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 prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
May 20, 2015;	2015_325568_0011 (A1)	L-002042-15	Resident Quality Inspection

Licensee/Titulaire de permis

PEOPLECARE Inc.
28 William Street North P.O. Box 460 Tavistock ON N0B 2R0

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

HILLTOP MANOR CAMBRIDGE
42 ELLIOTT STREET CAMBRIDGE ON N1R 2J2

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

DOROTHY GINTHER (568) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date for CO #001 has been changed from May 22, 2015 to July 1, 2015.

Issued on this 20 day of May 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 20, 2015;	2015_325568_0011 (A1)	L-002042-15	Resident Quality Inspection

Licensee/Titulaire de permis

PEOPLECARE Inc.
28 William Street North P.O. Box 460 Tavistock ON N0B 2R0

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

HILLTOP MANOR CAMBRIDGE
42 ELLIOTT STREET CAMBRIDGE ON N1R 2J2

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

DOROTHY GINTHER (568) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 16, 17, 18, 19, 20, 25, 26, 27, 2015

Follow-up inspection L-001881-15 was completed in conjunction with the Resident Quality Inspection

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Nursing Care, 2 Directors of Resident Care, Corporate Director of Nursing Services, Corporate Policy representative, Director of Recreation, Administrator-Director of Environmental Services, Environmental Services Supervisor, Director of Food Services, Dietary Supervisor, Physiotherapist, Director of Resident Quality Outcomes, Staffing Coordinator, 2 Registered Nurses, 5 Registered Practical Nurses, 10 Personal Support Workers, 1 Cook, 1 Dietary Aide, 1 Housekeeping staff, 1 Recreations staff, Family Council representative, Resident Council representative, Residents and Families.

The inspectors also conducted a tour of all resident areas and common areas; observed residents and care provided to them; observed meal service, medication passes, medication storage areas; reviewed health care records and plans of care for identified residents; reviewed policies and procedures of the home, minutes from meetings; and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Food Quality

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.
- **14 WN(s)**
- **5 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #003	2015_226192_0008	192
LTCHA, 2007 s. 3. (1)	CO #001	2015_226192_0008	192
LTCHA, 2007 s. 6. (7)	CO #002	2015_226192_0008	192

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 #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care Specifically failed to comply with the following:

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

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 failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

a) Resident #003 was identified in record review and confirmed during interview to have altered skin integrity with no pressure relieving devices in use.

During the inspection resident #003 was observed to have a pressure relieving device in place.

Interview with the Director of Nursing Care confirmed that resident #003 had been provided with a pressure relieving device the day previous to our observations.

Record review revealed that the use of the pressure relieving device was not included in the plan of care.

b) Record review revealed that resident #001 had two falls during a one week period. A Falls Risk Assessment completed 10 months prior to the falls identified the resident as being at moderate risk to fall. A Falls Risk Assessment completed after the initial fall indicated the resident remained at moderate risk to fall, despite a significant increase in the fall risk score. Document review did not reveal a written plan of care for resident #001 pertaining to falls including strategies to mitigate risk.

Interview with a Personal Support Worker revealed that up until the last two months resident #001 was independent with transfers and mobility. Because of a decline in Resident #001's health they now required increased assistance with their activities of daily living.

A Director of Resident Care (DORC) acknowledged that resident #001's health had declined and that recent falls occurred when the resident attempted to mobilize without assistance. The DORC confirmed that given the change in resident #001's condition and their increased risk to fall there should have been a written plan of care that sets out the planned care pertaining to falls risk for the resident. (568) [s. 6. (1) (a)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

a) Resident #008's plan of care related to toileting revised in 2011 indicated the resident was independent the majority of the time, and the plan of care related to urinary incontinence revised 2009 indicated the resident toilets independently.

Resident #008 returned from hospital in 2014. The Minimum Data Set (MDS) assessment completed after their return indicated the resident had a decline in bladder function and was incontinent of urine. At the same time the clinical health record identified the resident as now requiring at least one to two staff members to assist with toileting.

The Director of Nursing Care verified that the resident's plan was not reviewed and revised when the resident's care needs related to toileting changed.

b) Review of resident #004's care plan for urinary incontinence revealed that the resident was incontinent of urine but has some control present. Interventions include offering the resident use of a bedpan or commode; and resident to use a continence product for days, evenings and nights.

Interview with two Personal Support Workers revealed that resident #004 did not use a bed pan or a commode. The resident was encouraged to ring for assistance to use the washroom, but there were occasions when the resident would toilet themselves.

Staff interview with a Director of Resident Care revealed that resident #004 had an injury early last year which required hospitalization. When the resident first returned from hospital their mobility was limited and they may have used a bedpan or commode at that time.

The Director of Resident Care acknowledged that the urinary continence plan of care for resident #004 had not been reviewed and revised when the resident's care needs changed. (568) [s. 6. (10) (b)]

3. The licensee has failed to ensure that if the plan of care was being revised because care set out in the plan has not been effective, different approaches were considered in the revision of the plan of care.

Resident #008's plan of care related to the risk for falls indicated that staff were to ensure the resident had specific interventions for staff to implement to assist in the prevention of falls for the resident.

Record review revealed that resident #008 sustained three falls over a five month period, all while attempting to self-transfer. One of the falls resulted in injury and transfer to hospital.

The home's Fall Prevention Management Program dated September 10, 2014 included specific equipment for staff to consider for fall prevention and/or to reduce risk of injury from a fall.

Review of the resident's clinical health record indicated that post fall assessments were completed after each fall however, there were no different approaches considered including the use of equipment for the prevention of further falls.

The Director of Nursing Care confirmed that different approaches were not considered

when the current plan had not been effective in fall prevention for this resident. The Director of Nursing reported that different approaches should have been tried after each fall and fall prevention interventions should be considered in the revision of the plan of care.

The licensee has failed to ensure that if the plan of care was being revised because care set out in the plan has not been effective, different approaches were considered in the revision of the plan of care. [s. 6. (11) (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 there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #11: 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 has failed to ensure that a written response is provided within 10 days of receiving Residents' Council advice related to concerns or recommendations.

An interview with the President of the Residents' Council revealed that the home did not always provide a written response to concerns raised by Residents' Council. In some cases their response would be to look into the item further or to consult someone, but there was no follow-up afterward. A concern was brought forward to the Executive Director in the summer of 2014 regarding access to the garden pathway. A verbal response was provided by the Executive Director indicating that they would have to consult with the engineer. The Residents' Council has not yet been advised in writing or otherwise as to the outcome of this consultation.

Review of the the Residents' Council Minutes for 2014 and February 2015 did not reveal a completed concern form related to the garden pathway. Minutes from the September 30, 2014 meeting which was attended by the Executive Director have documented under the Administrators section, "Automatic door to the pathway and the ramp". There was no explanation as to what this comment refers to, nor was there a response by the Executive Director.

The Residents' Council Assistant reported being aware of the issue regarding resident access to the Garden Path but they were unsure when this was identified. During an interview with the Executive Director they reported being aware of the concern raised by residents in the summer of 2014 regarding access to the garden path for residents that were not fully independent. The Executive Director acknowledged that he had advised the Council that he would need to consult with the engineer, however; he confirmed that a response to the Residents' Council regarding this issued had not yet been provided. [s. 57. (2)]

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 failed to ensure that 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, is in compliance with and is implemented in accordance with applicable requirements under the Act.

The home's policy titled Skin and Wound Care Management Program, reference number 006020.00 last reviewed January 2014 and in effect in the home on March 19, 2015 stated that a complete Head to Toe Skin Assessment Form would be completed upon admission, quarterly, annual and change in status assessments, on return of a resident from hospital after a stay greater than eight hours and following a leave of absence greater than twenty-four hours.

The home's Readmission from Hospital Checklist dated July 2013 indicated that a Head to Toe assessment was to be completed if the resident was absent from the home for longer than twenty-four hours.

The legislative requirement under regulation s. 50(2)(a)(ii) states that a resident at risk of altered skin integrity was to receive a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

The home's policy titled Skin and Wound Management Program failed to be in compliance with and implemented in accordance with applicable requirements under the Act. [s. 8. (1) (a)]

2. 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, was complied with.

a) The home's Fluid Consistencies/Thickened Fluids Guidelines policy, last dated August 17, 2012 indicated that thickened fluids were prepared using a variety of thickening agents and using standardized recipes and/or manufacturers recommendations.

During observation of an afternoon nourishment pass, a Personal Support Worker was observed preparing a specific consistency of thickened fluids for resident #013. The Personal Support Worker was observed preparing the thickened fluids however, it was not consistent with the manufacturers recommendations for the appropriate consistency.

The Director of Food Services confirmed that the preparation of the thickened fluid was not completed as indicated on the manufacturers recommendations.

The Director of Food Services reported that the home began using the thickening agent
in December 2014 however, education on following manufacturers recommendations was not completed for all staff who were responsible for using the thickening agent.

The licensee failed to ensure that the home's Fluid Consistencies/Thickened Fluids Guidelines policy was complied with.

b) The Home's Fall Prevention Management Program policy, Reference No. 005190.00 effective September 10, 2014 indicates that post fall the registered staff will:
1. Re-evaluate, and update the residents' care plan with preventative measures following the falls conference or "huddle".
2. Document in the progress notes in PCC under Incident Note, including the status of the resident, notification of the family, assessment and outcomes and interventions taken to prevent further falls or related injury.

Each member of the multidisciplinary team (Registered staff, PT, OT, Restorative, Recreation) will:
1. Complete their respective assessments and discuss the appropriate interventions with the multidisciplinary care team.

Record review revealed that resident #001 two falls over a two week period in 2015,

but, the home did not follow their Falls Prevention Management Program policy.

Interview with the Director of Nursing Care confirmed that it was the home's expectation that staff would review the fall and discuss interventions to reduce risk of further falls during the post fall huddle. The care plan would then be updated based on these discussions. In addition, the physiotherapist would assess residents upon receipt of a referral post fall and discuss appropriate interventions with the team.

The licensee failed to ensure that the Falls Prevention Management Program policy and procedure related to updating the care plan post fall with preventative measures, documentation in the incident note interventions to prevent further falls, and physiotherapy assessment post fall was complied with. (568)

c) The home's bowel protocol indicated indicated specific interventions for staff to initiate when resident's did not have bowel movements for three days.

A review of resident #008's bowel records indicated that the resident did not have a bowel movement for six days. Records indicated that interventions were not initiated until the fourth day, however, the Director of Nursing Care reported that interventions should have started on the third day.

A review of resident #008's bowel records indicated the resident did not have a bowel movement for five days. A review of progress notes indicated the resident received interventions on the fourth day, however, there were no other interventions provided and the resident did not have a bowel movement until two days after the initial intervention was provided. The Director of Nursing Care confirmed that the home's bowel protocol was not followed.

d) The policy titled Preventative Maintenance Schedule, reference number 007040.00 effective date of October 17, 2011 stated that preventative maintenance is completed on a daily, weekly, monthly, quarterly, semi-annual and annual basis as per the task list. The task list identified under painting that all resident suites and common areas are to be inspected for necessary repairs and painting; under lighting to check and replace burnt out lamps on a daily basis.

Interview with the Environmental Supervisor confirmed that resident rooms were not routinely checked for preventative maintenance. It had been the expectation that nursing staff would report any maintenance concerns occurring in a resident room through the maintenance binder located on each home area.

Observation on March 25, 2015 with the Administrator and the Environmental Supervisor confirmed that a bathroom light in a residents' room was burnt out as identified in stage one of this inspection on March 16, 2014, nine days prior. Observation of a residents' bathroom identified a burnt out light and a very dim light over the vanity.

Observation on March 25, 2015 with the Administrator and the Environmental Supervisor identified flooring that was lifting on the edges and damage to the wall behind both chairs in an identified residents' room had not been identified by the home. Interview confirmed that there was no preventative maintenance monitoring completed with regard to wall damage.

The licensee failed to ensure that the preventative maintenance schedule was complied with. (192)

e) The home's Food Temperature Recording-Production policy dated August 17, 2012 indicated that the cook would use a properly calibrated thermometer to record the temperature of all cold foods 30 minutes prior to meal service on the production sheets and record the temperature of all hot foods prior to placing in the hot holding cabinet on the production sheets.

On March 27, 2015 during production observation, it was observed that the production sheets for the dinner meal on March 23, 2015 did not have any recorded temperatures for any foods prepared.

A review of the home's kitchen production sheets for the week of March 9 to 15, 2015 indicated that there were no recorded temperatures for any foods prepared for the March 10, 2015 breakfast meal and the dinner meal on March 14, 2015.

Director of Food Services reported that the expectation was for staff to record the temperatures of all food items on the menu production sheet.

The licensee failed to ensure that the Food Temperature Recording-Production policy was complied with.

f) The home's Food Temperatures-Point of Service policy dated August 17, 2012 indicated that dietary staff would insert the thermometer in the food for 15 seconds and record the temperature of all food items on the food temperature audit form.

The Director of Food Services reported that the expectation was for dietary staff to take the temperatures of all food items and record it on the menu production sheet designated for the home area prior to meal service.

A review of the menu production sheets for one home area on March 15, 2015 indicated that there were no temperatures of food items recorded for the dinner meal.

A review of several menu production sheets on multiple days for all home areas indicated that temperatures of all food items were not recorded.

The licensee failed to ensure that the home's Food Temperatures-Point of Service policy was complied with.

f) The home's Standardized Recipes policy dated August 17, 2012 indicated that the recipe yields were to exactly match the total to prepare number on the production sheets.

On March 27, 2015 during production observation the production sheets and standardized recipes were reviewed. The production quantity of menu items listed on the production sheets did not match the recipe yields on the standardized recipes. The cook reported that they prepare menu items closest to the number on the production sheets and confirmed that the recipe yields did not match the quantities listed on the production sheets.

The Director of Food Services provided the diet census record and confirmed that the current yields for the standardized recipes did not accurately correspond with production quantities and shortages of food have been a concern raised by Resident's Council.

A resident reported that the home often runs short of menu items resulting in residents not receiving their first choice of entrée. It was reported that the home ran short of Oktoberfest sausage on Sunday March 15, 2015 resulting in several residents not receiving their first choice entrée. A review of menu production sheets indicated that the home ran short of at least eight servings of sausage resulting in resident's not receiving their first choice entrée.

It was reported that the home often runs short of pie when it is on the menu. A resident reported that the home was short coconut cream pie served at dinner March

26, 2015 and that residents have asked for three pies to be sent however, reported that the home only provided two pies on each home area. The cook confirmed that two pies were provided to each home area.

The Director of Food Services reported that they were unaware that the home was short pie and the menu production sheet did not accurately reflect the shortage when reviewed March 27, 2015.

During lunch meal observation on March 16, 2015 on one home area, it was observed that the home ran short of chicken pot pie and one identified resident was not provided their choice of entree.

Resident's Council minutes dated February 24, 2015 identified that residents raised a concern related to resident's not receiving their choices and not being offered seconds.

The licensee failed to ensure that the home's standardized recipe policy was complied with. [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 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, is in compliance with and is implemented in accordance with applicable requirements under the Act, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to 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:
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.

Record review revealed that the annual evaluation for the Bowel and Continence Program was conducted in December 2014. The evaluation outlined a number of recommendations specific to components of the program, but it did not include a summary of the changes made and the date those changes were implemented. The Corporate Director of Nursing verified that the annual evaluation for the Bowel and Continence Program was not complete as it did not provide a summary of the changes made and the date those changes were implemented. [s. 30. (1) 4.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A Minimum Data Set (MDS) assessment indicated that resident #008 was occasionally incontinent of bladder. Several weeks later a significant change in status MDS assessment indicated that the resident was now incontinent of bladder.

A review of the resident's clinical health record indicated there was no continence assessment completed that included identification of causal factors, patterns, type of

incontinence and potential to restore function with specific interventions, using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A Registered Nurse reported there was no hard copy continence assessment and that continence assessments were completed electronically. The Director of Nursing Care verified that there was no electronic continence assessment completed and confirmed that an assessment should have been completed for this residents change in continence.

b) The MDS assessment for resident #004 identified the resident's urinary bladder function as usually incontinent, where incontinent episodes occur once a week or less. Three months later, the MDS assessment for resident #004 identified a decline in their urinary bladder function.

Interview with a Personal Support Worker revealed that resident #004 was sometimes incontinent and their product was wet when toileted, but other times their brief was dry and they would void in the toilet.

Record review revealed a Bladder and Bowel Continence Assessment completed for resident #004 on admission. There were no further continence assessments completed over the next three years that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A Director of Resident Care verified that no continence assessment had been completed for resident #004 since admission and confirmed that an assessment should have been completed for this residents' change in continence. (568)

The licensee has failed to ensure that each resident who was incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. [s. 51. (2) (a)]

2. The licensee has failed to ensure that each resident who was incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the

time.

The MDS assessment for resident #007 indicated that the resident was usually continent of bowel and frequently incontinent of bladder.

Record review indicated that the resident did not have a toileting plan in place to assist and support the resident.

Interview with the Director of Nursing Care confirmed that the resident should be on a toileting plan to ensure that the resident receives the assistance and support from staff to become continent some of the time.

The licensee has failed to ensure that each resident who was incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time. [s. 51. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who was incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviors, where possible.

Interview with a Personal Support Worker revealed that resident #004 exhibited responsive behaviors which they felt were escalating.

During a review of resident #004's clinical record, behaviors were identified and documented on a number of occasions in 20l4 and 2015.

Interview with a registered staff revealed that residents' exhibiting behaviors should have a care plan which identifies their specific behaviors and outlines strategies / interventions that can be used by staff to manage these behaviors. If the behaviors are escalating or if there has been a recent change then a referral can be initiated to the BSO team in the home. A Director of Resident Care acknowledged that resident #004 exhibited a number of behaviors and confirmed that strategies had not been developed to respond to the resident demonstrating these responsive behaviors. [s. 53. (4) (b)]

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 failed to ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

A resident returned from hospital with an area of altered skin integrity. Records indicated that a skin assessment was not completed by a member of the Registered Nursing staff until ten days after the identified resident returned from hospital. The assessment identified that the resident had two areas of altered skin integrity.

A Director of Resident Care reported that skin assessments were to be completed by registered nursing staff within 24 hours of the resident's return from hospital.

The licensee failed to ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including pressure ulcers, received immediate treatment and interventions to promote healing.

a) Record review and interview revealed that resident #002 was identified to have an area of altered skin integrity related to skin to skin contact when in bed. Two other areas of altered skin integrity related to pressure were identified over the next six weeks.

Review of the plan of care and interview revealed that no interventions were initiated related to pressure reduction for resident #002. The Wound Care Nurse confirmed that the resident should have specific interventions and devices in place to reduce pressure however; they were not initiated in spite of multiple areas of altered skin integrity related to pressure.

Interview with the Wound Care Nurse revealed that five pressure relieving surfaces were in use and five were purchased at the end of 2014 but as of March 19, 2015 they had not been utilized.

b) Resident #012 was identified to have an area of altered skin integrity related to pressure. Several other areas of altered skin integrity were identified over the next three months.

Record review and interview with the Wound Care Nurse confirmed that the resident did not have a therapeutic surface in place and was not identified to be on a turning and repositioning program.

Review of the plan of care and interview with the Wound Care Nurse confirmed that the identified resident was to have specific interventions and devices in place to promote healing, including pressure relief.

c) Record review and interview with the Wound Care Nurse confirmed that resident #003 had several areas of altered skin integrity related to pressure. Review of the plan of care and interview with the Wound Care Nurse revealed that the resident had not

been provided equipment, supplies, devices or positioning aids to relieve pressure.

Interview with the Director of Nursing Care confirmed that resident #003 had pressure related altered skin integrity and that a pressure relieving device was not provided to the resident for six months. No pressure relieving surface was in use for the resident although it is the home's expectation that a resident with altered skin integrity would be considered for a pressure relieving surface.

The licensee failed to ensure that resident #002, #012, and #003 who had altered skin integrity related to pressure, received treatment and interventions to promote healing, including pressure relief. [s. 50. (2) (b) (ii)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

Resident #002 was identified in progress notes and confirmed by the Wound Care Nurse to have multiple pressure areas.

Interview with the Wound Care Nurse identified that a referral to the registered dietitian (RD) was to be completed when a "skin new" note was completed. The Wound Care Nurse confirmed that no referral was completed to the RD when the areas of altered skin integrity were first identified for resident #002. It was only after one of the areas deteriorated that an assessment by the RD was completed.

The licensee failed to ensure that resident #002 who was exhibiting altered skin integrity had been assessed by the registered dietitian. [s. 50. (2) (b) (iii)]

4. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including pressure ulcers had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) Record review and interview with the Wound Care Nurse confirmed that resident #002 had several areas of altered skin integrity related to pressure.

Review of the medical record indicated that during an eight week period; weekly wound assessments were not completed on six of the eight weeks for one of the

areas of altered skin integrity, on two of the eight weeks for a second area of altered skin integrity, and on none of the weeks for a third area of identified altered skin integrity.

b) Resident #003 was identified to have an area of altered skin integrity that had not healed. Record review and interview with the Wound Care Nurse confirmed that 10 weekly skin assessments were not completed over a six month period.

Record review and interview with the Wound Care Nurse also confirmed that five weekly skin assessments were not completed for a second area of altered skin integrity over an eight week period.

c) Record review and interview revealed that resident #012 had several areas of altered skin integrity.

Record review and interview confirmed that weekly skin assessments were not completed for one of the areas of altered skin integrity for a period of four weeks; a second area of altered skin integrity for five of ten weeks; and for two weeks for two areas of altered skin integrity.

Interview with the Wound Care Nurse confirmed that weekly skin assessments have not consistently been completed for residents of the home. The licensee failed to ensure that resident #002, #012 and #003 received weekly wound assessments by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

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:
a) A resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.
b) A resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives,
(ii) immediate treatment and interventions to promote healing,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: 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. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) 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. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of the annual Infection Prevention and Control program evaluation included the date of the evaluation, the names of the persons who participated, a summary of the changes made, and the date those changes were implemented.

Record review and interview with the Director Nursing Services confirmed that evaluation of the infection prevention and control program was conducted on February 27, 2014 and that the written record of the evaluation failed to include a summary of the changes made to the program and the date those changes were implemented. [s. 229. (2) (e)]

2. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Record review and interview confirmed that resident #002 had signs and symptoms of infection over a 24 hour period. A Personal Support Worker confirmed the resident had signs and symptoms of infection that morning.

Observation of resident #002's room identified that there was no signage on the resident's door indicating precautions. No personal protective equipment was available at the entrance to the room or within the room.

Interview with the Infection Prevention and Control (IP&C) practitioner confirmed that at the first signs and symptoms of infection a resident should be isolated from contact with other residents, signage should be posted to alert staff and personal protective equipment should be accessed from the storage area. The IP&C practitioner confirmed that clean isolation carts were readily available for all registered staff.

A Personal Support Worker was observed entering resident #002's room. A beverage was provided and the staff member exited the room. No personal protective equipment was observed being used when having contact with the resident with signs and symptoms of infection and no hand hygiene was performed when the staff member exited the room.

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program when signage was not posted for a resident exhibiting signs of infection, when personal protective equipment was not made available to and used by staff having contact with the resident and when staff

providing care to the resident failed to complete hand hygiene. [s. 229. (4)]

3. The licensee has failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices.

During the inspection it was identified and confirmed by a Personal Support Worker that an identified resident had experienced signs and symptoms of infection. A staff member was heard notifying a family member that their loved one was feeling unwell. Interview with another resident revealed that this resident had signs and symptoms of infection.

Record review conducted for the previous 72 hours identified documentation of symptoms of infection, on all shifts, for 19 residents on all home areas. The Infection Prevention and Control Nurse stated that she was not aware that four of five residents identified on the second floor had symptoms of infection.

Interview with the Infection Prevention and Control Nurse confirmed that monitoring of residents on all floors was being completed.

The Infection Prevention and Control Nurse identified that the home's definition of an enteric infection was when a resident exhibited two or more symptoms or had two episodes of the same symptom in a twenty-four hour period above what was normal for the resident. An outbreak would be considered and Public Health notified if there were two or more residents in a home area with symptoms over a 48 hour period.

The Infection Prevention and Control Nurse confirmed that it would be the expectation of staff in the home that any resident exhibiting signs and symptoms of infection would be included on the line listing to be maintained on each home area and reported at morning huddle. The Infection Prevention and Control Nurse also confirmed that line listings on the home areas were not consistently completed with each resident exhibiting signs and symptoms of infection.

The licensee failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices. [s. 229. (5) (a)]

4. The licensee has failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required.

During the inspection it was identified and confirmed that three residents were

exhibiting signs and symptoms of infection.

Interview with the Infection Prevention and Control Nurse and the Director of Nursing Services confirmed that it would be the home's expectation that any resident with signs and symptoms of infection would have precautions initiated until infection could be ruled out as the cause for the signs and symptoms.

The home's policy titled Enteric Outbreak reference number 006060.00 dated as effective December 30, 2011 stated signage was to be posted and that personal protective equipment would be used. The family would be notified and the resident should be restricted to their room until signs and symptoms are resolved.

Resident #002 was confirmed by record review and interview to have ongoing symptoms of infection. Observation of the resident's room identified that no signage was posted alerting other staff entering the room of potential risks.

Record review identified that family had taken resident #002 to the dining room during the meal time. The resident presented with symptoms after returning to their room.

Observation identified that a Personal Support Worker provided care to the resident, offering the resident a beverage and repositioning the resident with out use of personal protective equipment and the completion of hand hygiene following the provision of care.

The licensee failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required. [s. 229. (5) (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:
a) A written record of the annual Infection Prevention and Control program evaluation included the date of the evaluation, the names of the persons who participated, a summary of the changes made, and the date those changes were implemented,
b) Staff participate in the implementation of the infection prevention and control program,

c) Staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices,

d) Staff on every shift record symptoms of infection in residents and take immediate action as required, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 228.
Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements: improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' council.

An interview with the Residents' Council President revealed that the Residents' Council was not always kept informed of changes or improvements being made in the home related to programs, changes to scheduling for staffing, and planned maintenance / repairs . It was reported to the inspector that a number of residents stated that in the last two weeks they had some concerns with having to wait for their evening care. After asking questions residents were advised that this may be the result of changes to the staffing schedule for Personal Support Workers which went into effect a number of weeks ago.

Resident's Council Minutes revealed that the last update provided by the Executive Director with regards to quality improvements and utilization regarding care, services, programs and goods was at the September 30, 2014 meeting. The minutes did not indicate that Residents' Council had been informed of the recent change to scheduling for Personal Support Workers. The Executive Director acknowledged that the recent changes to scheduling for Personal Support Workers had not been communicated to the Residents' Council.

The licensee failed to ensure that improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents was communicated to the Residents' Council. [s. 228. 3.]

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

On March 17, 2015 at 1215 hours it was observed that the hair salon was left open and unattended with sharps and chemicals accessible to anyone entering the room. The hair salon was located on the main level near the entrance to the home and was adjacent to a lounge area. Residents and visitors were observed in the lounge area and in proximity to the open salon.

Interview with the Hairdresser confirmed that the salon was left open and unattended when she has to leave to return a resident to a home area and that sharps would be accessible to anyone entering the salon.

Interview with the Executive Director and Administrator confirmed that the salon should be kept locked when not attended.

The licensee failed to ensure that the home is a safe and secure environment for its residents on March 17, 2015 when the hair salon was left open and unattended. [s. 5.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of, a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

During an observation of the afternoon nourishment pass it was noted that resident #013 was not offered a beverage.

The Personal Support Worker was observed placing a beverage on the residents bedside table while they were sleeping. The remaining nourishment pass was completed for the home area and the resident remained sleeping during this time.

A review of the resident's clinical health record indicated that at 1522 hours the resident consumed 125 milliliters of fluid however, the resident was observed sleeping during this time. At 1645 hours, the resident's beverage was observed full on their bedside table.

The licensee failed to ensure that the resident was offered a minimum of a between-meal beverage in the afternoon. [s. 71. (3) (b)]

2. The licensee has failed to ensure that each resident was offered a minimum of, a snack in the afternoon and evening.

During an observation of the afternoon nourishment pass, it was noted that resident #013 was not offered a snack.

The nourishment cart contained a labeled snack that was identified for resident #013 .

At 1520 hours, the Personal Support Worker was observed providing the labeled snack to another identified resident.

A review of the resident's clinical health record indicated that the Personal Support Worker documented at 1526 hours that resident #013 consumed their snack however, the Personal Support Worker did not return to the residents room to offer a snack during this time.

The licensee has failed to ensure that each resident was offered a minimum of, a snack in the afternoon. [s. 71. (3) (c)]

3. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

During an observation of the afternoon nourishment pass on one of the home areas, it was observed that the cart did not have puree textured snacks available on the cart to offer residents who required puree textured diets.

The Personal Support Worker confirmed that they had labeled snacks for residents and regular textured cookies however, there was no puree textured snacks available.

The Director of Food Services confirmed that the home's planned menu indicated that residents requiring puree texture were to receive puree textured cookies and that the home area had at least three residents that required puree textured snacks. The Director of Food Services reported that the puree textured snacks were in the servery fridge in the home area and were not placed on the afternoon nourishment cart.

The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack. [s. 71. (4)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that no person simultaneously assists more than two residents who need total assistance with eating or drinking.

During observation of the lunch meal in Stage 1 of the Resident Quality Inspection, one Personal Support Worker was observed assisting three identified residents with feeding simultaneously.

A Personal Support Worker confirmed that one Personal Support Worker was assisting all three residents simultaneously and that all three residents required total assistance to eat during this lunch meal. It was not until 1237 hours when one of the residents' family members arrived to assist, that the Personal Support Worker was able to provide assistance to just two residents simultaneously.

The licensee failed to ensure that, no person simultaneously assists more than two residents who need total assistance with eating or drinking. [s. 73. (2) (a)]

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:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, interdisciplinary assessment of safety risks.

Record review and interview confirmed that residents #005, #030 and #031 were assessed in February 2015 to require the use of bed rails.

Observation on March 17, 2015 identified that resident #005 had one or more bed rails raised in the up position.

Review of the plan of care including tasks on point of care, with a Director of Care, failed to identify the use of bed rails within the plan of care for residents #005, #030 and #031.

The licensee failed to ensure that the plan of care was based on interdisciplinary assessment of safety risks for the identified residents. s. 26. (3) 19.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written record of each annual evaluation of the staffing plan including 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.

The Director of Nursing Care identified in an interview that the staffing plan for the home was evaluated on an ongoing basis.

Record review and interview with the Director of Nursing Care confirmed that there was no written record of an annual evaluation of the staffing plan that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of changes made and the date that those changes were implemented. [s. 31. (4)]

Issued on this 20 day of May 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568), DEBORA SAVILLE (192), TAMMY SZYMANOWSKI (165)
Inspection No. / No de l'inspection :	2015_325568_0011
Log No. / Registre no:	L-002042-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 6, 2015
Licensee / Titulaire de permis :	PEOPLECARE Inc. 28 William Street North, P.O. Box 460, Tavistock, ON, N0B-2R0
LTC Home / Foyer de SLD :	HILLTOP MANOR CAMBRIDGE 42 ELLIOTT STREET, CAMBRIDGE, ON, N1R-2J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Blair Philippi

To PEOPLECARE Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

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

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

Order / Ordre :

The licensee shall ensure that resident #002, #003 and #012 and any other resident exhibiting altered skin integrity, including pressure ulcers, receives immediate treatment and interventions to promote healing, including pressure relief.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including pressure ulcers, received immediate treatment and interventions to promote healing.

a) Record review and interview revealed that resident #002 was identified to have an area of altered skin integrity related to skin to skin contact when in bed. Two other areas of altered skin integrity related to pressure were identified over the next six weeks.

Review of the plan of care and interview revealed that no interventions were initiated related to pressure reduction for resident #002. The Wound Care Nurse confirmed that the resident should have have specific interventions and devices in place to reduce pressure however; they were not initiated in spite of multiple areas of altered skin integrity related to pressure.

Interview with the Wound Care Nurse revealed that five pressure relieving surfaces are in use and five were purchased at the end of 2014 but as of March 19, 2015 they had not been utilized.

b) Resident #012 was identified to have an area of altered skin integrity related to pressure. Several other areas of altered skin integrity were identified over the next three months.

Record review and interview with the Wound Care Nurse confirmed that the resident did not have a therapeutic surface in place and was not identified to be on a turning and repositioning program.

Review of the plan of care and interview with the Wound Care Nurse confirmed that the identified resident was to have specific interventions and devices in place to promote healing, including pressure relief.

c) Record review and interview with the Wound Care Nurse confirmed that resident #003 had several areas of altered skin integrity related to pressure.

Review of the plan of care and interview with the Wound Care Nurse revealed that the resident had not been provided equipment, supplies, devices or positioning aids to relieve pressure.

Interview with the Director of Nursing Care confirmed that resident #003 had pressure related altered skin integrity and that a pressure relieving device was not provided to the resident for six months. No pressure relieving surface was in use for the resident although it is the home's expectation that a resident with altered skin integrity would be considered for a pressure relieving surface.

The licensee failed to ensure that resident #012, #002 and #003 who had altered skin integrity related to pressure, received treatment and interventions to promote healing, including pressure relief.

(192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 22, 2015

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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

Issued on this 6th day of April, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dorothy Ginther

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