Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 1, 2016	2016_217137_0001	024282-15	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF HURON
77722A London Rd R R 5 CLINTON ON N0M 1L0

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

HURONVIEW HOME FOR THE AGED
R. R. #5, LOT 50, CON 1 MUNICIPALITY OF HURON EAST CLINTON ON N0M 1L0

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

MARIAN MACDONALD (137), AMIE GIBBS-WARD (630), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 5 - 8 and 13 - 15, 2016.

A Critical Incident System (CIS) inspection was also conducted during the Resident Quality Inspection (RQI) under Log # 024841-15, CIS # M541-000019-15, related to Falls Prevention, and an anonymous Complaint Inspection was completed, under Log # 034249-15, IL# 41849-LO, related to Housekeeping.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing Care, Associate Director of Care, Nutrition Services Manager, Environmental Services Manager, Program and Social Services Coordinator, six Registered Nurses, eight Registered Practical Nurses, seven Personal Support Workers, one Administrative Assistant, two Housekeeping Aides, two Activation Aides, one Laundry Aide, one Maintenance Worker, six Dietary Aides, one Cook, a Residents' Council and a Family Council Representative, three Family Members and 40+ residents.

The Inspectors also toured all resident home areas, common areas, medication storage areas, observed dining service, care provision, resident/staff interactions, recreational programs, medication administration, reviewed residents' clinical records, relevant policies and procedures, staff education records and pertinent meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **7 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

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

1. A clinical record review, for an identified resident, indicated that the resident sustained a fall and was unable to confirm what had happened.

The home's policy titled "Falls Prevention and Management Program - A09 RC 001 11" last revised November 2012, indicated the following: "Initiate Head Injury (HIR) for all un-witnessed falls and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy." "Monitor every hour for the first 4 hours and then every 4 hours for 24 hours, post fall for signs of neurological changes (e.g. facial droop, behaviour changes, and weakness on 1 side)."

The progress notes revealed Post-Fall Head Injury Routine documentation was incomplete and the home's policy was not complied with.

The progress notes also indicated that the resident was assessed by the Falls Team and was placed on the falling leaf program, as the resident had experienced previous falls.

"Falls Prevention Program, The Falling Leaf Program - A09-RC-012-12 last revised November 2012, Appendix D, indicated the following:
"The "leaf" is an autumn coloured leaf which is attached to the resident name plate on the door of their room, in the handle with care logo pocket above their bed, to the mirror in the resident bathroom and to any mobility aid the resident uses, wheelchair, walker.

Observations revealed that the leaf logo was present on the resident name plate on the door and on the resident's walker but was not present on the bathroom mirror or in the care logo pocket above the bed.

The Director of Care #101 confirmed that it was the expectation that a leaf logo should have been present in the care logo pocket above the resident's bed and also on the bathroom mirror. [s. 8. (1) (a),s. 8. (1) (b)]

2. A review of the "Fall Prevention & Management Program - Policy # A09 RC 001 11- dated November 2012," indicated that registered nursing staff would complete a critical incident worksheet if the fall or injury resulted in injury and/or transfer to hospital and the

multidisciplinary team would conduct a multidisciplinary conference to determine the possible cause of the falls and develop changes to prevent reoccurrence based on DAR (data, action, response) charting principles.

An identified resident sustained a fall, resulting in injury and transfer to hospital for treatment.

During a review of the clinical records, for the identified resident, and fall committee meeting minutes, there was no documented evidence that a critical incident worksheet had been completed and the multidisciplinary team did not conduct a multidisciplinary conference to determine the possible cause of the falls and develop changes to prevent re-occurrence based on DAR (data, action, response) charting principles.

During an interview, the Associate Director of Care # 121, confirmed registered nursing staff did not complete a critical incident worksheet, the multidisciplinary team did not conduct a multidisciplinary conference to determine the possible cause of the falls and develop changes to prevent re-occurrence based on DAR (data, action, response) charting principles and the home's policy was not complied with.

A review of "Falls Prevention Program - The Falling Leaf Program - Policy # A09-RC-012 -12 - dated November 2012," indicated an autumn coloured leaf would be attached to the resident name plate on the door of their room, in the handle with care logo pocket above their bed, to the mirror in the resident bathroom and to any mobility aid the resident uses, wheelchair, walker.

During observations, it was revealed that there was no autumn coloured leaf attached to the resident's name plate on the bedroom door and to the resident's wheelchair.

Personal Support Worker (PSW) # 117 confirmed there was no autumn coloured leaf attached to the resident's name plate on the bedroom door and to the resident's wheelchair.

During interviews, the Director of Care and Associate Director of Care, confirmed the autumn coloured leaf was to be attached to the resident's name plate on the bedroom door and to the resident's wheelchair. Both acknowledged the home's policy was not complied with.

A review of the "Personal Alarms - Policy # A09-Rc-031-13 - dated September 2013,"

indicated staff must check the battery each shift to ensure the alarm was functioning and a logo indicating a personal alarm, would be inserted into the holder above their bed. This would inform all staff, volunteers and family members of the need for the personal alarm.

During observations, for an identified resident, it was revealed there was no logo, indicating a personal alarm, inserted into the holder above the bed and there was no documented evidence that staff checked the battery each shift to ensure the alarm was functioning.

Personal Support Worker # 117, confirmed there was no logo, indicating a personal alarm, inserted into the holder above the bed and staff do not check the batteries each shift to ensure the alarms are functioning.

During an interview, the Associate Director of Care # 121, confirmed that there was no process in place to ensure bed/chair alarms were checked to ensure functioning and the home’s policy was not complied with. [s. 8. (1) (b)]

3. During interviews, identified residents indicated that they often felt the temperatures of the food served were not hot enough.

Review of the Residents’ Food Committee minutes from February 2, 2015, through to January 4, 2016, identified that there were documented complaints about the temperature of the food at 40 per cent of these meetings.

During an interview, with the Nutrition Services Manager # 122, it was confirmed that temperatures of hot foods, especially vegetables, had been a concern voiced by residents on a regular basis.

Observations in multiple dining rooms, during two lunch meals, identified that Dietary Aides were not consistently recording temperatures, prior to meal service.

A review of the "Daily Temperature Logs", for an identified time period, revealed that food temperatures were not recorded for one or more menu items at the following meals:

- Sugar Bush Dining Room incomplete three out of twelve meals (25 per cent).
- Primrose Parlour Dining Room incomplete eight out of twelve meals (67 per cent).
- Magnolia Café Dining Room incomplete nine out of twelve meals (75 per cent).

- Sunshine Dining Room incomplete five out of twelve meals (42 per cent).

A review of the policy, "Food Service Temperatures Policy #A09-NC-402-10" last review date August 2009, indicated "food temperatures recording chart is completed for all hot menu items and for cold foods, especially perishable products such as milk and milk based desserts, in the serveries, prior to meal services."

During an interview, with the Nutrition Services Manager # 122, it was confirmed that the "Daily Temperature Logs" were incomplete and that it was the expectation that temperatures were measured and recorded, prior to each meal service, as per the home's policy. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A review of the clinical records, for an identified resident, revealed the resident sustained several falls.

Through observation and staff interviews, it was revealed the resident utilizes a Hi-Lo bed and a bed/chair alarm. The plan of care did not include either of these fall prevention interventions.

During an interview, the Associate Director of Care # 121, confirmed the plan of care did not include the use of a Hi-Lo bed and a bed/chair alarm and that the plan of care did not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

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

During a lunch meal, an identified resident was observed to be served and fed a regular texture diet. A review of the diet kardex, therapeutic menu and plan of care revealed the identified resident was to be served a minced texture diet, as a result of chewing/swallowing concerns and cognitive decline.

During an interview, with Nutrition Services Manager #122, it was confirmed that the resident should have been served the minced texture diet as per the therapeutic menu, diet order and the plan of care. Nutrition Services Manager #122 confirmed that it was the expectation of the home that staff follow the plan of care including the prescribed diet order for residents at all meals. [s. 6. (7)]

3. The licensee has failed to ensure that the plan of care was reviewed and revised when the resident's care needs changed.

A review of the care plan, for an identified resident, indicated that the resident utilized a personal aid.
Observations revealed there was no personal aid in place.

During interviews, with an identified resident and PSW #107, RPN #115 and a Registered Nurse (RN) #116, also indicated that the resident no longer utilized a personal aid.

A review of the Point Click Care Tasks revealed the personal aid task had been completed when the aid was no longer available for use.

RN # 116 confirmed that the plan of care had not been revised to reflect the change in care and the Director of Care #101 confirmed that it was the expectation that the plan of care was to be reviewed and revised at any time when the resident's care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

4. The licensee has failed to ensure that when the resident was reasssessed that the plan of care was reviewed and revised when the resident's care needs changed.

Review of three Falls Risk Assessments, for an identified resident, revealed that the resident was assessed as a high falls risk.
The care plan indicated that the resident was at moderate risk for falls.

The Resident Assessment Instrument (RAI) Coordinator confirmed that the resident had been assessed as a high falls risk and that the plan of care was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the plan of care set out clear directions to staff and others who provided direct care to the resident, the care set out in the plan of care was provided to the resident as specified in the plan of care and the plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of the "Restraint Program: Bed Assist Rails Policy # A09-RC-072-15," indicated that Bed/Assist rail use will be determined upon completion of the Bed Rail Assessment in Point Click Care.

During a clinical record review, for an identified resident, there was no documented evidence that a bed rail assessment was completed.

During interviews, with the Administrator # 102 and Director of Care # 101, it was confirmed that bed rail assessments were not completed and that a bed rail assessment had been developed but not implemented.

Another identified resident was observed in bed, with two quarter bed rails in the upright position. PSW #104 and RPN #123 indicated that bed rails were used whenever the resident was in bed.
A review of the plan of care revealed the resident had two bed rails in the raised position when in bed but there was no documented evidence of a completed bed rail assessment.

A review of the home's policy titled "Restraint Program: Bed/Assist Rails Policy # A09-RC-072-15" last revised May 2015, revealed "bed/assist rail use will be determined upon completion of the Bed Rail Assessment in Point Click Care".

During an interview, with the Administrator #102 and Director of Resident Care #101, it was confirmed that bed rail assessments were not being done for residents in the home.

The Administrator confirmed the expectation that bed rails were to be assessed by staff prior to implementing this intervention. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents had their personal items, including personal aids, labeled within 48 hours of admission and in the case of new items, of acquiring.

A review of the care plan, for an identified resident, indicated that the resident utilized a personal aid.
Observations revealed there was no communication device in place.

During interviews, with an identified resident and PSW #107, RPN #115 and a Registered Nurse (RN) #116, also indicated that the personal aid was not being utilized and was no longer available in the home.

A personal aid, stored in the Nurses' Room, was not labeled and staff were unable to identify the rightful owner.

During an interview with the Director of Nursing Care #101, it was indicated that the home did not have a process for the labeling of the specific personal aid. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents have their personal items, including personal aids, labeled within 48 hours of admission and in the case of new items, of acquiring, to be implemented voluntarily.

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 has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed at least weekly by a member of the registered nursing staff.

A clinical record review, for an identified resident, revealed a Comprehensive Wound Assessment Tool (CWAT) was completed by the Wound Care Specialist and indicated an area of impaired skin integrity. There were corresponding treatment orders which included a comprehensive wound assessment to be completed weekly.

A review of the clinical record, for the identified resident, revealed that weekly wound assessments were not completed for this resident for 13/29 weeks (45 per cent).

An interview with Registered Practical Nurse (RPN) #126 verified that this resident had an area of impaired skin integrity, that it was to be treated per the physician order, a weekly wound assessment should have been completed and confirmed the weekly wound assessments were not consistently completed.

The home's policy titled "Assessment and Treatment of Pressure Ulcers - A09-RC-009-11", last revised July 2014, states: " Residents exhibiting altered skin integrity will be reassessed by registered nursing staff at least weekly using the CWAT (Comprehensive

Wound Assessment Tool) on Point Click Care (PCC), and will monitor and evaluate resident outcomes."

The Director of Care # 101, Associate Director of Care #121 and the Administrator #102, confirmed that an identified resident exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds and was not assessed, at least weekly, by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

2. A clinical record review, for another identified resident, revealed a Comprehensive Wound Assessment Tool (CWAT) was completed by Registered Practical Nurse #126 and indicated an area of impaired skin integrity. There were corresponding treatment orders which included a comprehensive wound assessment to be completed weekly.

A review of the clinical record, for the identified resident, revealed that weekly wound assessments were not completed for this resident for 7/8 weeks (87.5 per cent).

An interview with a Registered Practical Nurse #126, confirmed that this resident had an area of impaired skin integrity, that it was to be treated per the physician order, a weekly wound assessment should have been completed and confirmed the weekly wound assessments were not consistently completed.

The home's policy titled "Assessment and Treatment of Pressure Ulcers - A09-RC-009-11", last revised July 2014, states: " Residents exhibiting altered skin integrity will be reassessed by registered nursing staff at least weekly using the CWAT (Comprehensive Wound Assessment Tool) on Point Click Care (PCC), and will monitor and evaluate resident outcomes."

The Director of Care # 101 Associate Director of Care #121 and the Administrator #102, confirmed that an identified resident exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds and was not assessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #6: 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).

Findings/Faits saillants :

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

Interviews with a Registered Practical Nurse (RPN) #123, PSWs #127, #124 and # 117, indicated that an identified resident was frequently incontinent of urine. A review of the clinical record identified the resident was frequently incontinent of urine since admission but there was no documented evidence that a continence assessment had been completed.

A review of the home’s policy, "Resident Care: Continence Care Assessment Tools # A09-RC-102-12" last revised January 2012, revealed “Registered staff will complete "Screening Continence Assessment" at minimum for the resident's quarterly assessment or when the resident's need changes."
During an interview with the Director of Resident Care, #101, on January 14, 2016, it was confirmed that continence assessments were not completed for this resident.

The Director of Resident Care confirmed the expectation that continence assessment were to be done for all residents as per the policy.

A review of the "Continence Care, Assessment Tools - Policy # A09-RC-102-12 - dated January 2012," indicated that "each resident shall be assessed within 7 days of admission, as part of the interdisciplinary assessment, reassessed at least quarterly and re-assessed when there was any change in the resident's health status that affects continence.
Upon admission, each resident would have a Voiding Record initiated and completed over the course of 3 days, by PSW/HCA.
At the completion of the 3 day Voiding Record, Registered Staff would complete the "Screening Continence Assessment" on the resident".

A clinical record review, for an identified resident, revealed there was no documented evidence of a Continence Assessment completed on admission or anytime thereafter.

There was a three day voiding record completed on admission.

During an interview, with the Director of Care # 101, it was confirmed that continence assessments were not completed and the expectation was that continence assessments were to be completed, to ensure the home’s policy was complied with. [s. 51. (2) (a)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle includes menus for regular, therapeutic and texture modified diets for both meals and snacks.

Observations, during a lunch meal, revealed that residents, in an identified dining room, were offered Chicken Wings and Macaroni Salad as the "Resident Choice", alternative to the Egg Salad Sandwiches and Coleslaw.

PSW #117 offered choice to the residents using a show plate which was observed to contain one chicken wing with approximately 50 millilitres (mls) macaroni salad.

PSW #117 was observed ordering the residents' meals by stating the first name of the resident, as well as the item and the portion to serve and then Dietary Aide #119 portioned the food based on this order.

Neither staff member was observed to reference a diet list or a therapeutic menu, throughout meal service. Portion sizes observed to be served to residents ranged from one to six chicken wings with a range of portion sizes for the salads.

An interview with Dietary Aide #119, confirmed that staff had not referenced a therapeutic menu during this meal service.
A review of the therapeutic menu with Dietary Aides #118 and #119, identified that the Chicken Wings and Macaroni Salad were not listed on this menu, as the menu only stated "Resident's Choice".

An interview with the Nutrition Services Manager #122, confirmed that a therapeutic menu was not available for the staff to reference for the "Resident's Choice" menu.
The Nutrition Services Manager #122, further confirmed it was the home's expectation that staff reference a therapeutic diet at all meals, to ensure residents were receiving the correct interventions. [s. 71. (1) (b)]

2. The licensee failed to ensure that the home's menu cycle included alternative choice of vegetables at all lunch meals.

Observations, during a lunch meal, revealed that residents, in an identified dining room, were offered and served Chicken Wings and Macaroni Salad as the "Resident Choice" alternative to the Egg Salad Sandwiches and coleslaw.

Interviews, with Dietary Aides #118 and #119, confirmed that there was no alternative vegetable available at this meal.

During an interview, with the Nutrition Services Manager #122, it was confirmed that there was no alternative vegetable served on the menu for this lunch meal and that it had been the practice in the home not to serve an alternative vegetable for "Resident's Choice" menus at lunch on week one and week three of the menu cycle.

The Nutrition Services Manager #122 confirmed it was the home's expectation that an alternative vegetable was available at all lunch and dinner meals for residents. [s. 71. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's menu cycle included menus for regular, therapeutic and texture modified diets for both meals and snacks and that the home's menu cycle included alternative choice of vegetables at all lunch meals, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance, as part of the organized program of maintenance services.

Observations, during the initial tour and throughout the Resident Quality Inspection (RQI), revealed identified deficiencies, such as damaged and paint chipped doors, door frames, radiator covers and walls in 25 of 40 (62.5 per cent) of resident rooms.

During a tour, the Administrator # 102, confirmed the identified deficiencies and there were no schedules and procedures in place for routine, preventive and remedial maintenance, as well as the expectation that there should be schedules and procedures in place for routine, preventive and remedial maintenance, as part of the organized program of maintenance services. [s. 90. (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 there were schedules and procedures in place for routine, preventive and remedial maintenance, as part of the organized program of maintenance services, to be implemented voluntarily.

Issued on this 4th day of February, 2016

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) :	MARIAN MACDONALD (137), AMIE GIBBS-WARD (630), NANCY SINCLAIR (537)
Inspection No. / No de l'inspection :	2016_217137_0001
Log No. / Registre no:	024282-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 1, 2016
Licensee / Titulaire de permis :	CORPORATION OF THE COUNTY OF HURON 77722A London Rd, R R 5, CLINTON, ON, N0M-1L0
LTC Home / Foyer de SLD :	HURONVIEW HOME FOR THE AGED R. R. #5, LOT 50, CON 1, MUNICIPALITY OF HURON EAST, CLINTON, ON, N0M-1L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Connie Townsend

To CORPORATION OF THE COUNTY OF HURON, 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. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

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

The licensee must take action to achieve compliance with O. Reg. 79/10, s.8(1) (b) to ensure policies implemented in the home were complied with, specifically related to:

a) Falls Prevention and Management Program - ensuring Head Injury Routine (HIR) is initiated with unwitnessed falls or falls with injury, Falling Leaf Program is fully implemented, Critical Incident Worksheets are completed with each fall, multidisciplinary conferences are held post-fall and personal alarm batteries are checked each shift to ensure functioning.
b) Food Service Temperatures - ensuring food temperatures are measured and recorded prior to each meal service
c) Restraint Program - Bed Assist Rails - ensuring bed rail assessments are completed for all residents.
d) Ensuring a process is in place to monitor on-going compliance related to policies being complied with, including assigning responsibility for the monitoring.

Grounds / Motifs :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on April 23, 2015, under Log # 005714-15 and

Inspection # 2015_264609_0024, related to Head Injury Routine (HIR) policy was not complied with.

(1) A clinical record review, for an identified resident, indicated that the resident sustained a fall and was unable to confirm what had happened.

The home's policy titled "Falls Prevention and Management Program - A09 RC 001 11" last revised November 2012, indicated the following: "Initiate Head Injury (HIR) for all un-witnessed falls and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy." "Monitor every hour for the first 4 hours and then every 4 hours for 24 hours, post fall for signs of neurological changes (e.g. facial droop, behaviour changes, and weakness on 1 side)."

The progress notes revealed Post-Fall Head Injury Routine documentation was incomplete and the home's policy was not complied with.

The progress notes also indicated that the resident was assessed by the Falls Team and was placed on the falling leaf program, as the resident had experienced previous falls.

"Falls Prevention Program, The Falling Leaf Program - A09-RC-012-12 last revised November 2012, Appendix D, indicated the following:
"The "leaf" is an autumn coloured leaf which is attached in the following manner , to the resident name plate on the door of their room, in the handle with care logo pocket above their bed, to the mirror in the resident bathroom and to any mobility aid the resident uses, wheelchair, walker.

Observations revealed that the leaf logo was present on the resident name plate on the door and on the resident's walker but was not present on the bathroom mirror or in the care logo pocket above the bed.

The Director of Care #101, confirmed that it was the expectation that a leaf logo should have been present in the care logo pocket above the resident's bed and also on the bathroom mirror.

(537)

2. During interviews, identified residents indicated that they often felt the

temperatures of the food served were not hot enough.

A review of the Residents' Food Committee meeting minutes, from February 2, 2015, through to January 4, 2016, identified that there were documented complaints about the temperature of the food at 40 per cent of these meetings.

During an Interview, with the Nutrition Services Manager # 122, it was confirmed that temperatures of hot foods, especially vegetables, had been a concern voiced by residents on a regular basis.

Observations, in multiple dining rooms, during two lunch meals, identified that Dietary Aides were not consistently recording temperatures, prior to the meal service.

A review of the "Daily Temperature Logs", for an identified time period, revealed that food temperatures were not recorded for one or more menu items at the following meals:

- Sugar Bush Dining Room incomplete three out of twelve meals (25 per cent).
- Primrose Parlour Dining Room incomplete eight out of twelve meals (67 per cent).
- Magnolia Café Dining Room incomplete nine out of twelve meals (75 per cent).
- Sunshine Dining Room incomplete five out of twelve meals (42 per cent).

A review of the policy "Food Service Temperatures Policy #A09-NC-402-10" last review date August 2009, revealed: "food temperatures recording chart is completed for all hot menu items and for cold foods, especially perishable products such as milk and milk based desserts, in the serveries prior to meal services."

During an interview, with the Nutrition Services Manager, it was confirmed that the "Daily Temperature Logs" were incomplete and that it was the expectation that temperatures were measured and recorded prior to each meal service as per the home's policy. (630)

3. A review of the "Fall Prevention & Management Program - Policy # A09 RC 001 11- dated November 2012," indicated that registered nursing staff would complete a critical incident worksheet if the fall or injury resulted in injury and/or transfer to hospital and the multidisciplinary team would conduct a

multidisciplinary conference to determine the possible cause of the falls and develop changes to prevent reoccurrence based on DAR (data, action, response) charting principles.

An identified resident sustained a fall, resulting in injury and transfer to hospital for treatment.

During a review of the clinical records, for the identified resident, and fall committee meeting minutes, there was no documented evidence that a critical incident worksheet had been completed and the multidisciplinary team did not conduct a multidisciplinary conference to determine the possible cause of the falls and develop changes to prevent re-occurrence based on DAR (data, action, response) charting principles.

During an interview, the Associate Director of Care # 121, confirmed registered nursing staff did not complete a critical incident worksheet, the multidisciplinary team did not conduct a multidisciplinary conference to determine the possible cause of the falls and develop changes to prevent re-occurrence based on DAR (data, action, response) charting principles and the home's policy was not complied with.

A review of "Falls Prevention Program - The Falling Leaf Program - Policy # A09-RC-012-12 - dated November 2012," indicated an autumn coloured leaf would be attached the resident name plate on the door of their room, in the handle with care logo pocket above their bed, to the mirror in the resident bathroom and to any mobility aid the resident uses, wheelchair, walker.

During observations, it was revealed that there was no autumn coloured leaf attached to the resident's name plate on the bedroom door and to the resident's wheelchair.

Personal Support Worker # 117, confirmed there was no autumn coloured leaf attached to the resident's name plate on the bedroom door and to the resident's wheelchair.

During interviews, the Director of Care # 101 and Associate Director of Care # 121 confirmed the autumn coloured leaf was to be attached to the resident's name plate on the bedroom door and to the resident's wheelchair. Both acknowledged the home's policy was not complied with.

A review of the "Personal Alarms - Policy # A09-Rc-031-13 - dated September 2013," indicated staff must check the battery each shift to ensure the alarm was functioning and a logo indicating a personal alarm, would be inserted into the holder above their bed. This would inform all staff, volunteers and family members of the need for the personal alarm.

During observations, for an identified resident, it was revealed there was no logo, indicating a personal alarm, inserted into the holder above the bed and there was no documented evidence that staff checked the battery each shift to ensure the alarm was functioning.

Personal Support Worker # 117, confirmed there was no logo, indicating a personal alarm, inserted into the holder above the bed and staff do not check the batteries each shift to ensure the alarms are functioning.

During an interview, the Associate Director of Care # 121, confirmed that there was no process in place to ensure bed/chair alarms were checked to ensure functioning and the home's policy was not complied with.

The scope of this area of non-compliance is widespread, there is previous related non-compliance and the severity is determined to be a level 2. (137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2016

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 1st day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARIAN MACDONALD

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