Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 6, 2014	2014_248214_0017	H-000638-14	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

CATHY FEDIASH (214), GILLIAN TRACEY (130), ROSEANNE WESTERN (508)

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): May 27, 28, 29, 30, June 3, 4, 5, 6, 2014.

This inspection was conducted simultaneously with inspection #H-000486-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered staff, Personal Support Workers(PSW), Nutrition Manager, Physiotherapist, laundry staff, dietary staff, residents and family members.

During the course of the inspection, the inspector(s) interviewed staff and residents, reviewed clinical records, relevant policies and procedures, meeting minutes and observed care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 did not ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

a) The plan of care for resident #200 indicated the resident required a medium pull up at all times for continence care, however the same plan indicated the resident wore a large pull up during the day and night. Staff confirmed the plan did not provide clear directions to staff. (130)

b) Resident #204 sustained a fall on an identified date in May 2014. A review of this resident's written plan of care for transfers, indicated that they required extensive assistance of two staff for transferring and also indicated to teach the resident to transfer with the assistance of one person. An interview with Registered staff confirmed that the resident required the assistance of two staff for transferring at all times and that the written plan of care had not set out clear directions to staff and others who provided direct care to this resident.(214) [s. 6. (1) (c)]

2. The licensee did not ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

a) According to staff interviewed, resident #200 required a special surface on their bed, due to an alteration in their skin integrity and required staff to take special

precautions when providing direct care to the resident because of the presence of a potentially transmissible infection. Registered staff confirmed this information was not included in the plan of care. (130)

b) According to resident #100’s nutritional care plan, the resident had to avoid food or beverages that would irritate the resident’s condition. The resident also had preferences and dislikes that were identified in the care plan. The Diet Information Form that the dietary staff refer to when serving resident's their meals did not include this information. Staff confirmed that this information was not provided to the dietary staff and that the Diet Information Form should have included the information documented on the care plan.(508) [s. 6. (2)]

3. The licensee did not ensure that care set out in the plan was provided to the resident as specified in the plan.

a) The plan of care for resident #200 indicated the resident required supervision and assistance of one staff for transfers, mobility in their wheelchair and toileting. Staff interviewed confirmed the resident transferred themselves to and from bed to wheelchair, propelled their own wheelchair around the unit and toileted independently all or most of the time.(130)

b) According to resident #100’s plan of care, the resident wore dentures and staff were required to assist to ensure dentures were in the resident's mouth and cleaned after meals (PC); remove, ensure labeled and soaked every night. Resident #100 indicated that staff only assist in the morning and soak the dentures during the night. It was confirmed by staff that they only provided assistance with cleaning the resident’s dentures twice a day and not according the resident's care plan.(508)

c) According to resident #101’s plan of care, the resident wore dentures and staff were required to assist to ensure dentures were in the resident's mouth and cleaned after meals (PC); remove, ensure labeled and soak every night. Resident #101 indicated that staff only assist in the morning and soak the dentures during the night. It was confirmed by staff that they only provide assistance with cleaning the resident’s dentures twice a day and not according the resident's care plan.(508) [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 there is a written plan of care for each resident that set's out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

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 did not ensure that every plan, policy, protocol, procedure, strategy or system was complied with.

The home's Falls Prevention and Management Program indicated: when a resident had fallen, registered staff would, 4. Notify the Power of Attorney/Substitute Decision Maker (POA/SDM) and the physician of the fall, interventions and status of the resident, 5. Complete the Fall Risk Assessment Tool on Point Click Care (PCC) on shift fall occurred; and Post Fall Analysis on PCC, 9. Document in the inter-disciplinary notes the status of the resident for the following 72 hours.

a) The clinical record for resident #201 indicated the resident was high risk for falls and had sustained two falls on identified dates in March and April, 2014. Staff interviewed confirmed there were no Falls Risk Assessments completed or Post Falls Analysis completed in PCC, no documentation for 72 hours post falls, nor was the physician notified of the falls on the identified dates. (130)

b) The clinical record of resident #202 indicated the resident was high risk for falls and had sustained five falls on four identified dates in February 2014 and one identified date in March 2014. Staff interviewed confirmed there were no Falls Risk Assessments completed or Post Falls Analysis completed in PCC, no documentation for 72 hours post falls, nor was the physician notified of the falls on any of the identified dates. (130)

c) A review of resident #204's clinical record indicated that they had sustained a fall on an identified date in May 2014. Further review of this resident's clinical record indicated that the physician had not been notified of the resident's fall; no Fall Risk Assessment Tool on PCC was completed; no Post Fall Analysis on PCC was completed and no Physiotherapy referral was completed. An interview conducted with Registered staff confirmed that the physician had not been notified of the resident's fall; the Fall Risk Assessment Tool on PCC had not been completed at all and that the Post Fall Analysis that was to be completed on PCC as per the home's policy, had not been completed and that the home's practice was to complete a paper copy of the Post Fall Analysis. An interview with the Physiotherapist confirmed that no referral was completed for this resident's fall.(214) [s. 8. (1) (a),s. 8. (1) (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 every plan, policy, protocol, procedure, strategy or system in relation to the Fall's Prevention and Management Program is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #202 was observed to have had a laceration which resulted from a fall on an identified date in May 2014. A review of this resident's clinical record indicated that the incident had not been documented. An interview with the DOC confirmed that the incident had not been documented in the resident's clinical record. [s. 30. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

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 following interdisciplinary program was developed and implemented in the home: A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

The home's policy, Skin and Wound Care-Program (dated February 2014) indicated that the Dietitian would be notified by the unit's Registered staff by email and complete the dietary referral/consult for all stage 2 or higher pressure ulcers and full thickness wounds. The requirements set out in the Ontario Regulation 79/10, indicate that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian. The licensee did not ensure that their skin and wound program included this requirement. [s. 48. (1) 2.]

2. The Licensee did not ensure that the continence care and bowel management program provided for assessments and reassessment instruments.

a) According to the minimum data set (MDS) coding completed for resident #202 on an identified date in March 2014, the resident was usually continent of bowel, but incontinent of bladder. The MDS coding completed on an identified date in May 2014, indicated the resident was incontinent of both bowel and bladder. Registered staff confirmed the home did not have a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required it. (130)

b) According to the Minimum Data Set (MDS) coding for resident #101 in January 2014, the resident was assessed as frequently incontinent for bowel and incontinent for bladder. In April 2014, resident #101 was assessed as incontinent for both bladder and bowels. Staff confirmed that the coding in MDS on these dates was accurate. (508)

c) According to the Minimum Data Set (MDS) coding for resident #100 in January 2014, the resident was assessed as incontinent for bowel and frequently incontinent for bladder. In March 2014, resident #100 was assessed as frequently incontinent for both bladder and bowels. Staff confirmed that the coding in MDS on these dates was accurate.(508) [s. 48. (2) (b)]

WN #5: 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 did not ensure that 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) The clinical record for resident #200 indicated the resident had an alteration in their skin integrity that dated back to 2013. According to the clinical record, weekly skin and wound assessments were completed in a progress note. Registered staff confirmed the home did not have a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.(130)

b) A review of resident #202's clinical record indicated that they sustained a laceration, as a result of a fall on an identified date in May 2014. Further review of this resident's record indicated that they had not received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument. Interview conducted with the registered staff confirmed that a skin assessment was not completed, using a clinically appropriate assessment instrument.(214)

c) Resident #102 had altered skin integrity to an identified area on their body,

requiring a treatment cream to be applied twice a day. The clinical record also indicated that on an identified date in March 2014, the resident had a new open area. According to the resident's clinical record, the Registered staff did not assess the resident's skin, using a clinically appropriate assessment instrument.(508)

d) Resident #103 had altered skin integrity to an identified area on their body, requiring a treatment cream to be applied twice a day. The clinical records indicate that the resident's skin was not assessed using a clinically appropriate assessment instrument. The registered staff confirmed they do not use this assessment instrument when assessing resident's altered skin integrity and wounds.(508) [s. 50. (2) (b) (i)]

2. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) The clinical record for resident #200 indicated the resident had an alteration to their skin integrity that dated back to 2013. The record indicated there were no weekly skin assessments completed from January 20 to February 24, 2014, from April 5 to 28 and from April 28 to May 29, 2014. Progress notes indicated another area was identified to their upper body on an identified date in March 2014 for which a treatment was ordered, however, there were no further assessments completed. (130)

b) According to the clinical records for resident #102, the resident developed an open area to their skin on an identified date in March 2014, and physician orders were received. The resident's clinical record indicated that the resident's open area was not reassessed until approximately two months later, on an identified date in May 2014. It was confirmed by registered staff that the resident's open area was not reassessed weekly.(508) [s. 50. (2) (b) (iv)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents’ Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home’s mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home’s policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home’s procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home’s policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents’ Council meetings, with the consent of the Residents’ Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee did not ensure that an explanation of the measures to be taken in case of a fire were posted and communicated.

A review of the Long Term Care Home (LTCH) Licensee Confirmation Checklist Admission Process that was completed on an identified date in May 2014 indicated that the home did not post an explanation of the measures to be taken in case of a fire. The Administrator confirmed that measures to be taken in case of a fire had not been posted in the home. [s. 79. (3) (i)]

2. The licensee did not ensure that an explanation of evacuation procedures were posted and communicated.

A review of the Long Term Care Home (LTCH) Licensee Confirmation Checklist Admission Process that was completed on an identified date in May 2014 indicated that an explanation of the home's evacuation procedures had not been posted and communicated. The Administrator confirmed that an explanation of the home's evacuation procedures had not been posted nor communicated. [s. 79. (3) (j)]

WN #7: 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were developed and implemented for cleaning of the home that included: i. resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
ii. common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces?

During this inspection it was identified through resident interviews and observation that the procedures that were developed for the home's Resident Room Special Cleaning Program were not implemented. A review of the cleaning schedules from January to May 2014, referred to by the home as the Resident Room Special Cleaning Checklist, indicated that staff had not completed a deep clean in the resident's rooms on a monthly basis. It was confirmed by the Nutrition Manager, who is also responsible for the housekeeping department that it was the expectation of the home that deep cleaning of resident's rooms were to be done monthly and that a majority of the resident's rooms had not been deep cleaned for three months. [s. 87. (2) (a)]

WN #8: 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 did not ensure that there was a process to report and locate residents' lost clothing and personal items.

a) An interview conducted with resident #212 indicated that they were missing articles of clothing, approximately one month ago and had reported this to the home. An interview with the Nutrition Manager, who was also responsible for managing the laundry services in the home, identified that the home did have a Missing Clothing Form in place; however it had not been implemented.

b) An interview conducted with resident #100 indicated that they were missing a personal item as well as an article of clothing, within the last year. The resident indicated that this was reported this to the home.
An interview conducted with resident #101 indicated that they were missing a personal item that had been missing for approximately two weeks. An interview with the Nutrition Manager, who was also responsible for managing the laundry services in the home, identified that the home did have a Missing Clothing Form in place; however it had not been implemented.(508) [s. 89. (1) (a) (iv)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that all residents were offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Resident #201 was admitted to the home on an identified date in May 2013 and resident #304 was admitted on an identified date in April 2013. Registered staff confirmed the residents were not offered and did not receive immunization against pneumoccocus on admission.(130) [s. 229. (10) 3.]

Issued on this 24th day of June, 2014

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