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
May 14, 2015	2015_168202_0005	T-1680-15	Resident Quality Inspection

Licensee/Titulaire de permis

IOOF SENIORS HOMES INC.
20 Brooks Street BARRIE ON L4N 5L3

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

ODD FELLOW AND REBEKAH HOME
10 BROOKS STREET BARRIE ON L4N 5L3

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

VALERIE JOHNSTON (202), DIANE BROWN (110), VALERIE PIMENTEL (557)

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): April 07, 08, 09, 10, 13, 14, 15, 16, 17, 20, 2015.

During the course of the inspection, the inspector(s) spoke with CEO, director of resident care (DRC), assistant director of resident care (ADRC), director of program support & volunteer service, director of support services (DSS), food service manager (FSM), nurse manager/skin and wound care lead, registered dietitian (RD), registered nursing staff, personal support workers, dietary aides, housekeeping aides, residents, families.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **8 VPC(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

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

On April 15, 2015 at 1:20 p.m., the inspector observed a large platform resident wheelchair weigh scale placed on the floor at the end of a hall on an identified home area not in use. The signage on the wall behind the resident wheelchair scale stated, "when NOT in use the scale is to be STORED in an area that is NOT independently accessible to residents". Adjacent to the wheelchair scale was an open, unsecured two step staircase, leading to a lower level. The lower level housed a resident bath/shower room, confirmed to be used by residents. The bath/shower room was observed to be unlocked, with sween spray foam, shaving cream, perineal wash, one step surface and disinfectant cleaner, two deodorant spray pumps, dry kill spray on the counter and in an unlocked cupboard.

An interview with an identified PSW confirmed the above findings and stated that the bath/shower room should always be locked. The PSW indicated that the area is accessible to residents and that residents could potentially trip on the wheelchair weigh scale or fall down the set of stairs to the lower level. The PSW indicated that he/she has always seen the wheelchair weigh scale placed on the floor at the end of the hallway and never stored in another area of the home when not in use.

On April 15, 2015 at 1:30 p.m., the inspector observed that the main elevator of the home is used by residents of identified home areas and can provide resident access to the basement, a non-residential area. The basement contained an unlocked garbage room, unlocked chemical storage room, staff locker rooms, wheelchair ramp and a two step staircase to a lower level. An interview with the DSS confirmed that the basement is a non-residential area and should not be accessible to residents by an elevator and that the doors in the area should always be locked. The DSS further confirmed that both staircases located on an identified home area and the basement posed a safety risk to residents. [s. 5.]

2. On April 15, 2015, the inspector observed on an identified home area, resident #20 rummaging through an unattended housekeeping cart in the hallway which contained an accessible screwdriver and a metal paint scraper. Interview with an identified housekeeping staff confirmed that he/she left the housekeeping cart unattended and this was not safe because there was a screwdriver and a metal scraper accessible to residents and visitors. [s. 5.]

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 is a safe and secure environment for its residents, to be implemented voluntarily.

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

A review of the clinical records for an identified time period, for resident #01 identified the resident as having altered skin integrity.

An interview with an identified PSW indicated that the care required for each resident is written in a Kardex and found on the computer in point of care. The PSW indicated that the Kardex contains key components of care that has been generated from the resident's

full and detailed care plan. PSW staff indicated that they do not have access to the full care plan and only use the Kardex for direction when providing care.
A review of the Kardex for resident #01, did not include any direction to staff with respect to the resident's skin condition. The Kardex indicated that the resident is to be turned and repositioned every two hours, however, there was no direction as to how the resident is to be cared for in relation to the identified altered skin integrity. The PSW indicated in an interview that he/she was only aware that the resident had a skin concern by the bandages found on an identified area of the body.
An interview with the skin and wound care lead confirmed that the Kardex is the only written source of information available to PSW's with respect to residents care needs. The lead confirmed that the Kardex did not include the necessary direction to staff in order to provide the assessed care needs for resident #01. [s. 6. (1) (c)]

2. The licensee has failed to ensure that different approaches are considered in the revision of the plan of care when the resident is reassessed and the plan of care reviewed and revised because care set out in the plan of care has not been effective.

Resident #03's plan of care identified the resident at high nutritional risk related to poor intake. Record review revealed the resident usually consumed 25-50%, and occasionally refused meals. On an identified date, the plan of care for the resident directed staff to provide extra nourishments if meals are refused.
Record review and staff interviews identified that the resident skips one meal a day. Food intake records revealed that in month A, seventeen meals were not taken; month B , sixteen meals were not taken and in month C, 29 meals were not taken. A review of the nourishment records revealed an average of 79% of the time nourishments were also not taken.

Record review revealed that at an identified dietary quarterly review, resident #03's intake was again identified as increasingly variable, usually consumed 25-50%, and occasionally refused meals. The resident's weight had decreased 2.0 kg within three identified months. The written plan of care remained the same with the intervention to direct staff to provide extra nourishments if meals refused, despite records revealing that the resident refuses nourishments 79% of the time.
Staff interviews and record review revealed that the care set out in the plan of care had not been effective. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that care set out in the written plan of care provides clear directions to staff and others who provide direct care to the resident and that different approaches are considered in the revision of the plan of care when the resident is reassessed and the plan of care reviewed and revised because care set out in the plan of care has not been effective , 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 the home's Changes in Resident Weight, effective November 27, 2013, is complied with.

The home's above mentioned policy indicated that residents identified with significant weight changes will be assessed by the interdisciplinary team who shall evaluate the contributing factors to the weight change and create a plan of action to address the issues. The policy directs the registered staff to do the following:
-prior to inputting the weight into "point click care", compare the weight to the previous month recorded weight and ensure the re-weigh has been done if there is a difference of +/- 2 kg;
-add comments in progress notes "underweight change note" indicating areas of concern

that may be contributing to weight change.
-the interdisciplinary team will discuss a plan of action for improvements and identify the department responsible for implementing and follow up.

Resident #03 had a significant weight loss between month A and month B, when the resident's weight decreased 3.2 kg in one month. Record review and interview with the RD confirmed that the resident had not been reweighed when a greater than 2 kg weight loss was identified. The RD confirmed that the above mentioned policy had not been followed and requested that the resident be reweighed as the plan of action at the weight management committee meeting on an identified date.
Record review identified that nursing had not identified in the referral to RD-Weight variance or in the progress notes areas of concern that may be contributing to weight change, according the home's policy.
The interdisciplinary team at the weight management committee identified resident #03's declining intake as the reason for weight change, however, there was no plan of action for improvement with the department responsible for implementing and follow up according to the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. Resident #04 had a significant weight loss between month A and month B when the resident's weight decreased 5.0kg in one month. A reweigh was completed month B and the resident's weight was confirmed.
Record review revealed that nursing had not identified in month B, referral to RD-Weight variance or in the progress notes areas of concern that may be contributing to weight change, according to the home's policy.
The interdisciplinary team at the weight management committee of an identified date, identified a request for reweigh as for the reason for change. Resident was reweighed for the third time later in month B, when resident #04's weight had further decreased 2.6 kg. There was no plan of action for improvements with the department responsible for implementing and follow up, as in accordance to the home's policy.

The ADRC confirmed that the home's policy had not been followed for residents #03 and #04. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policy, titled, Changes in Resident Weight, effective November 27, 2013, is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

On April 15, 2015, at 1:30 p.m., the inspector observed that the main elevator of the home used by residents of three identified home areas can provide resident access to the basement, a non-residential area. An interview with the DSS indicated that the basement area is a non-residential area that should not be accessible to residents when the elevator is used. [s. 10. (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 any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following is complied with respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols for the referral of residents to specialized resources where required.

The legislative requirement under the LTCHA, 2007, O.Reg. 79/10 s. 50 (2) (b) (i)(iv) states, 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,
(iv)is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of the home's Skin and Wound Care Program, RCM 12-03-01, effective July 03, 2013, did not provide any direction to registered staff to reflect the above mentioned legislative requirements for those resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.
The home's skin and wound care program does not include any reference to a clinically appropriate assessment instrument, specifically designed for skin and wound assessment. Registered staff interviews indicated no knowledge of and do not use a clinical tool for skin and wound assessment. Staff indicated that when a resident has been identified with altered skin integrity, they do not complete an assessment and send an email referral to the skin and wound care lead.

The skin and wound care lead indicated in an interview that registered staff are to assess the resident found with skin integrity concerns and document their initial and weekly assessment in the progress notes under the title of 'skin and wound care assessment'. The skin and wound lead indicated that the 'skin and wound care assessment' note is considered a clinical assessment tool for skin and wound care assessment. An interview with the DOC indicated that registered staff are to not use the 'skin and wound care assessment' note for skin and wound assessment and to use the 'head to toe' assessment tool located in point click care, as a clinical assessment tool for skin and wound care assessment. Both the skin and wound care lead and the DOC confirmed that the skin and wound care program does not include reference to any identified clinical assessment instrument specifically designed for skin and wound care assessment and confirmed their discrepancy on completing skin and wound assessments. The DOC and the skin and wound care lead further confirmed that policies relevant to registered staff direction in respect to use of a clinically appropriate assessment tool specifically designed for skin and wound care assessment, and direction for weekly skin and wound care assessments had not been included in the home's skin and wound care program.

Upon further review of the home's skin and wound care program, residents with altered skin integrity can be referred to specialized resources, such as the physician, pharmacist, dietitian, physiotherapist, occupational therapist (community based), nurse practitioner, RAI lead for nursing rehab, restorative care coordinator, and enterostomal nurse (community based). The skin and wound care program, however, does not include the procedures and protocols for referring the resident to specialized resources. Registered staff interviews indicated that any residents with altered skin integrity can be referred to the home’s RD for nutrition assessment, however, had no knowledge of when to refer. An interview with the DOC and the skin and wound care lead confirmed that the home’s skin and wound care program does not include the procedures and protocols for the referral of residents to specialized resources. [s. 30. (1) 1.]

2. The licensee has failed to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Interviews with the DOC and the skin and wound care lead indicated that the home's Skin and Wound Care Program, RCM 12-03-01, effective July 03, 2013, had not been evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 30. (1) 3.]

3. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

A review of the clinical records for an identified time period, for resident #01 identified the resident as having altered skin integrity. The plan of care directed staff to turn and reposition the resident every two hours. An interview with the skin and wound care lead indicated that the resident's altered skin integrity placed the resident under the home's skin and wound care program. The skin and wound care lead indicated that it is the expectation of staff to reposition the resident every two hours, however, confirmed that staff have not documented any resident response related to the turning and repositioning intervention. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following is complied with respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols for the referral of residents to specialized resources where required, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The plan of care for resident #01 identified the resident as having altered skin integrity. A review of the resident's progress notes and treatment medication records for an identified time period, indicated that the resident had altered skin integrity on seven identified dates.

Interviews with registered staff and the skin and wound care lead confirmed that resident #01's altered skin integrity noted above had not been assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds been assessed by a registered dietitian who is a member of the staff of the home.

The plan of care for resident #01 identified the resident as having altered skin integrity. A review of the resident's progress notes and treatment medication records for an identified six month period of time, indicated that the resident was found to have ongoing altered skin integrity.

An interview with the RD indicated that he/she had not received a referral, for the above mentioned skin integrity issues. The resident’s skin was assessed as part of a regular quarterly dietary assessment at three months within the identified six month period. The dietary quarterly assessment notes identified that resident’s skin integrity concerns had healed. Treatment records reviewed for the same time period during the dietary quarterly review, identified that the resident had been continuously treated for altered skin integrity during this time. The treatments sheets reviewed after the quarterly dietary assessment, indicated that the resident's above mentioned skin integrity had worsened. No referrals were sent or nutrition assessments completed related to the resident’s altered skin integrity.
Interviews with the RD and the skin and wound care lead confirmed that resident #01's skin integrity issues had not been assessed by the dietitian. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity,

including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The plan of care for resident #01 identified the resident as having altered skin integrity. A review of the resident's progress notes and treatment medication records for an identified nine month time period, indicated that the resident had ongoing altered skin integrity with seven dates identified.

Registered staff interviews and an interview with the skin and wound care lead indicated that residents identified with altered skin integrity are to receive a skin and wound assessment weekly on Sundays and registered staff are to document the assessment in the progress notes under the skin and wound assessment note. The skin and wound care lead indicated that the registered staff identified that the resident had altered skin integrity as indicated above, however, the resident had not been reassessed weekly by the registered staff as required. [s. 50. (2) (b) (iv)]

4. The licensee has failed to ensure that, (c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

The home's Skin and Wound Care Program Policy, #RCM 12-03-01, effective July 03, 2013, states "the IOOF Seniors Homes Inc. (Corporation) is committed to an interdisciplinary Skin and Wound Care Program for the residents to preserve skin integrity, prevent pressure ulcers, prevent infection and promote comfort and mobility". The program further directs staff to "use items that aide in reducing pressure caused by beds, bed linens and wheelchairs (e.g. low air-loss mattress system, pillows, cushions, foam padding".

A review of the clinical records from resident #01's admission four years ago, identified the resident as having altered skin integrity. The plan of care for the resident indicated that the resident was at high risk for skin integrity issues. The plan of care indicated that the resident received a Pressure Relieving Air Surface on an identified date in 2013, as an intervention to maintain skin integrity, and that the mattress was removed on an identified date in 2014.

An interview with the skin and wound care lead indicated that the resident's Pressure Relieving Air Surface was removed on an identified date in 2014, from resident #01's bed as the resident's skin integrity issues had healed. The skin and wound care lead

indicated that because there are only a few air and pressure relieving surfaces available for use in the home, the air mattress that had been provided to resident #01 was removed on the identified date, in order for the air surface to be provided to another resident who needed it more than resident #01.
A review of the resident's progress notes and treatment medication records from the time that the Pressure Relieving Air Surface was removed to a date three months later, indicated that the resident had been identified with multiple skin integrity issues that registered staff were treating. The progress notes indicated that after the Pressure Relieving Air surface had been removed the resident's skin condition had worsened.

An interview with the skin and wound care lead confirmed that the resident's skin integrity had worsened since the removal of the air surface, but only one mattress was available in the home at the time. The skin and wound care lead indicated that resident #01 was again provided an air mattress three months after the removal of the original Pressure Relieving Air Surface, when an air mattress became available in the home. The skin and wound care lead indicated in an interview that pressure relieving air surfaces are part of the home's skin and wound care program used to prevent skin integrity issues. The skin and wound care lead indicated that there are not enough air surfaces in the home to continuously support a resident under the skin and wound care program and that air surfaces are provided to only the resident that is assessed to require it the most at the time of availability. [s. 50. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
-receive 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,
-is assessed by a registered dietitian, and reassessed at least weekly by a member of the registered nursing staff, if clinically indicated,
-to ensure that the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months

Record review identified that resident #03 was at high nutritional risk and that the resident had a 5 per cent weight loss between month A and month B, when the resident's weight decreased 3.2 kg in one month. This weight further triggered a 7.5 per cent or greater weight loss over three months and a 10 per cent or greater weight loss over 6 months.

Record review identified that on an identified date, the registered dietitian (RD) documented that the resident's intake was increasingly variable, usually consumed 25-50%, occasionally refused and requested a reweigh. Record review and an interview with ADRC confirmed that there was no nursing assessment of the resident's identified weight loss. The weight management committee meeting minutes for the month identified the reason for weight change was unplanned loss and intake declining. The plan of action in the minutes indicated that the resident currently receives resource 2.0 and a reweigh was requested.
A review of the resident's food intake records and staff interviews identified that the resident is often skipping one meal per day. In month A, there were 14/31 days recorded where by the resident missed one meal a day, in month B, there were 14/28 days, month C there were 23/26 days and 10/16 days in month D.
An interview with the RD confirmed that the weight was accurate after a reweigh in month A. The RD indicated that no action had been taken related to residents declining intake. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. Record review identified that resident #04 was at high nutritional risk and that the resident had a 5 per cent weight loss between month A and month B, when the resident's weight decreased 5.4 kg in one month. This weight further triggered a 7.5 per cent or greater weight loss over three months and a 10 per cent or greater weight loss over 6 months. A reweigh was completed twice in month B which confirmed the resident had a significant weight loss.
The weight management committee meeting minutes of month B, revealed a request for a reweigh and to continue to monitor and that nutritional interventions remain in place. Record review and interviews with the registered dietitian and ADRC confirmed that there was no interdisciplinary assessment of residents confirmed significant weight loss in month B.

Resident #04 had a 10% per cent weight loss over 6 months when the resident's weight decreased 4.7 kg. Record review revealed that nursing identified poor intake as a concern that may be contributing to residents unplanned weight loss.

Staff interviews revealed that the resident does not eat much for lunch but always takes the nutritional supplement provided.
The weight management committee meeting minutes of an identified month, revealed the reason for weight change was that the resident's intake remains variable and that interventions remain in place according to resident preferences.
An interview with the ADRC and RD revealed that no assessment of resident's variable intake was completed in the identified month. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (1) Every licensee of a long-term care home shall ensure that there is an organized food production system in the home. O. Reg. 79/10, s. 72 (1).

Findings/Faits saillants :

1. The licensee of a long-term care home failed to ensure that there is an organized food production system in the home.

On April 07, 2015, at lunch meal service in an identified dining room, regular textured mushroom cheese quiche was served as an entree choice to residents on regular and minced diets. Observations of the entree identified thick slices of mushrooms in the quiche and the quiche being served to those on minced diets. The dietary staff revealed that the slices appeared big for those on a minced diet that it was the first time he/she had served this entrée.
Record review identified that the recipe called for canned mushrooms with no clear direction for the minced texture diets.
Interviews with the food service manager and dietitian confirmed that the mushroom slices as described and demonstrated were not suitable for all residents on a minced diet texture. The food service manager indicated that the order guide referred to mushroom pieces, but the recipe was not clear. [s. 72. (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 ensure that there is an organized food production system in the home, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee fully respected and promoted the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

On April 7, 2015, the inspector was conducting an interview with resident #06 in his/her room with the door closed and curtain drawn. A PSW staff opened the resident room door and pulled the curtain back entering the residents room without knocking. The resident stated that staff should knock before coming into his/her room and that "it would be a good thing". The PSW staff confirmed that she/he had not knocked and that he/she was just tired that day. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act is fully respected and promoted.

On April 09, 2015, the inspector observed personal health information for residents #36 and #37 within an unlocked drawer of the activity room on an identified home area. The personal health information included the medication administration records for an identified month, medical diagnosis, and a completed medical review form for both residents. An interview with the DOC confirmed that the personal health information should not have been kept in the activity room drawer and removed it immediately. The DOC indicated that the information had been left by Multigem, a contract dental service company who had used the activity room for dental services conducted in December 2014. The DOC indicated that the information would have been left in the activity room drawer from the last dental session held in December, until identified by inspectors and that residents and families have use of the room and would have had access to the personal health information. [s. 3. (1) 11. iv.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's desired bedtime and rest routine supported and individualized to promote comfort, rest and sleep.

Resident #04 responded, when asked by a Ministry inspector during stage 1 interviews, that he/she prefers to go to bed at 9:00 p.m. The resident indicated that one staff will come in and assist him/her to bed just before 8:30 p.m., but other staff know that he/she prefers to go to bed around 9:00 p.m. and will ring the call bell to let staff know when he/she is ready.
Staff interviews revealed that the resident prefers to go to bed later, between 8:30 p.m. and 9:00 p.m.
Record review of the plan of care revealed that the resident prefers to go to bed at 8:30 p.m. and that the preferred time to go to bed was changed in 2013 from a 9:00 p.m. preference to the 8:30 p.m. preference. An interview with the resident revealed that he/she did not make that request and that he/she prefers to go to bed around 9:00 p.m. [s. 41.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements. The required information for the purposes of subsections (1) and (2) is copies of the inspection reports from the past two years for the long-term care home.

On April 7, 2015, the inspector observed and reviewed the inspection reports that were posted. The following reports were not posted: 2014-169292-0010, 2014-299559-002, 2013-108110-002 and 2013-109153-0016. An interview with an identified staff member informed the inspector that only the past year of inspection reports were required to be posted. The home did not comply with the posting of inspection reports from the past two years. [s. 79. (3) (k)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in the medication cart that is used exclusively for drugs and drug-related supplies.

On April 13, 2015, the inspector observed in the medication cart on an identified home area the following items: resident #18's purse and in the double locked bin his/her birth certificate, as well as, two rings identified as belonging to resident #19 and another ring with a found date of January 20, 2013, not identified as belonging to any resident.

The registered nursing staff member and the DOC confirmed that only drugs and drug related supplies should be stored in the medication cart. [s. 129. (1) (a)]

Issued on this 1st day of June, 2015

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

Original report signed by the inspector.