensure that, (iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, O. Reg. 79/10, s. 89 (1).

Resident #035, #036 and #037 were resident's admitted to the home's Convalescent Care Program. A review of the three residents' Convalescent Care Program Admission Agreements indicated that the families were responsible to care for laundry during a residents' stay and they were required to keep track of their laundry needs. A progress note documented in residents #037's clinical record in December 2015 indicated the family member was unable to do the residents laundry and after speaking with the Acting DOC agreed to pay for the service. Interview with the Acting DOC confirmed that the residents' personal laundry, under the home's Convalescent Care Program ,was not part of the organized program of laundry services within the home and when a family was unable to provide the service, a fee would be charged to the resident per load. [s. 89. (1) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented to ensure that, (b) all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.

During the initial tour of the home on January 6, 2016, 14 of 14 wooden chairs were observed to have extensive deep scratches noted to extend up all four legs nearly half way up the legs of the chairs which exposed bare wood. The arm rests of the chairs also were observed to have surface and deep scratches on the surface of the arm chairs which allowed for the residents' arms and hands to be exposed to areas of bare wood. Interview with the ESM indicated that the home had a policy for the repair and maintenance of all equipment, devices, assistive aids and positioning aids in the home and agreed that the 14 chairs in the dining room were not in a state of good repair. [s. 90. (2) (b)]

WN #14: 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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of 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 was missing for less than three hours and who returned to the home with no injury or adverse change in condition.

A review of a Critical Incident Report (CIS) submitted to the MOHLTC on a date in May 2015 indicated that an identified resident was missing from the home on a date in May 2015 for less than three hours. This report was submitted 5 days after the incident.
A review of a Critical Incident Report (CIS) submitted to the MOHLTC on a date in September 2015 indicated that an identified resident was missing from the home on a date in September 2015 for less than three hours. This report was submitted 2 days after the incident.

Interview with the acting DOC confirmed that the home failed to inform the Director of the incidents in the home no later than one business day after the occurrence of the incidents. (511) [s. 107. (3) 1.]

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

A) An identified resident fell with injury in May 2015 and was transferred to hospital. The home submitted the Critical Incident report to the Director 12 days later. The Administrator confirmed that the submission of the report had been overlooked and was late. (146)

B) On a date in May 2015 an identified resident sustained a fall that resulted in injury to the resident, and the resident was transferred to hospital. This incident was initially submitted to the Ministry of Health and Long Term Care 11 days later.
The late reporting of this incident was confirmed by the Administrator on January 14, 2016. (611) [s. 107. (3) 4.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

During Stage one of this inspection, an identified resident had complained that all of the resident's morning medications had been crushed and mixed together. The health record indicated that the medications were not to be crushed and that the one medication should have been administered two hours earlier while fasting.
Interview with RN #104 confirmed that the medications were crushed, mixed together and administered in apple sauce at 0925 hours. The medications were not administered in accordance with the directions for use.

Issued on this 25th day of January, 2016

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

Original report signed by the inspector.