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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 6, 2013	2013_182128_0021	L-000488-13	Complaint

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

RUTH HILDEBRAND (128), JUNE OSBORN (105)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 17, 19, 25, & 26, 2013

This inspection was completed in conjunction with a Critical Incident, L-000466-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care(DOC), Assistant Director of Care(ADOC), RAI Coordinator, 4 Registered Nurses(RN), 4 Registered Practical Nurses(RPN), 8 Personal Support Workers(PSW), Receptionist, Food Services Manager, 3 Dietary Aides, 2 Physiotherapy Assistants, and 3 Residents.

During the course of the inspection, the inspector(s) observed partial breakfast and lunch meals, observed care provided to 6 residents, reviewed clinical records for 11 residents, as well as policies and procedures pertinent to the inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Critical Incident Response

Falls Prevention

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are not neglected by the licensee or staff.

[redacted]. A review of the resident's clinical record and staff interviews revealed the licensee of the long-term care home failed to ensure that the resident was cared for consistent with his/her needs and not neglected.

Initial admission assessments, except for a head to toe assessment, were not completed despite the home being aware that the resident had a history of falling.
Interventions to mitigate the risk of falling were not put in place.
The resident had an unwitnessed fall.
A personal safety alarm was initiated as an intervention to prevent falls, after the resident fell. Additional interventions, such as call bell within reach and use of side rail when in bed, were not implemented.
The progress notes reveal that the resident's family asked the staff about putting on the chair alarm during a subsequent admission and the staff then put it in place.
The Director of Care indicated that the home's expectation was that a falls assessment, as well as a pain assessment, should have been done upon admission. She also acknowledged that interventions related to falls should have been in place as the home was aware that the resident had a history of falls. Additionally, she agreed that the resident's plan of care was not followed as the personal safety alarm should have been in place during all of the admissions and it was not.

A clinical record review revealed that the home did not obtain a diet order, including food texture, fluid consistencies and food restrictions for the resident. Upon further inspection, it was noted that the home failed to ensure that the identified resident had his/her admission orders signed by a physician for any of the admissions nor did the resident have access to medical services in the home 24 hours a day.

The home admitted the resident with the knowledge that they did not have signed orders nor a physician who was willing to assume care for the resident.
[redacted] She acknowledged that the resident should not have been admitted without access to a physician and admission orders, including a diet order, approved by a physician.

Bowel movement records in Point of Care reveal that the resident did not have a bowel movement for 3 days for 75% of the admissions.
A registered nurse indicated that the home's bowel protocol is to give Lactulose on Day 3, if the resident has not had a bowel movement. However, a review of the Medication Administration Record revealed that the identified resident was not given any Lactulose.
The Bowel Protocol indicates that 15cc Lactulose is given twice daily, Day 3.
Upon further inspection, it was noted that the home doesn't actually follow their own protocol since they don't administer the first dose of Lactulose until 1700 on Day 3.
The DOC acknowledged that "it is not okay that a resident does not have a bowel movement for 3 days". She confirmed that the medical directives do not provide clear direction and don't match the bowel protocol because Lactulose is not being provided twice daily as per the protocol.

The resident did not receive bladder/continence care as per assessed need, as noted in the progress notes.
The Director of Care confirmed this and the indicated the home plans to provide education for staff.

The plan of care indicated that staff were to "record output and report any alterations in amount, colour, clarity to registered staff ongoing".
Review of the progress notes revealed that no output of urine was recorded for 29% shifts that the resident was in the home.
The DOC acknowledged that the plan of care had not been followed and the output should have been recorded on all shifts.

The plan of care specified that the resident was to be provided a minimum of 8 glasses of water or juice, daily related to risk of Urinary Tract Infections.
Review of the Point of Care records revealed that the resident's intake did not meet the 8 glasses of fluid per day. The intake ranged from 780 mls to 1160mls.
Documentation was noted to include 360 mls prior to the resident being admitted on the first admission and 720 mls prior the resident being admitted on another admission. Additionally, it was recorded twice that the resident was not available when he/she was still in the home.
The Director of Care indicated that her expectation was that staff should have escalated their concerns to registered staff, if the resident was not drinking. She also acknowledged that the home had work to do related to accuracy of documentation.

She recognized that there were errors and staff should not be documenting fluid intake for times when the resident was not even in the building.

A review of the Medication Administration Record revealed that all medications were not signed for as being provided to the resident and there was no documentation in the nurses notes to support whether the medications were given or not.
The Director of Care confirmed that the home's expectation is that medications are given as ordered and that if the registered staff indicated that a note was in the nurses' notes, then there should be a note there to support this. She stated she would follow-up with the registered staff involved.

The identified resident experienced a serious/emergency situation and the home did not notify a physician or the family.
The DOC acknowledged that this would be considered a serious/emergency situation and the family and a doctor should have been called. She stated that the home's physician would have responded in an emergency situation.
The home submitted a Critical Incident to the Ministry and acknowledged that they were reporting an incident related to "Improper/Incompetent treatment of a resident that results in harm or risk to a resident".

The home also failed to document the provision of the care and the outcomes of care, set out in the plan of care, related to personal care. All activities of daily living, including combing hair, brushing teeth, shaving, washing etc are recorded in one section in Point of Care. On the morning of the incident nothing is recorded for activities of daily living.
The Director of Care indicated that this incident has made the home aware that they need to change how they are recording the care provided to residents and they are looking into making changes. The Critical Incident submission indicates that the home will be developing a checklist to ensure that adaptive aides and other needs are contained in the Point of Care documentation.

[redacted] [s. 19. (1)]

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.
A clinical record review, for an identified resident, revealed that assessments related to falls are inconsistent and are not integrated. The resident was assessed by the physiotherapist as being at high risk for falls on admission and at the quarterly review. However, the fall risk assessment, completed by nursing, indicated that the resident was at medium risk, for falls, on both assessments.
A review of the home's Falls Prevention program also revealed that residents' are deemed to be at either low or high risk of falls. Medium risk of falls is not detailed in the program.
The Director of Care acknowledged that the assessments are not integrated because the nursing assessment that is done in Point Click Care is not consistent with the assessment tool the physiotherapist uses.
She also acknowledged that the nursing assessment is not consistent with the falls prevention program because the program only describes residents at low or high risk of falls. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
An identified resident's plan of care indicates that he/she required an intervention to promote wound healing.
Observation of a lunch meal revealed that the resident was not provided the intervention and staff were not aware that the resident required the intervention until MOHLTC intervention was provided.
The Food Services Manager indicated that the intervention is on the resident's kardex and staff should be following the kardex to ensure that each resident is provided with the care set out in their plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other. The plan must also ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 Policy A09RC 003 11, dated April 2011 was complied with related to weekly assessments of altered skin integrity not being completed. The policy states, on page 11, " The skin and wound care team shall ensure that:
c. Residents exhibiting altered skin integrity will be assessed by registered nursing staff at least weekly, and will monitor and evaluate resident outcomes.
There was no documented evidence to support that weekly wound assessments were completed for two identified residents.
This was confirmed by the Assistant Director of Care. [s. 8. (1)]

2. Policy # A09RC 003 11, dated April 2011 was not followed related to the wound assessment tool in use.
In the Policy/procedure section #16 c., entitled, Wound Assessment Tool, a wound assessment tool is described. However, the policy is not current since the home is now using a form on Point Click Care.
This was confirmed by the Assistant Director of Care. [s. 8. (1)]

3. Resident Care Policy A09RC00311, dated April 2011, Section 16 f. Referrals: i. 1., indicates that registered Staff will request a nutritional assessment by the registered dietitian if the resident is assessed as being at risk using the appropriate diet requisition form.
The policy was not complied with, related to referrals being made to the Registered Dietitian as no referral was made for an identified resident's wound.
The Food Services Manager confirmed the referral was not done. [s. 8. (1)]

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 policies and procedures are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

---

Findings/Faits saillants :

1. The licensee has failed to ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home.
The care plan must identify the resident and must include, at a minimum, the following with respect to the resident: 1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. 2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. 3. The type and level of assistance required relating to activities of daily living. 4. Customary routines and comfort requirements. 5. Drugs and treatments required. 6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. 7. Skin condition, including interventions. 8. Diet orders, including food texture, fluid consistencies and food restrictions.
[redacted]
A clinical record review revealed that there is no documented evidence to support that a care plan was developed for any of the admissions.
The Assistant Director of Care acknowledged that the home's expectation is that a care plan is developed for each resident but one could not be located in the clinical record for this resident. She indicated that since his/her care needs were not documented, assistance that he/she required would have had to have been communicated to staff verbally. [s. 24.]

2. Another identified resident was admitted to the home [redacted]. A clinical record review revealed that there is no documented evidence to support that the care plan was developed based on any risks and interventions to mitigate those risks. The care plan noted that having staff stay with the resident while he/she was on the toilet was not necessary despite his/her risk of falling having been identified.
The Assistant Director of Care acknowledged that the home's expectation is that a care plan is developed for each resident based on their assessed needs and risks are identified.
Additionally, she agreed that the care plan should not have indicated the diet that it did based on the documented diagnosis.
It was also noted that the care plan did not have a date on it, nor was it updated during any of the admissions.
The Director of Care acknowledged that the care plan should have been reviewed and updated as this resident's care needs had changed from the time of the initial admission until his/her last admission. She also verified that there is space allowed for

the date and revisions to be noted on the hard copy care plan utilized. [s. 24.]

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 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home.
The plan must also ensure that the care plan identifies the resident and includes, at a minimum, the following with respect to the resident: 1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. 2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. 3. The type and level of assistance required relating to activities of daily living. 4. Customary routines and comfort requirements. 5. Drugs and treatments required. 6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. 7. Skin condition, including interventions. 8. Diet orders, including food texture, fluid consistencies and food restrictions, 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. There is no evidence of weekly wound assessments, in the medical record of an identified resident, despite an identified wound that was being and is still currently being treated.
This was confirmed by the Assistant Director of Care. [s. 50. (2) (b) (iv)]

2. The Treatment Administration Record indicated a wound was being dressed, for another identified resident, for 23 days.
However, there is no evidence in the medical record of weekly wound reassessments.
This was confirmed by the Assistant Director of Care. [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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, 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 each resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

A clinical record review revealed that there is no documented evidence to support that an identified resident, who is incontinent, had an admission continence assessment completed.
The RAI coordinator confirmed that an admission continence assessment was not completed. [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 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, to be implemented voluntarily.

WN #7: 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. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were utilized to assist residents with eating, including safe positioning of residents who require assistance.
A Personal Support Worker was observed assisting a resident with eating while standing to feed the resident, at a lunch meal. The resident was not in a safe eating position.
A registered Nurse, stated that the resident was at choking risk and that staff are expected to be seated while they are assisting all residents with eating, to ensure that residents are being fed safely. [s. 73. (1) 10.]

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 proper techniques were utilized to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug has been prescribed for a resident.
A clinical record review for an identified resident revealed that he/she has had multiple admissions. However, it was noted that he/she did not have his/her admission orders signed during two admissions.
The Assistant Director of Care acknowledged that the staff provided the resident with his/her medications without the orders being signed by a physician for each admission. She agreed there is no evidence to support that orders were signed for either noted admission. [s. 122. (1)]

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 no drug is acquired, received or stored by or in the home or kept by a resident unless the drug has been prescribed for a resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week: 1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. 2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. 3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week.

The Administrator was not on site the morning of July 26, 2013. She was reported to be at Huronlea where she also works as Administrator.
Huronview has 120 beds and requires an administrator to be on site for at least 35 hours per week.
Huronlea has 64 beds and requires an administrator to be on site for at least 16 hours per week.
An interview with the Administrator revealed that she is responsible for both homes but she has an Assistant Administrator who works 16 hours per week.
The Administrator confirmed that she works 40 hours per week which does not meet the minimum requirement of 51 hours of Administrator time for both sites. [s. 212. (1)]

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 Administrator works regularly in that position on site at the home for the following amount of time per week: 1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. 2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. 3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week, to be implemented voluntarily.

WN #10: 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:
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on, at a minimum, the interdisciplinary assessment of the following with respect to the resident: Nutritional status, including height, weight and any risks relating to nutrition care.

An identified resident was assessed, by the Registered Dietitian, as requiring a Regular diet with a modified texture. However, the resident's plan of care has not been based on the assessed need.
A Dietary Aide acknowledged that the resident does not receive the modified texture.
The Food Services Manager indicated that the home's expectation is that all residents' nutritional plans of care are based on their assessed needs. [s. 26. (3) 13.]

WN #11: 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).

Findings/Faits saillants :

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

Observation of a lunch meal revealed that meals were served on a side plate and the portion sizes appeared quite small. There was no therapeutic menu available to guide staff.
The Food Services Manager indicated that it was a Resident's Choice meal and that she had not provided staff with a therapeutic menu to guide them with serving regular, therapeutic or texture modified diets. [s. 71. (1) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).
(c) removal and safe disposal of dry and wet garbage; and O. Reg. 79/10, s. 87 (2).
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping that procedures are developed and implemented for, (a) cleaning of the home, including common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

Observation of common areas of the home revealed that carpets were very stained and soiled in a number of areas, and especially in the hallway outside the dishwashing area in Unit B.
The Administrator stated that she was not aware that the carpets were so soiled and stained. She expressed concern and arranged for spot cleaning of carpets to be initiated July 29, 2013 at 0700. [s. 87. (2)]

Issued on this 12th day of August, 2013

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

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) :	RUTH HILDEBRAND (128), JUNE OSBORN (105)
Inspection No. / No de l'inspection :	2013_182128_0021
Log No. / Registre no:	L-000488-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 6, 2013
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 :	BARB SPRINGALL

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:

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must conduct an immediate review of the processes in place for [redacted] admissions to ensure compliance with LTCHA, 2007, c. 8, s. 19 (1) and make certain that residents who are admitted are not neglected by the staff.

The licensee must prepare, submit and implement a plan that includes how each the following issues will be addressed:
1. All staff in the home must be made aware of the evidence outlined in this order to ensure that they have knowledge related to this particular respite resident being neglected.
2. All direct care nursing staff must receive training related to catheters.
3. Bowel protocols/medical directives must be reviewed and individualized to each resident.
4. A process must be developed to ensure a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home.
5. A process must be put in place to ensure that a care plan is developed for each respite stay resident and it must identify the resident and must include, at a minimum, the following with respect to the resident: a) Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. b) Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. c) The type and level of assistance required relating to activities of daily living. d) Customary routines and comfort requirements. e) Drugs and treatments required. f) Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. g) Skin condition, including interventions. h) Diet orders, including food texture,

fluid consistencies and food restrictions.
6. A process must be developed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.
7. A process must be developed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
8. The licensee must reevaluate their documentation system to ensure that the provision of the care set out in the plan of care and outcomes of the care set out in the plan of care are documented.
9. The licensee must develop a process to ensure that prior to the admission of a resident that they ensure that the resident will have access to medical services in the home 24 hours a day and that admission orders are signed.
10. Registered nursing staff must provide medications as ordered, including required documentation.
11. Food and fluid documentation must be reviewed with all personal support workers and a process developed to ensure that residents who are at hydration risk are monitored and their intake is evaluated.
12. The licensee must also ensure that a process is in place to ensure the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.
13. The licensee must also develop policies and procedures that reflect the above requirements as related to respite care and ensure that all staff receive education regarding the polices prior to any further admissions to respite care.

Please submit the plan being implemented, in writing, to Ruth Hildebrand, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King Street, 4th Floor, London, ON N6B 1R8, by email, at ruth.hildebrand@ontario.ca, by August 16, 2013.

Grounds / Motifs :

1. The licensee failed to ensure that residents are not neglected by the licensee or staff.

[redacted]

[redacted]. A review of the resident's clinical record and staff interviews revealed the licensee of the long-term care home failed to ensure that the resident was cared for consistent with his/her needs and not neglected.

Initial admission assessments, except for a head to toe assessment, were not completed despite the home being aware that the resident had a history of falling. Interventions to mitigate the risk of falling were not put in place.
The resident had an unwitnessed fall.
A personal safety alarm was initiated as an intervention to prevent falls, after the resident fell. Additional interventions, such as call bell within reach and use of side rail when in bed, were not implemented.
The progress notes reveal that the resident's family asked the staff about putting on the chair alarm during a subsequent admission and the staff then put it in place.
The Director of Care indicated that the home's expectation was that a falls assessment, as well as a pain assessment, should have been done upon admission. She also acknowledged that interventions related to falls should have been in place as the home was aware that the resident had a history of falls. Additionally, she agreed that the resident's plan of care was not followed as the personal safety alarm should have been in place during all of the admissions and it was not.

A clinical record review revealed that the home did not obtain a diet order, including food texture, fluid consistencies and food restrictions for the resident. Upon further inspection, it was noted that the home failed to ensure that the identified resident had his/her admission orders signed by a physician for any of the admissions nor did the resident have access to medical services in the home 24 hours a day.

The home admitted the resident with the knowledge that they did not have signed orders nor a physician who was willing to assume care for the resident. [redacted] She acknowledged that the resident should not have been admitted without access to a physician and admission orders, including a diet order, approved by a physician.

Bowel movement records in Point of Care reveal that the resident did not have a bowel movement for 3 days for 75% of the admissions.

A registered nurse indicated that the home's bowel protocol is to give Lactulose on Day 3, if the resident has not had a bowel movement. However, a review of the Medication Administration Record revealed that the identified resident was not given any Lactulose.
The Bowel Protocol indicates that 15cc Lactulose is given twice daily, Day 3.
Upon further inspection, it was noted that the home doesn't actually follow their own protocol since they don't administer the first dose of Lactulose until 1700 on Day 3.
The DOC acknowledged that "it is not okay that a resident does not have a bowel movement for 3 days". She confirmed that the medical directives do not provide clear direction and don't match the bowel protocol because Lactulose is not being provided twice daily as per the protocol.

The resident did not receive bladder/continence care as per assessed need, as noted in the progress notes.
The Director of Care confirmed this and the indicated the home plans to provide education for staff.

The plan of care indicated that staff were to "record output and report any alterations in amount, colour, clarity to registered staff ongoing".
Review of the progress notes revealed that no output of urine was recorded for 29% shifts that the resident was in the home.
The DOC acknowledged that the plan of care had not been followed and the output should have been recorded on all shifts.

The plan of care specified that the resident was to be provided a minimum of 8 glasses of water or juice, daily related to risk of Urinary Tract Infections.
Review of the Point of Care records revealed that the resident's intake did not meet the 8 glasses of fluid per day. The intake ranged from 780 mls to 1160mls. Documentation was noted to include 360 mls prior to the resident being admitted on the first admission and 720 mls prior the resident being admitted on another admission. Additionally, it was recorded twice that the resident was not available when he/she was still in the home.
The Director of Care indicated that her expectation was that staff should have escalated their concerns to registered staff, if the resident was not drinking. She also acknowledged that the home had work to do related to accuracy of documentation. She recognized that there were errors and staff should not be documenting fluid intake for times when the resident was not even in the

building.

A review of the Medication Administration Record revealed that all medications were not signed for as being provided to the resident and there was no documentation in the nurses notes to support whether the medications were given or not.
The Director of Care confirmed that the home's expectation is that medications are given as ordered and that if the registered staff indicated that a note was in the nurses' notes, then there should be a note there to support this. She stated she would follow-up with the registered staff involved.

The identified resident experienced a serious/emergency situation and the home did not notify a physician or the family.
The DOC acknowledged that this would be considered a serious/emergency situation and the family and a doctor should have been called. She stated that the home's physician would have responded in an emergency situation.
The home submitted a Critical Incident to the Ministry and acknowledged that they were reporting an incident related to "Improper/Incompetent treatment of a resident that results in harm or risk to a resident".

The home also failed to document the provision of the care and the outcomes of care, set out in the plan of care, related to personal care. All activities of daily living, including combing hair, brushing teeth, shaving, washing etc are recorded in one section in Point of Care. On the morning of the incident nothing is recorded for activities of daily living.
The Director of Care indicated that this incident has made the home aware that they need to change how they are recording the care provided to residents and they are looking into making changes. The Critical Incident submission indicates that the home will be developing a checklist to ensure that adaptive aides and other needs are contained in the Point of Care documentation.

[redacted] [s. 19. (1)]

(128)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2013

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the Director

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 August, 2013

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RUTH HILDEBRAND

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