Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 7, 14, 31, 2014	2014_226192_0001	L-000003-14	Resident Quality Inspection

Licensee/Titulaire de permis

LAPOINTE-FISHER NURSING HOME, LIMITED
1934 DUFFERIN AVENUE, WALLACEBURG, ON, N8A-4M2

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

LAPOINTE-FISHER NURSING HOME
271 METCALFE STREET, GUELPH, ON, N1E-4Y8

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

DEBORA SAVILLE (192), NUZHAT UDDIN (532), SHERRI GROULX (519), TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 7, 8, 9, 10, 13, 14, 15, 16, and 21, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Care Plan Coordinator, Food and Nutrition Manager, Maintenance Manager, Environmental Supervisor, Activation Manager, Registered Nurses, Registered Practical Nurses, Personal Support Worker, Housekeeping Aides, Dietary Aides, Nursing Support Clerk, Activity Aides, Restorative Facilitator, family, and residents.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage areas and care provided residents, reviewed medication records and plans of care for specified residents, reviewed policy and procedure, observed recreational programing, staff interaction with residents and general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During initial tour of the home on January 7, 2014 at 1035 and again at 1415 it was observed that the laundry chute rooms and laundry chutes on the first and second floors of the home were not locked and they were not being supervised by staff. The doors were not locked to restrict unsupervised access. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 901 was 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 failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

In 2014 documentation review identified that resident #238 was found to have become entrapped between the bed rail and the therapeutic surface upon which they were laying.

Interview and documentation review identified that the resident was placed on the therapeutic surface about twenty-four hours prior to becoming entrapped.

Interview confirms that no assessment of the entrapment zones was completed for resident #238 who was identified to require the use of bed rails. [s. 15. (1) (a)]

2. Interview with the Administrator and the Maintenance Manager revealed that where bed rails were used, including for residents on therapeutic surfaces, residents were not assessed and their bed system was not evaluated.

Administrator confirmed that the home did not have a policy to direct staff in completing resident assessments and bed system evaluations. [s. 15. (1) (a)]

3. The licensee failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

In 2014 resident #238 had their mattress replaced with a therapeutic surface.

In 2014 documentation review identified that resident #238 was found to be trapped between the therapeutic surface and the half bed rail.

Interview confirms that the resident remained on the therapeutic surface with bed rails in place. Steps to prevent further entrapment had not been initiated. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 902 was served on the licensee. CO # - 006 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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee of the long term care home did not protect residents from abuse by anyone.

In 2014, resident #245 was observed to be in need of assistance from staff. A Personal Support Worker (PSW) encouraged the resident to come with her while assisting another resident to their room however, the resident refused and kept walking. The PSW alerted another staff member to assist the resident. A few minutes later, the inspector overheard staff stating to the resident "no, she's trying to help you". A short time later, staff were observed with the resident. The resident had received assistance. Staff attempted to get the resident to lay down however, the resident exited their room within a few minutes. The resident walked by staff and stated "now leave me alone".

Interview with the PSW confirmed that the resident was provided assistance. It was reported that the resident was kicking and scratching at staff during the process and staff stated that they forced the resident to sit by using their hands to hold the residents hands down while they provided care. The second PSW confirmed that there were three staff members present during the process however, staff stated that the third PSW left because it was too much for the resident who may have thought they were being attacked. Documentation in the clinical record by the RPN indicated the resident was observed to have been injured.

The resident was observed in January 2014 to have sustained an injury.

Resident #245 was not protected from abuse. [s. 19. (1)]

Additional Required Actions:

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

WN #4: 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents provides that abuse and neglect are not to be tolerated, contains an explanation of the duty under section 24 of the Act to make mandatory reports; sets out the consequences for those who abuse or neglect residents and complies with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations.

The home's Policy related to "Resident Abuse" Section A, Page 1.0 dated as revised January 1, 2013 and signed December 7, 2013 was reviewed.

Interview with the Administrator and Director of Care confirm that this is the most current Abuse Policy and that the policy is not comprehensive.

The Policy does not clearly state that abuse and neglect are not tolerated and does not contain the following:
i) an explanation of the duty under section 24 of the Act to make mandatory reports;
ii) the consequences for those who abuse or neglect residents
iii) items referred to in O.Reg 97/10 s.96 related to the policy to promote zero tolerance of abuse and neglect,
iv) items referred to in O.Reg 97/10 s.97 related to notification of incidents,
v) items referred to in O. Reg 97/10 s.98 related to police notification and
vi) items referred to in O. Reg 97/10 s.99 related to evaluation. [s. 20. (2)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to immediately report the suspicion and the information upon which it is based, to the Director, related to abuse of a resident by anyone or neglect of a resident by a licensee or staff that resulted in harm or risk of harm.

A review of the home's Risk Reporting System and Complaint Binder identified that more than twenty incidents of abuse had occurred in the home during 2012 and 2013.

Review of the Critical Incident System used to report incidents to the Director, failed to identify reports related to the identified incidents.

Interview with the Administrator and Director of Care confirmed that the incidents identified in the Risk Report System and Complaint Binder were not reported to the Director.

Interview with the Administrator and Director of Care identified that an incident of alleged financial abuse had not been immediately reported in 2014. [s. 24. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee did not ensure that the persons who have received training under subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

Review of the home's education records revealed that all staff at the home did not receive retraining in the long term care home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports.

The Administrator confirmed that approximately 14% of the home's staff received training related to abuse and neglect in 2013. [s. 76. (4)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: 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 long term care home's policy related to Pain Assessment, section P 3.0, was complied with.

The procedure section of the home's Pain Assessment Policy indicated for Registered Staff to complete a seven day pain evaluation at least once per shift or based upon scheduled analgesic delivery during the seven day post admission of a new resident.

Resident #319 admitted to the home in 2012, with a physician's order for analgesic twice daily had a pain assessment initiated in 2012, however, the assessment was not completed once per shift or based upon the resident's scheduled analgesic delivery. On a specified date in 2012, a pain assessment was only completed for the evening shift and there was no completed pain assessment for the scheduled morning analgesic delivery. [s. 8. (1)]

2. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with.

The home's policy titled "Critical Incident/Mandatory Reporting" Section 12, Page (b) dated as revised September 2013 and signed December 3, 2013 was reviewed. The home's policy indicated that an emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding required reporting within one business day rather than the required immediate reporting for an emergency including fire, unplanned evacuation or intake of evacuees.

The home's policy indicated that a resident who is missing for less than 3 hours and who returns to the home with an injury or any adverse change in condition should be reported within one business day. The legislation on reporting requires that a resident missing for less than 3 hours and who returns with no injury or adverse change in condition is reported within one business day.

The policy related to "Critical Incident/Mandatory Reporting" as noted above was not complied with.

A review of the home's Risk Management System and interview confirmed that incidents of abuse and neglect as well as resident elopement for periods of less than three hours were not reported to the Director as outlined in the homes policy. [s. 8. (1)]

3. Where the Act or this regulation required the licensee of a long term care home to have institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

The home's policy related to "Residents Eating in their Rooms", section E 6.0 directed staff to leave a tray at the end of the meal service and a charge nurse would assign a Personal Support Worker for each tray.

In 2014, lunch meals were left outside the small dining room on first floor, prior to the main dining room being served. Each tray was not assigned to a Personal Support Worker to serve and it was 42 minutes after the tray was prepared that one of the trays was offered to a resident.

The Food Service Manager confirmed that meals should not have been prepared and left outside the small dining room and that staff were to prepare the trays after meal service was completed in the main dining room. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 ensuring that the long term care home's policy related to Pain Assessment, and Residents Eating in their rooms, are complied with, to be implemented voluntarily.

WN #8: 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 failed to ensure that drugs are stored in an area or a medication cart, ii. that is secure and locked.

The medication cart was observed to be unlocked on two different occasions.
1) On January 10, 2014 at 1155 a Registered Practical Nurse (RPN) was observed to be giving medication to a resident who was in their room. The RPN left the medication cart unlocked and unattended.

2) On January 10, 2014 at 17:05 on the second floor by room 227, an RPN was observed leaving medications unattended on top of the medication cart. The RPN was in the room with the resident, the medication cart was left unlocked, unattended and the monitor with resident information was left open.

The policy "Medication and Treatment Cart Protocol" Section M page 0.0 indicates that the medication cart and treatment cart are to be locked at all times when not in the locked medication room. [s. 129. (1) (a)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: 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,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).

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

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that the home's menu cycle was approved by a Registered Dietitian who was a member of the staff of the home.

The Food Service Manager reported that the winter menu cycle was initiated the second week of November 2013, and that the Registered Dietitian had a copy of the home's menu however, approval of the menu cycle was not completed as of January 14, 2014. [s. 71. (1) (e)]

2. The licensee did not ensure that each resident was offered a minimum of three meals daily.

Resident #401 was observed sleeping during the lunch meal and was not in the dining room for the lunch meal on a specified date in 2014.

A lunch tray was plated for the resident at approximately 1218 hours outside the dining room.

At approximately 1310 hours, the Personal Support Worker was observed throwing the lunch meal tray out.

The Personal Support Worker reported that the resident had refused to come to the dining room however, it was too late to provide the tray to the resident because it had been sitting out for too long.

The Personal Support Worker confirmed that they did not offer the resident a lunch meal prior to throwing the meal out and that the resident would get a nourishment at 1400 hours.

At approximately 1430 hours the resident was observed finishing a snack and a family member commented that the resident must have been hungry as they ate the snack quickly.

Review of the resident's clinical health record revealed that the resident has lost a specified amount of weight in the past ten months. [s. 71. (3) (a)]

3. The licensee did not ensure that the planned menu items were offered and available at each snack.

On January 15, 2014, it was observed and confirmed by a Personal Support Worker that there was no puree snack available to offer residents requiring puree textured snacks during the afternoon nourishment pass on first floor. [s. 71. (4)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

A) Resident #255 was observed to use bed rails at all times.
Interview with registered staff confirms that the resident uses bed rails for mobility while in bed.

Documentation review and interview confirm that the plan of care for resident #255 does not include the use of two bed rails.

B) Resident #319 and staff interviewed confirmed that the resident had dentures however, the lower dentures did not fit well and therefore the resident did not wear them. The resident stated that the dentures were cleaned daily and staff reported the dentures were cleaned in the morning and night.

The resident's plan of care did not include oral status including oral hygiene for the resident. [s. 6. (1) (a)]

2. The licensee did not ensure that the care set out in the plan of care was provided to resident #319 as specified in the plan.

The urinary incontinence plan of care last revised in 2013, indicated the resident's toileting routine was 0730-0800 hours, 0930-1000 hours, 1130-1200 hours, 1500-1530 hours, 1800-1830 hours and 2000-2030 hours.

The resident was observed from 0950 to 1205 hours on January 10, 2014. The resident was toileted at approximately 1000 hours, this was confirmed by the resident and a Personal Support Worker.

It was observed and confirmed by the resident that they were not toileted from 1130-1200 hours as indicated in the plan of care. [s. 6. (7)]

3. The licensee did not ensure that the care set out in the plan of care was provided to resident #319 as specified in the plan.

The resident's plan of care for falls indicated that a bed alarm with a sensor pad would be activated when the resident was in bed and the bed alarm would trigger staff to answer the alarm as soon as possible.

On January 10, 2013, at approximately 1437 hours the resident was observed getting out of bed and entering the bathroom independently. The bed alarm did not activate when the resident exited their bed. The resident was returning from the bathroom when two Personal Support Workers observed the resident.

A Personal Support Worker confirmed that the bed alarm did not activate when the resident got out of bed and indicated that the alarm was in place to alert staff so the resident did not go to the bathroom independently. [s. 6. (7)]

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

The plan of care for resident #292 identified as part the fall prevention plan of care that the call bell was to be within reach at all times.

On January 10, 2014 the resident was observed to be laying in bed, the call bell was not accessible to the resident and was found to be behind the head of the bed. [s. 6. (7)]

5. The licensee of the long term care home did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #239's plan of care for nutrition indicated the resident was to receive nectar consistency fluids however, during the lunch meal January 15, 2014, the resident received honey consistency water and pudding consistency milk.

Resident #259's plan of care for nutrition indicated the resident was to receive nectar consistency fluids however, during the lunch meal January 15, 2014, the resident received pudding thickened milk. During the afternoon nourishment pass January 15, 2014, the resident received honey thickened fluids. [s. 6. (7)]

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

Toileting Routine as per the plan of care for resident #267 indicated that the resident was to be toileted at 0600-0630, 0930-1000, 1330-1400, 1630-1700, 2000-2030

Observation revealed that on January 15, 2014 resident #267 was not toileted between the hours of 1630-1700 and on January 16, 2014 the resident was not toileted between the hours of 1330-1400.

Staff and resident interview confirmed that resident was not toileted as set out in the plan of care. [s. 6. (7)]

7. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any time when the resident's care needs changed.

The plan of care for resident #292 indicated that a personal alarm was to be pinned to the resident's clothes while in bed and that the resident was to have one bed rail elevated.

Resident #292 was observed on January 10, 2014 laying in bed with two quarter bed rails elevated. No personal alarm was observed on the bed.

Personal Support Worker (PSW) interviewed searched for the alarm and was unable to located it. The PSW stated that the resident normally used the personal alarm at all times.

Registered staff identified that the resident no longer used the personal alarm as there had been no recent falls, and that the plan of care had not been updated.

The plan of care for resident #292 was not updated to reflect that the resident no longer required the use of a personal alarm while in bed and that the resident now used two quarter bed rails. [s. 6. (10) (b)]

8. The licensee did not ensure that the resident was reassessed and the plan of care was reviewed and revised when the residents care needs changed.

Resident #311 had a care plan dated on July 2, 2013 that documents they are a one person transfer with intermittent supervision and some physical assistance.

Staff reported and the progress notes in the clinical health record indicated that residents transfer status had changed to a two person transfer. This has not been revised in the current plan of care. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that there is a written plan of care for each resident that sets out the planned care for the resident, that the care set out in the plan of care is provided to the resident and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any time when the resident's care needs changed, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement.

The schedule provided by the home for the period December 23, 2013 to January 19, 2014 indicated that on December 24, 2013 there was no Registered Nurse available on the night shift.

Interview with the Director of Care (DOC) confirms that on December 24, 2013 no Registered Nurse was on duty and present in the home between 2300 hours and 0700 hours. In addition, the DOC identified that on November 6, 2013 no Registered Nurse was available in the home between 2300 hours and 0700 hours. [s. 8. (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 ensuring that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement, to be implemented voluntarily.

WN #12: 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 failed to ensure that, (a) the home, furnishings and equipment are kept clean and sanitary.

During tour of the home conducted January 7, 2014; during observation on January 8 and again on January 15, 2014 in the presence of the Maintenance Manager the following was observed:

The shower room on the west end of the second floor was observed to have dirt build up in the corners and around the perimeter of the floor. The corner where a broom is stored contains loose debris.

The shower chair located in the tub room on the second floor is noted to be coated with a white substance and is not clean.

Room 206 and the small Dining Room on second floor have loose dirt in the corners

of the room.

On January 8, 2014 in specified rooms the toilet seat was observed to be soiled with brown substance, the call bell in a specified room was also noted to be soiled with a brown substance. The bed rail in a specified room nearest the door, was observed to be soiled.

On January 7, 2014 and January 15, 2014 the stools used in the dining rooms on second floor were observed to have spillage on the legs and table legs were noted to be soiled.

The home, furnishings and equipment were not kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On January 8, 2014 the call bells in specified rooms would not activate after multiple attempts. It is noted that the home completed repairs on these call bells after being notified.

On January 8, 2014 the light cover in the first floor tub room was observed to be hanging down, with a potential of falling on anyone in the room. No drain cover was observed in the shower area.

On January 8, 2014 shower chairs on the second floor were observed to have rusty wheels and the shower room on the west end contained a shower chair with signage indicting that the "wheel does not turn".

On January 8, 2014 door frames in the tub rooms on first and second floor, and specified rooms were observed to have scaring, with chunks missing from the door frames and in some cases raw wood was exposed, prohibiting the ability to effectively clean the surface.

On January 8, 2014 the base board heater in the small dining room on the first floor was observed to be badly scarred and the wooden trim in this room is rough, and badly marked prohibiting effective cleaning.

On January 7, 2014 vinyl flooring was noted to be lifting in specified rooms.

During a tour conducted on January 15, 2014 with the Maintenance Manager the following was observed:

Observations in the tub room on the east end of the first floor from January 8, 2014 were confirmed.

Wooden cabinets in both the first and second floor small dining rooms are worn with finishing coming off and scarring at floor level.

In a specified room there was a commode in the BR - the wheels are rusty and would prohibit proper cleaning and disinfection.

Cold air is blowing from the register near the nursing station on the first floor. Several residents and staff were heard to be complaining about the temperature in the corridor.

Four linen carts were observed to be rusted at the bottom prohibiting proper cleaning and sanitation

In the second floor dining room the wood paneling was observed to be scarred and soiled with spilled items, table and stool legs are noted to be soiled, the wood paneling is broken at the entrance to the Dining Room and the paneling is not secure.

The shower room at the west end of the second floor has a shower chair that has rusty legs and wheels that would prohibit proper cleaning and sanitation, the tile at the bottom of the half wall is cracked at floor level the entire length of the wall.

The home, furnishings and equipment are not maintained in a safe condition and in a good state of repair. [s. 15. (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 ensuring that the home, furnishings and equipment are kept clean and sanitary and that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

On January 10, 2014 it was observed that resident #292's call bell was not accessible and was found on the floor behind the head of the bed. It is noted that the call bell was functioning at this time. [s. 17. (1) (a)]

2. During tour of the home and while interviewing residents in room 206 on January 8, 2014 it was identified that the call bell was not audible at the far end of the west corridor and while in the resident room.

Interview with staff confirmed that if working in a resident room at the far end of the west corridor, they would not be able to hear the call bell. [s. 17. (1) (g)]

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 ensuring that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :