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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 26, 2017	2016_247508_0017	032375-16	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

ROSEANNE WESTERN (508), KELLY HAYES (583)

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): November 14, 15, 16, 17, 18, 21, 23, 24 and 25, 2016.

During this inspection, the Inspectors toured the facility, reviewed resident clinical records, relevant policies and procedures, observed provision of care, interviewed staff, residents and family members, Residents' Council President and Family Council President.

The following inspection was conducted concurrently during this Resident Quality Inspection: Critical Incident (CI), log# 008845-16 related to a resident elopement.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, the Executive Director, the Director of Clinical Services, the Resident Assessment Instrument (RAI) Co-Ordinator, the Recreation Manager, the Chaplain, Family Council President, Residents' Council President, registered staff, Personal Support Workers (PSW), residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Medication
Residents' Council
Skin and Wound Care

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

10 WN(s)
8 VPC(s)
1 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. 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. Where the Act or this Regulation required the licensee to have, institute or otherwise put in place any policy or strategy, the licensee failed to ensure that the policy or strategy was complied with as required under O. Reg. 79/10, s. 49, Falls Prevention and Management, s. 50, Skin and Wound Care and s. 51, Continence Care and Bowel Management.

A review of the home's Skin and Wound policy titled, "Skin and Wound Care - Program" under the section "Objections of the Skin and Wound Care Program" indicated that all residents that exhibited altered skin integrity were to be reassessed at least weekly and documented in Point Click Care (PCC).

Resident #005 had several areas of altered skin integrity that required treatments daily and as needed (PRN). A review of the resident's clinical record indicated that staff were not reassessing the resident's altered skin integrity weekly.

It was confirmed during an interview with registered staff #102 that staff did not comply with the skin and wound policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. A review of the Falls Prevention and Management Committee – Terms of Reference policy, last revised June 2016, and the Falls Prevention and Management Program policy, last revised May 2016, directed staff to complete the following:

i) "Ensure that when a resident falls that resident is assessed and a post fall assessment is conducted using a clinically appropriate assessment instrument specifically designed for falls."
ii) "Registered Nursing Staff shall: 8. Complete Post-Fall Analysis in PCC" when a

resident has fallen.

A) A review of resident #001's plan of care identified they had an unwitnessed fall in October, 2016, when left unattended. A post-fall analysis assessment was not found in PCC related to resident #001's fall.

B) A review of resident #003's plan of care identified they had an unwitnessed fall in October, 2016, that resulted in injuries. A post-fall analysis assessment was not found in PCC related to resident #001's fall.

C) A review of resident #006's plan of care identified they had a witnessed fall in November, 2016, when transferring to a chair without staff assistance. A post-fall analysis assessment was not found in PCC related to resident #001's fall.

In an interview with the Director of Clinical Services on November 24, 2016, it was confirmed that this was resident #006's third fall in 8 weeks.

In an interview with the Director of Clinical Services on November 23, 2016, it was confirmed that a post-fall analysis was not completed in PCC for resident #001 and #003.

A review of the Falls Prevention and Management Program policy, last revised May 2016, directed staff to complete the following:

i) "Initiate Head Injury Routine for all unwitnessed falls and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy."

A) A review of resident #001's plan of care identified they had an unwitnessed fall in October, 2016, when left unattended. A head injury routine was not found on the paper or electronic plan of care.

In an interview with staff #071 it was confirmed that a head injury routine had not been initiated for resident #001 after their unwitnessed fall.

A review of the Falls Prevention and Management Program policy, last revised May 2016, and the falls prevention strategies directed staff to complete the following:

i) "For each resident, complete on PCC a Falls Risk Assessment on admission, readmission, quarterly, and as a result of a significant change of status. Assess

resident’s level of risk as high, moderate, or low.
ii) “Communicate fall risk and strategies to all disciplines.”
iii) “Each high risk resident will have a fall leaf placed over their bed to identify them.” and “Each resident who is a high risk resident will have a wristband placed on his or her mobility aids to inform and remind staff of the risk of fall.

A review of resident #001’s, #003’s and #006’s falls care plans identified they were at risk of falls but did not identify if their level of risk was low, moderate or high. A review of their falls risk assessments in PCC identified a numerical score.

In an interview with the Director of Clinical Services on November 25, 2016, it was confirmed resident #001’s, #003’s and #006’s falls risk was not identified on the falls risk assessment or in the falls care plan and it was shared at the time of the inspection the home did not know what the definition of the falls risk score.

In interviews with PWS’s, RPN’s and RN’s is was shared that they did not know which residents were assessed to be at high risks of falls.

In an interview with the Director of Clinical Services on November 25, 2016, it was confirmed that the falls prevention fall leaf and wristband on mobility aids strategies for residents at high risk of falls had not been implemented in the home. (583) [s. 8. (1) (b)]

3. A review of the home's policy titled "Continence Care and Bowel Management Program" under the Assessment section directed staff to conduct a bowel and bladder continence assessment on admission, quarterly and after any change in condition that may affect bladder or bowel continence.

During a review of the clinical records for residents #004 and #006, it was identified that the residents had changes with their level of bowel continence over a six month period. The Minimum Data Set (MDS) coding under section H - "continence in the last 14 days" indicated that in August, 2016, resident #006 had a change in their bowel continence. In November, 2016, the resident declined again.

The Minimum Data Set (MDS) coding under section H - "continence in the last 14 days" indicated that in July, 2016, resident #004 had a change in their bowel continence. In October 2016, the resident had another change.

Bowel assessments had not been conducted when the residents had changes with their

level of bowel continence as directed in the home's policy. During an interview with the DOC, it was confirmed that the home did not have a bowel assessment tool and that staff were not conducting bowel assessments when residents had changes in their level of bowel continence. [s. 8. (1) (b)]

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. 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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited 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 review of the progress notes for resident #005 in the resident's clinical record indicated that the following occurred:

On an identified date in August, 2016, registered staff identified that the resident had an area of altered skin integrity.

On an identified date in September, 2016, registered staff identified that the alteration in skin integrity had worsened. The resident also had a reddened area on their an extremity.

In late September, 2016, the resident's altered skin integrity worsened.

In October, 2016, registered staff identified that the resident had an alteration in skin integrity on another extremity.

Further review of the resident's clinical record revealed that the registered staff did not conduct skin assessments using a clinically appropriate assessment instrument on two identified dates when it was identified that the resident had exhibited altered skin integrity.

It was confirmed during an interview with registered staff #102 and with the Director of Clinical Services on November 23, 2016, that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, did not receive 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 failed to ensure that the equipment, supplies, devices and positioning aids referred to in subsection (1) were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

Resident #005 was ordered an intervention to be implemented daily. A review of the electronic Treatment Administration Record (eTAR) for November, 2016, indicated that on two identified dates in November, 2016, these interventions were not available.

It was confirmed by registered staff #102 during an interview and through documentation

that the equipment, supplies, devices and positioning aids were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing. [s. 50. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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 every resident had the right to 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.

On November 24, 2016, it was observed in the medical storage room located in the basement area that an empty medication card containing a resident's personal information had been discarded into a clear garbage bag.

The card contained the resident's name, the type of medication and the prescriber's directions on it. When pointed out by the Inspector, the Registered Nurse (RN) who was present indicated that the card should not have been discarded into that garbage and that the home had a process in place to protect the resident's Personal Health Information (PHI).

This process included disposing of medication pouches with PHI into a container which was picked up by their pharmacy provider and destroyed by the pharmacy. The medication cards were only disposed of into the garbage after the PHI had been removed by nursing staff and then placed into this container.

It was confirmed during an interview with the RN on November 24, 2016, that the resident's Personal Health Information had not been kept confidential. [s. 3. (1) 11. 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 every resident has the right to 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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).

Findings/Faits saillants :

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

A review of resident #001's progress notes and the internal fall incident report documented in October, 2016, identified the resident had an unwitnessed fall. It was identified that resident #001 was found by a PSW who had started their shift. A review of resident #001's plan of care identified they were at risk for falls characterized by multiple risk factors. The care plan directed one staff to provide extensive assistance for safety.

In an interview with staff #071 it was confirmed that staff did not follow the direction set out in resident #001's plan of care in October, 2016. [s. 6. (7)]

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

Resident #005 had treatments ordered for altered skin integrity on their extremeties to be done daily and as necessary (PRN). The resident was also ordered an intervention to be applied daily.

A review of the electronic Treatment Administration Record (eTAR) for November, 2016, revealed that on two identified dates in November, 2016, the resident did not have their daily intervention implemented due to availability. On eight identified dates in November, 2016, the resident's treatments ordered for their areas of altered skin integrity were not provided to the resident.

It was confirmed during an interview with registered staff #102 and #103 on November 24, 2016, that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the continence care and bowel management program provided for assessment and reassessment instruments.

A review of the Minimum Data Set (MDS) coding under section H - "continence in the last 14 days" indicated that in August, 2016, resident #006 had a change in their bowel continence. In November, 2016, the resident declined again.

A review of the resident's clinical record indicated that when the resident had changes in their bowel continence, staff did not conduct an assessment using a clinically appropriate assessment instrument. During an interview with the DOC it was revealed that the home had not developed or implemented an assessment instrument for bowel incontinence.

It was confirmed on November 23, 2016, that the home did not have a bowel continence assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required it. [s. 48. (2) (b)]

2. A review of the Minimum Data Set (MDS) coding under section H - "continence in the last 14 days" indicated that in July, 2016, resident #004 had a change in their bowel continence. In October 2016, the resident had another change.

A review of the resident's clinical record indicated that when the resident had changes in their bowel continence, staff did not conduct an assessment using a clinically appropriate assessment instrument. During an interview with the DOC it was revealed that the home had not developed or implemented an assessment instrument for bowel incontinence.

It was confirmed on November 23, 2016, that the home did not have a bowel continence assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required it. [s. 48. (2) (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 continence care and bowel management program provides for assessment and reassessment instruments, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to respond to the Family Council in writing within ten days of receiving concerns or recommendations from the Family Council.

During a review of the Family Council meeting minutes for a meeting held on September 26, 2016, it was identified that numerous concerns and recommendations had been raised by the Council at this meeting. A review of the Family Council Response Form indicated that the form dated September 28, 2016, was blank.

Staff representative #104 who attended the meeting communicated these concerns to the managers responsible to respond to the Council. Although the managers then responded to staff representative #104 by email, these responses had not been communicated to or received by the Family Council in writing within 10 days.

It was confirmed during an interview with staff #104 and through review of the meeting minutes that the concerns or recommendations were not responded to the Family Council in writing within 10 days of receiving the advice. [s. 60. (2)]

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 concerns or recommendations are responded to the Family Council in writing within 10 days of receiving the advice, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in any other areas provided for in the regulations.

In an interview with the Director of Clinical Services on November 24, 2016, it was confirmed that the home did not have documentation of the training materials used in the required program of falls prevention management or documentation of any direct care staff that attended training for falls prevention management in 2015. [s. 76. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas provided for in the regulations, to be implemented voluntarily.

WN #8: 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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff members had been trained by a member of the registered nursing staff in the administration of topicals.

During an interview with PSW #100 on November 24, 2016, the PSW indicated that it is the responsibility of the PSW staff to administer topical creams and medications to the residents including prescription topical medications.

The PSW indicated during the interview that she had not received training from registered staff but will ask for guidance if necessary. She also stated that the instructions she had received regarding the administration of topical creams and medications were from the full time PSW's, not registered staff.

The Director of Care confirmed that the they were currently in the process of providing the training to the PSW's on the administration of topical creams and medication; however this had not been done.

It was confirmed during interviews with the DOC and PSW #100 on November 24, 2016, that staff members had not been trained by a member of the registered nursing staff in the administration of topicals. [s. 131. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff members are trained by a member of the registered nursing staff in the administration of topicals, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that Residents' Council concerns were responded to in writing within ten days of receiving the advice.

The Residents' Council meeting minutes were reviewed from June, 2016 to November, 2016. The following concerns were documented in the meeting minutes:

i) On June 13, 2016, the residents identified the doors to the sun room café had a large threshold which made it difficult or impossible for walkers and wheel chairs to go through and wanted to know if this could be fixed. Maintenance provided a response on June 23, 2016, but did not identify if the door could be fixed or a resolution as to how residents using walkers or wheel chairs could get through. Dietary concerns and therapeutic recreation recommendations made by the residents on June 13, 2016, were responded to in writing on June 27, 2016, 14 days later.

ii) On August 15, 2016, the residents raised concerns that more staff assistance was needed to help feed residents at meal time. A review of the Resident Council response form showed no written response was provided to Residents' Council related to their concern.

iii) On September 19, 2016, the residents recommended frozen yogurt as a dessert option and recommended doing a bible study on the book of Ruth. A review of the Resident Council response form showed no written response was provided to Residents' Council related to their recommendations.

iv) On November 14, 2016, the residents raised a concern that meals especially breakfast were being served late in the sun room café. A review of the Resident Council response form showed no written response was provided to Residents' Council related to their concern.

The documentation found in the meeting minutes and the Resident Council response forms confirmed this information. It was also confirmed with the Therapeutic Recreation Supervisor and the Nutrition Manager on November 24, 2016. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Residents' Council concerns are responded to in writing within ten days of receiving the advice, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On November 24, 2016, during an observation of the first floor medication room, it was identified that the discontinued narcotics were being stored in a single locked cupboard that had an opening cut out for staff to deposit these narcotics through. The Inspector was able to put a hand through the slot and grab two cards of discontinued narcotics.

It was confirmed by the RN on November 24, 2016, that controlled substances were not stored in a separate, double-locked stationary cupboard in the locked area. [s. 129. (1) (b)]

Issued on this 6th day of February, 2017

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

Original report signed by the inspector.

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROSEANNE WESTERN (508), KELLY HAYES (583)
Inspection No. / No de l'inspection :	2016_247508_0017
Log No. / Registre no:	032375-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 26, 2017
Licensee / Titulaire de permis :	PLEASANT MANOR RETIREMENT VILLAGE 15 Elden Street, Box 500, Virgil, ON, L0S-1T0
LTC Home / Foyer de SLD :	PLEASANT MANOR RETIREMENT VILLAGE 15 Elden Street, Box 500, Virgil, ON, L0S-1T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TIM SIEMENS

To PLEASANT MANOR RETIREMENT VILLAGE, 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 :

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 shall ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

This Order is being issued based on the application of the factors of severity (2), scope (2) and Compliance history of (3) in keeping with r. 299 of the Regulations. This is in respect to the severity of minimal harm or potential for actual harm, the scope of a pattern and the home's history of noncompliance that included a Written Notification in January, 2016.

The licensee shall:

a) educate all nursing staff on the home's Skin and Wound Care Program, outlining the responsibilities of the registered staff for assessing and reassessing residents with altered skin integrity,
b) educate all nursing staff on the home's skin assessment tool,
c) educate all nursing staff on the home's Falls Prevention and Management Program, including the requirements of conducting a post fall assessment using the clinically appropriate assessment instrument specifically designed for falls,
d) educate all staff on the definition of the fall risk scores and the requirement to identify residents at high risk for falls with a falling leaf as outlined in the home's program,
e) ensure that staff document the outcome of the fall risk assessments conducted in the resident's plan of care to ensure that all staff have access to this information.

Grounds / Motifs :

1. Where the Act or this Regulation required the licensee to have, institute or otherwise put in place any policy or strategy, the licensee failed to ensure that the policy or strategy was complied with as required under O. Reg. 79/10, s. 49, Falls Prevention and Management, s. 50, Skin and Wound Care and s. 51, Continence Care and Bowel Management.

A review of the home's Skin and Wound policy titled, "Skin and Wound Care - Program" under the section "Objections of the Skin and Wound Care Program" indicated that all residents that exhibited altered skin integrity were to be reassessed at least weekly and documented in Point Click Care (PCC).

Resident #005 had several areas of altered skin integrity that required treatments daily and as needed (PRN). A review of the resident's clinical record

indicated that staff were not reassessing the resident's altered skin integrity weekly.

It was confirmed during an interview with registered staff #102 that staff did not comply with the skin and wound policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. A review of the Falls Prevention and Management Committee – Terms of Reference policy, last revised June 2016, and the Falls Prevention and Management Program policy, last revised May 2016, directed staff to complete the following:

i) “Ensure that when a resident falls that resident is assessed and a post fall assessment is conducted using a clinically appropriate assessment instrument specifically designed for falls.”
ii) “Registered Nursing Staff shall: 8. Complete Post-Fall Analysis in PCC” when a resident has fallen.

A) A review of resident #001’s plan of care identified they had an unwitnessed fall in October, 2016, when left unattended. A post-fall analysis assessment was not found in PCC related to resident #001’s fall.

B) A review of resident #003’s plan of care identified they had an unwitnessed fall in October, 2016, that resulted in injuries. A post-fall analysis assessment was not found in PCC related to resident #001’s fall.

C) A review of resident #006’s plan of care identified they had a witnessed fall in November, 2016, when transferring to a chair without staff assistance. A post-fall analysis assessment was not found in PCC related to resident #001’s fall.

In an interview with the Director of Clinical Services on November 24, 2016, it was confirmed that this was resident #006’s third fall in 8 weeks.

In an interview with the Director of Clinical Services on November 23, 2016, it was confirmed that a post-fall analysis was not completed in PCC for resident #001 and #003.

A review of the Falls Prevention and Management Program policy, last revised May 2016, directed staff to complete the following:

i) “Initiate Head Injury Routine for all unwitnessed falls and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy.”

A) A review of resident #001’s plan of care identified they had an unwitnessed fall in October, 2016, when left unattended. A head injury routine was not found on the paper or electronic plan of care.

In an interview with staff #071 it was confirmed that a head injury routine had not been initiated for resident #001 after their unwitnessed fall.

A review of the Falls Prevention and Management Program policy, last revised May 2016, and the falls prevention strategies directed staff to complete the following:

i) “For each resident, complete on PCC a Falls Risk Assessment on admission, readmission, quarterly, and as a result of a significant change of status. Assess resident’s level of risk as high, moderate, or low.
ii) “Communicate fall risk and strategies to all disciplines.”
iii) “Each high risk resident will have a fall leaf placed over their bed to identify them.” and “Each resident who is a high risk resident will have a wristband placed on his or her mobility aids to inform and remind staff of the risk of fall.

A review of resident #001’s, #003’s and #006’s falls care plans identified they were at risk of falls but did not identify if their level of risk was low, moderate or high. A review of their falls risk assessments in PCC identified a numerical score.

In an interview with the Director of Clinical Services on November 25, 2016, it was confirmed resident #001’s, #003’s and #006’s falls risk was not identified on the falls risk assessment or in the falls care plan and it was shared at the time of the inspection the home did not know what the definition of the falls risk score.

In interviews with PWS’s, RPN’s and RN’s is was shared that they did not know which residents were assessed to be at high risks of falls.

In an interview with the Director of Clinical Services on November 25, 2016, it was confirmed that the falls prevention fall leaf and wristband on mobility aids strategies for residents at high risk of falls had not been implemented in the

home. (583) [s. 8. (1) (b)]

3. A review of the home's policy titled "Continence Care and Bowel Management Program" under the Assessment section directed staff to conduct a bowel and bladder continence assessment on admission, quarterly and after any change in condition that may affect bladder or bowel continence.

During a review of the clinical records for residents #004 and #006, it was identified that the residents had changes with their level of bowel continence over a six month period. The Minimum Data Set (MDS) coding under section H - "continence in the last 14 days" indicated that in August, 2016, resident #006 had a change in their bowel continence. In November, 2016, the resident declined again.

The Minimum Data Set (MDS) coding under section H - "continence in the last 14 days" indicated that in July, 2016, resident #004 had a change in their bowel continence. In October 2016, the resident had another change.

Bowel assessments had not been conducted when the residents had changes with their level of bowel continence as directed in the home's policy. During an interview with the DOC, it was confirmed that the home did not have a bowel assessment tool and that staff were not conducting bowel assessments when residents had changes in their level of bowel continence. [s. 8. (1) (b)]

(508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 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
TORONTO, 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
TORONTO, 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 26th day of January, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Roseanne Western

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