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

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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
Nov 28, 2014	2014_278539_0022	H-001170-14	Resident Quality Inspection

Licensee/Titulaire de permis

KING NURSING HOME LIMITED
49 Sterne Street Bolton ON L7E 1B9

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

KING NURSING HOME
49 Sterne Street Bolton ON L7E 1B9

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

VALERIE GOLDRUP (539), DARIA TRZOS (561), MICHELLE WARRENER (107), YVONNE WALTON (169)

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): September 3, 4, 5, 9, 10, 11, and 15, 2014.

The following Critical Incidents were reviewed during this inspection: H-000711-14, H-000875-14, and H-000975-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Director of Resident and Family Services, Dietary Services Manager, Registered Dietitian, Environmental Services Supervisor and employee, Behavioural Support Registered Practical Nurse,registered nursing staff including Registered Nurses(RN)and Registered Practical Nurses(RPN), personal support workers(PSW), dietary staff, housekeeping staff,residents and family members of residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

15 WN(s)
8 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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:
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the responsive behaviour plan of care for Resident #017 and Resident #042 was based on an interdisciplinary assessment that included drugs and treatments.

Resident #017 had 15 documented responsive behaviours from June, 2014 until present which included yelling and attempting to hit or kick other residents. The resident was seen by a physician in July, 2014 and had their psychiatric medication decreased. The Behavioural Support RPN confirmed that no interdisciplinary review had occurred afterward to address the resident's ongoing behaviour via a new medication or treatment.

Resident #042 had 31 responsive behaviours from July, 2014 to present involved the resident being aggressive, hitting and shaking tables and chairs. The resident's anti-psychotic medication was discontinued in June, 2014 after being determined ineffective. Another anti-psychotic was started in September, 2014. The Behavioural Support Officer RPN confirmed that no interdisciplinary review had occurred during the time outlined to address the resident's behaviour via a new medication or treatment. [s. 26. (3) 17.]

2. The licensee did not ensure that the falls prevention plan of care for Resident #401 was based on an interdisciplinary assessment of special treatments and interventions.

Resident #401 had a fall and sustained an injury. The physiotherapist recommended a call bell be lengthened for the resident to reach and this was not added to the plan of care. The physician recommended a falls mat be used, put the bed in the lowest position and to use an alarm and this was not added to the plan of care. The nursing staff were not implementing the interventions recommended by the allied disciplines. The registered nursing staff, Director of Care and Administrator confirmed this. Observation on three

separate days during the review confirmed the recommended interventions were not implemented. [s. 26. (3) 18.]

3. The licensee did not ensure that the skin and wound care plan of care for Resident #004 was based on an interdisciplinary assessment with respect to the resident's special treatments and interventions.

Resident #004 had a Stage three wound that had remained unchanged in size from May, 2014 to September, 2014 at 3 cm x 2 cm x 0.5 cm. The Skin and Wound Care Management Protocol, policy VII-G-20.10, revised October, 2013 stated the resident should be referred to the Registered Dietician for assessment. The last documented referral to the Registered Dietician for a wound nutritional assessment was in February, 2013. This was confirmed with a member of the registered staff.

The Skin and Wound Care Management Protocol, policy VII-G-20.10 stated the resident should be reassessed a minimum of monthly as the resident had a Pressure Ulcer Risk Score (PURS) score of three indicating they would be in the moderate category. The last wound treatment was issued from the Enterstomal Therapist and confirmed by the Physician in May, 2014. No documented interdisciplinary referral and assessment occurred during the time outlined.

The Director of Care confirmed the expectation was for the registered staff to review and implement interventions with the interdisciplinary team. [s. 26. (3) 18.]

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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The home had an outside agency (Joerns) conduct an assessment of the home's beds in relation to entrapment zones February 6, 2014; however, the report provided by the agency was not reviewed by the home and action was not taken to address the failed zones of entrapment identified in the safety audit. The Maintenance Supervisor confirmed that the report had not been reviewed and an action plan had not been developed to address the areas identified in the audit report. 46 out of 86 beds failed the safety audit for entrapment zones. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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:
2. Every resident has the right to be protected from abuse. 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 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 did not ensure that the following rights of residents were fully respected and promoted: 2. Every resident has the right to be protected from abuse.

Resident # 024 was asked during a resident interview on September 5, 2014 if they had ever been treated roughly by a staff member They described that once during care they were slapped. A critical incident report had been submitted by the home in regards to the incident which occurred in June, 2014. Shortly after the incident the resident was observed crying. When staff approached the resident to find out why the resident was crying the resident described the event above as having occurred with a member of staff. The Administrator confirmed that an investigation had occurred in regards to the situation above. The staff member had been removed from the area and no longer provided care to the resident. [s. 3. (1) 2.]

2. The licensee did not ensure that the following rights of residents were fully respected and promoted: 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Resident #100 was not provided privacy on September 4, 2014. The resident had a hospital gown on that was open at the back with their buttocks visible from the hallway. The gown was not secured and the resident was trying to get the gown to cover themselves. The door to the resident's room was open and the curtains were not pulled. A staff member was in the room with the resident. [s. 3. (1) 8.]

3. The licensee did not ensure that the following rights of residents were fully respected and promoted: 11. iv. Every resident has 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 that Act.

The medications within the home were provided in a pouch with residents' names and medication information on the pouch. After the registered nursing staff administered the medications, the registered nursing staff threw out the pouches, which have personal health information on them, into the garbage. The garbage then was removed by housekeeping and send to the local landfill site. The pouches were included in the regular garbage and were not disposed of in a manner that protected their personal health information. This was confirmed by the registered nursing staff and the Director of Care. [s. 3. (1) 11. 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 be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care for Resident #401 provided clear directions to staff who provided direct care to the resident.

Resident #401 had a fall with an injury, resulting in a transfer to hospital for treatment in June, 2014. Upon return to the home, the physician ordered to keep the resident's bed in the lowest position, use an alarm and a falls pad. The plan of care and the kardex did not include the directions from the physician regarding falls prevention. The plan of care was not updated to include the changes in care needs post fall. The nursing staff, Director of Care, Administrator and clinical documentation confirmed this. [s. 6. (1) (c)]

2. The licensee did not ensure that the care set out in the plan of care was provided as specified in the plan.

A) Resident #401 had a fall in June, 2014 and after the fall, the physician directed staff to

keep the bed in the lowest position at all times. Observation of the resident over several days during the review revealed the resident was in bed on three observation periods and the bed was not in the lowest position. Nursing staff and observation confirmed the resident was not receiving care as specified the plan of care.(169)

B) Resident #301 was a high risk for falls and the plan of care directed the staff to put the bed in the lowest position when the resident was in bed. Observation of the resident over several days during the review revealed the bed was not in the lowest position but in a middle position, based on feeding positioning. The registered nursing staff and observation confirmed this.(169)

C) Resident #028 had a plan of care that required a pureed texture menu with honey consistency thickened fluids. The resident was served regular texture soup which was not thickened. The PSW assisting the resident confirmed that the soup was not pureed or thickened and was trying to strain the chunks out prior to feeding the soup to the resident. The resident was also served a nutritional supplement; however, the supplement was not thickened to a honey consistency. The PSW assisting the resident confirmed the supplement was not as thick as the other fluids that were honey consistency.(107)

D) Resident #032 had a plan of care that required a pureed texture menu with nectar consistency thickened fluids. The resident was served regular texture soup (chunky and not thickened) and the resident was coughing while being fed the soup. Staff confirmed the resident required a pureed texture menu with thickened fluids.(107)

E) Resident #037 had a plan of care that required nectar consistency thickened fluids. The resident was provided honey consistency thickened milk. Staff confirmed the resident required nectar consistency thickened fluids. Staff confirmed that the thickened milk was thicker than the rest of the fluids the resident had.(107) [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 be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home's furnishings and equipment were kept clean and sanitary.

A) The raised toilet seats in four rooms were not removed and cleaned underneath on September 15, 2014. Inspectors removed the seats and significant soiling was noted under the seats. Management observed the condition of the toilet in one of the identified rooms. Interview with the housekeeper confirmed that they did not clean under the raised toilet seats on September 15, 2014.(107)

B) The raised toilet seat in the tub rooms were noted to be soiled with dried feces and/or urine numerous times throughout the review when the tub room had been vacant and the lights were out/room not being used. Staff interviewed stated that the raised seats were to be cleaned before and after each use. One example: At 1420 hours on September 11, 2014 the toilet seat in the first floor tub room was observed with dried feces on it. The tub room was empty and the lights were out. Staff confirmed that the raised toilet seat should have been cleaned after use and went to clean it when identified by the inspector.(107)

C) The furniture in the main lounges on all floors were noted to be significantly soiled looking with staining, dark worn areas on the arms, and a white dried substance on some of the chairs. The furniture was noted to appear soiled on September 3, 9, 10, 2014. Nursing staff stated they were to spot clean between deep cleaning when soiling occurred. The areas had not been spot treated on the days observed.(107)

D) The main lobby entrance had several couches and wing back chairs in them and they were all visibly soiled. This observation occurred on September 4, 2014. The area on the first floor at the end of the hall, by the kitty litter, had furniture that was visibly soiled with stains.(169)

E) The home's policies related to cleaning were not specific and did not provide clear direction for frequency of cleaning the lounge furniture and for cleaning soiled equipment in the tub rooms or bathrooms.(107) [s. 15. (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 be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the abuse and neglect policy was followed.

Two critical incident reports from June and July, 2014 were completed and submitted to the Ministry of Health and Long Term Care. Both critical incidents were in regards to possible physical abuse of residents by staff. One report was submitted two days after the incident and one report was submitted ten days after the incident. The Administrator of the home confirmed that the main responsibility for submitting the critical incidents reports was of the Administrator or two to three delegates. The ten day delay in the one report submission was due to the internal incident report being completed but not forwarded directly to the Administration for follow-up.

The Policy on Abuse and Neglect of a Resident- Actual or Suspected, dated May, 2013, directed the Charge Nurse to initiate the nursing checklist. Upon review of the two incidents it was found that the Nursing Checklist for Reporting and Investigating Alleged Abuse of resident by family or staff or visitor or volunteer were not completed. This form would have directed staff to submit the report to the Ministry of Health and Long Term Care within 24 hours of the incident. The Administrator confirmed that staff had not followed the policy to ensure the Ministry of Health and Long Term Care was notified immediately. [s. 20. (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 be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

Significant lingering odours of urine and feces were noted throughout the inspection on all three floors in multiple rooms on multiple occasions. The home did not have a specific policy for managing odours and clear direction was not provided for staff managing the odours. Residents voiced concerns to inspectors related to odours during this inspection and staff confirmed they were aware the ventilation system (for air circulation) was not consistently working in some areas of the home. Dried urine and feces were observed on and under raised toilet seats throughout the home on numerous days throughout the inspection. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance , to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 90. (3) The licensee shall ensure that the home's mechanical ventilation systems are functioning at all times except when the home is operating on power from an emergency generator. O. Reg. 79/10, s. 90 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the mechanical ventilation systems were functioning at all times.

On September 15, 2014 at 1300 hours the ventilation in two resident washrooms was not working. A resident in one room stated that the room frequently smelled bad, especially by the afternoon when the washroom had been used during the day. During interview on September 15, 2014, management stated that only so many of the washroom ventilation systems were being replaced at a time and they were aware of the problem. [s. 90. (3)]

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 be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee did not ensure that all hazardous substances at the home were kept inaccessible to residents at all times on the third floor.

On September 3, 2014 at 1045 hours, September 4, 2014 at 1040 hours, September 4, 2014 at 1356 hours and September 9, 2014 at 1203 hours, the housekeeping cart was left outside resident rooms (in hallway) and the cart was not visible to the staff member cleaning the rooms. The inspector was able to remove two bottles of hazardous chemicals from the cart without the staff member noticing. During interview, the staff member stated that during cleaning, the carts were to be taken into the rooms with the staff member to keep chemicals inaccessible to residents. [s. 91.]

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 be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the seat belt for resident #039 was applied in accordance with the manufacturer's instructions.

On September 9, 2014 at 1158 hours, resident #039 was observed sitting in their broda chair with their seatbelt applied. The seatbelt was loose (more than two hand widths) and the resident was visibly agitated and moving around in their chair pulling at the seatbelt. Staff confirmed that the seatbelt was not applied correctly and had loosened. Staff tightened the belt on the resident upon being identified by the inspector. [s. 110. (1) 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 be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the home's "Diabetes - Hypoglycemia policy, "VI-G-30.20 revised November 2013", was followed by staff providing care to resident #016.

The policy directed staff to: test a resident's blood sugar, if it is less than 4.0 mmol/L to treat with 15 grams of fast acting glucose (3 teaspoons of honey or 3 packages of sugar dissolved in water or 6 ounces of apple juice or regular soft drink); re-check blood sugar in 15 minutes after treatment, and if blood sugar remained less than 4.0 mmol/L to repeat treatment; if more than 1 hour to the resident's next meal to provide a snack of 1 protein and 1 starch as cheese and 4 crackers or soya pudding or 1/2 ready made sandwich; assess for causes of low blood sugar and document interventions and notify physician, dietitian and family.

The home's policy was not followed for resident #016 in August, 2014. Progress notes August 25, identified that the resident's blood sugar was checked at bedtime and was 3.2 mmol/L. "Snack was given. Had two slices of bread with jam. Blood sugar checked again and 5.7 mmol/L." The staff did not follow the home's policy with providing 15 grams of carbohydrate and following with a protein/carbohydrate snack as the resident's next meal was breakfast which was more than one hour away. Staff confirmed the home's policy was not followed. [s. 8. (1) (b)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that an alternate choice of entree, vegetable and dessert was planned at the lunch meal September 4, 2014.

The posted menu identified only one choice at the lunch meal and an alternative choice was not prepared and available at the same time as the first choice. Staff would have to get an alternative from the kitchen if a resident refused the planned item and residents were not provided a choice of entree at the meal. The Nutrition Manager confirmed that only one menu choice was planned for theme meal days. [s. 71. (1) (c)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not ensure that a critical incident was reported to Director within one business day.

Resident #401 had a fall resulting in being transferred to the hospital for treatment in June, 2014. The resident returned to the home after receiving sutures and a CT scan. The critical incident was not submitted to the Director until July 1, 2014 and amended on July 15, 2014. The Director of Care and Administrator confirmed this, along with the critical incident documentation submitted to the Director. [s. 107. (3)]

WN #14: 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 did not ensure that medications were stored in the fridge in the medication rooms on all three floors at a temperature that was recommended by the manufacturer of the drugs.

The fridge temperatures were noted to be greater than 15 degrees celcius and up to 18.7 degrees celcius on several days during August and September, 2014. The fridge contained insulin and injectable medication and the manufacturer recommended the medications be stored between 2 and 8 degrees celcius. The Registered staff and Director of Care confirmed the temperatures. [s. 129. (1) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that all resident's in the home had received vaccination for Tetanus, Diptheria and Pneumovax.

Immunization documents were reviewed for resident #008. Tetanus and Diptheria, and Pneumovax administration were not found in the clinical record for resident #008. A member of the registered staff confirmed that consent was signed for the administration of the vaccination by the resident upon admission to the home in 2013. The Assistant Director of Care confirmed the resident had not received the vaccination though they had provided consent to receive the immunization. [s. 229. (10) 3.]

Issued on this 8th day of December, 2014

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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) :	VALERIE GOLDRUP (539), DARIA TRZOS (561), MICHELLE WARRENER (107), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2014_278539_0022
Log No. / Registre no:	H-001170-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 28, 2014
Licensee / Titulaire de permis :	KING NURSING HOME LIMITED 49 Sterne Street, Bolton, ON, L7E-1B9
LTC Home / Foyer de SLD :	KING NURSING HOME 49 Sterne Street, Bolton, ON, L7E-1B9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To KING NURSING HOME LIMITED, 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee shall ensure ongoing interdisciplinary assessment occurs and the interventions are implemented, within the the following programs; Falls Prevention and Management, and Responsive Behaviours.

Grounds / Motifs :

1. The licensee did not ensure that the responsive behaviour plan of care for Resident #017 and Resident #042 was based on an interdisciplinary assessment that included drugs and treatments.

Resident #017 had 15 documented responsive behaviours from June, 2014 until present which included yelling and attempting to hit or kick other residents. The resident was seen by a physician in July, 2014 and had their psychiatric medication decreased. The Behavioural Support Officer confirmed that no interdisciplinary review had occurred afterward to address the resident's ongoing behaviour via a new medication or treatment.

Resident #042 had 31 responsive behaviours from July, 2014 to present involved the resident being aggressive, hitting and shaking tables and chairs. The resident's anti-psychotic medication was discontinued in June, 2014 after being determined ineffective. Another anti-psychotic was started in September, 2014. The Behavioural Support Officer confirmed that no interdisciplinary review had occurred during the time outlined to address the resident's behaviour via a new medication or treatment. (539)

2. The licensee did not ensure that the falls prevention plan of care for Resident #401 was based on an interdisciplinary assessment of special treatments and interventions.

Resident #401 had a fall and sustained an injury. The physiotherapist recommended a call bell be lengthened for the resident to reach and this was not added to the plan of care. The physician recommended a falls mat be used, put the bed in the lowest position and to use an alarm and this was not added to the plan of care. The nursing staff were not implementing the interventions recommended by the allied disciplines. The registered nursing staff, Director of Care and Administrator confirmed this. Observation on three separate days during the review confirmed the recommended interventions were not implemented. (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 27, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

1. Ensure that all residents who have been identified to require one or more bed rails while in bed, and who currently reside in a bed that has failed one or more zones of entrapment, shall have interventions instituted to mitigate the identified risk.
2. For bed systems that cannot be modified immediately to ensure entrapment zones are eliminated, monitor the interventions that were instituted and re-evaluate to determine if the interventions are effective for the resident.
3. Re-test the bed systems when the bed systems have been changed or altered.
4. Update the residents' plans of care to reflect what directions staff require to ensure that the resident who resides in a bed that has failed one or more entrapment zones will have their specific risk mitigated.
5. Educate health care staff who provide care to residents on the risks associated with bed rail use and overall bed safety.
6. Maintain documentation of all bed audits so that it clearly identifies when the bed system was tested for entrapment zones, who completed the test and what follow up action is/was taken for the beds that failed one or more zones of entrapment.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. The home had an outside agency (Joerns) conduct an assessment of the home's beds in relation to entrapment zones February 6, 2014; however, the report provided by the agency was not reviewed by the home and action was not taken to address the failed zones of entrapment identified in the safety audit. The Maintenance Supervisor confirmed that the report had not been reviewed and an action plan had not been developed to address the areas identified in the audit report. Forty six out of 86 beds failed the safety audit for entrapment zones. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 27, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

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

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

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

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

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

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

Issued on this 28th day of November, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Valerie Goldrup

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