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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 3, 2017	2017_486653_0019	022979-17	Resident Quality Inspection

Licensee/Titulaire de permis

ORILLIA LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

LEACOCK CARE CENTRE
25 MUSEUM DRIVE ORILLIA ON L3V 7T9

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

ROMELA VILLASPIR (653), DIANE BROWN (110), IVY LAM (646)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 2, 3, 4, 5, 6, and 10, 2017.

The following were inspected concurrently during this inspection:
Follow-up intake log #018853-17 related to abuse and responsive behaviours.

During the course of the inspection, the inspector (s) conducted a tour of the home, observed medication administration, observed staff to resident interactions, reviewed staff schedule, clinical health records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Dietary Aides, Life Enrichment Co-ordinator, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Registered Dietitian (RD), Food Service Supervisor (FSS), Environmental Service Supervisor (ESS), Physiotherapy Assistant (PTA), Education Co-ordinator, Infection Prevention and Control (IPAC) Lead, Co-Directors of Care (Co-DOCs), Director of Care (DOC), and the Administrator.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

10 WN(s)
6 VPC(s)
4 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_646618_0011	653
O.Reg 79/10 s. 54.	CO #002	2017_646618_0011	653

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. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices were readily available to meet the nursing and personal care needs of the residents.

This inspection had been inspector initiated as a result of staff interviews on an identified

Home Area (HA).

Interviews with Personal Support Workers (PSWs) #118, #123 and #124 identified an equipment had been broken since November–December 2016, and that resident #005 had been receiving an identified activity since this time.

Interview with the Environmental Service Supervisor (ESS), revealed he/she was unable to confirm the date when the equipment was broken and removed from use, but identified a time frame of November–December 2016.

The ESS revealed that prism medical is the company and service provider for the home’s identified equipments. Record review revealed a checklist dated May 9, 2017, indicating that the equipment did not pass inspection and the notes revealed that it was to be replaced and the client was waiting for a quote from prism medical. The checklist was signed by the Director of Care (DOC).

Interview with front line staff confirmed that the broken equipment for approximately 10 months had a negative impact on meeting resident’s personal care needs.

Interview with Co-Director of Care (Co-DOC) #116 revealed that a new equipment for the identified HA was on the capital equipment budget for 2016, as it was old. He/she stated that once the equipment had been broken, the process took longer than it should have and confirmed that the broken equipment impacted care for some residents. [s. 44.]

2. During stage one of the Resident Quality Inspection (RQI), residents #005 and #006 were triggered related to having low body mass index (BMI) and weight loss.

Record review of resident #005's weight history revealed he/she experienced significant weight changes. Further record review of the resident's weight history identified missing weights for three identified months.

Record review of resident #006's weight history revealed he/she experienced significant weight changes. Further record review of the resident's weight history identified missing weights for four different months.

Interviews with PSW #122 and Registered Nurses (RNs) #105 and #113 revealed that the scales in the home had been broken in December 2016. PSWs #121 and #122 revealed that one wheelchair scale had been shared by all home areas, which limited the

days on which residents had been weighed, and some residents had not been weighed by the 10th of the month, as per the home’s expectation.

Interview with Co-DOC #116 revealed that the home’s tub lift scales had been broken following November 2016, and that the new tub lifts that were purchased did not have scales. He/she further revealed that one wheelchair scale that had been purchased, was shared among residents on all five home areas. Co-DOC #116 also stated that the tub lift scale had been broken prior to August 2017, and that the one wheelchair scale was in disrepair in August 2017. He/she further indicated that the home was without a scale to use for a couple of weeks before a new scale had been obtained for the home. Co-DOC #116 further stated that the use of different scales may have contributed to the weight variations.

Interview with the Food Service Supervisor (FSS) revealed that since the weight had not been always completed by the 10th of the month, this did not consistently provide a 30-day gap to determine if it was an accurate significant weight change from month to month.

Interview with the RD revealed that he/she could not depend on the accuracy or reliability of the weights done in the home. The RD further revealed that weight was an important factor for the assessment of residents, and was used to determine if additional nutrition and nursing interventions were needed for the residents. He/she further indicated that due to the inaccurate weights, he/she was unable to determine the effectiveness of nutrition interventions in place, or whether additional interventions were required for residents, and this affected the care of the residents.

Interview with the DOC revealed that weight management meetings have become part of the home’s high risk rounds. Review of the home's monthly weight exception meeting report form for the weight exception meetings attended by the RD, FSS, and DOC in January, February, and April,2017, revealed that the RD has commented that the scales have not been taking residents' weights properly, that he/she queried the accuracy of weight records for residents, and that different scales have been used to take the residents' weights.

Interview with Co-DOC #116 revealed that the home currently uses two wheelchair scales for all residents, and one tub lift scale could be used, but staff mainly use the two wheelchair scales. He/she further indicated that it was unacceptable to have the limited number of scales in the home, as this impacted nursing care, where not all residents had

been weighed by the 10th of the month.

Interview with the DOC revealed weight management was part of the high risk meetings in the home, and that the home needed to tighten the weight management process to ensure that weight scale equipments and devices were readily available in the home to meet the nursing and personal care needs of the residents.

The severity of the non-compliance was potential for actual harm.

The scope of the non-compliance was a pattern.

A review of the home's compliance history revealed one or more unrelated non-compliances in the last three years. [s. 44.]

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. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition care and hydration program included a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

During stage one of the RQI, residents #005 and #006 were triggered related to having low BMI and weight loss.

Record review of resident #005's weight history revealed he/she experienced significant weight changes. Further record review of the resident's weight history identified missing weights for three identified months.

Record review of resident #006's weight history revealed he/she experienced significant weight changes. Further record review of the resident's weight history identified missing weights for four different months.

Interviews with PSW #122 and RNs #105 and #113 revealed that the scales in the home had been broken in December 2016. PSWs #121 and #122 revealed that one wheelchair

scale had been shared by all home areas, which limited the days on which residents had been weighed, and some residents had not been weighed by the 10th of the month, as per the home's expectation.

Interview with Co-DOC #116 revealed that the home's tub lift scales had been broken following November 2016, and that the new tub lifts that were purchased did not have scales. He/she further revealed that one wheelchair scale that had been purchased, was shared among residents on all five home areas. Co-DOC #116 also stated that the tub lift scale had been broken prior to August 2017, and that the one wheelchair scale was in disrepair in August 2017. He/she further indicated that the home was without a scale to use for a couple of weeks before a new scale had been obtained for the home. Co-DOC #116 further stated that the use of different scales may have contributed to the weight variations.

Interview with the DOC revealed that the home's expectation was for residents' weights to be done monthly, and that residents #005 and #006 should have been weighed every month.

The severity of the non-compliance was potential for actual harm.

The scope of the non-compliance was a pattern.

A review of the home's compliance history revealed one or more unrelated non-compliances in the last three years. [s. 68. (2) (e) (i)]

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 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 were assessed using an interdisciplinary approach, and that actions were taken and outcomes were 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.

During stage one of the RQI, residents #005 and #006 were triggered related to having low BMI and weight loss.

Record review of resident #005's weight history revealed he/she experienced significant weight changes. Further record review of the resident's weight history identified missing weights for three identified months.

Record review of resident #006's weight history revealed he/she experienced significant weight changes. Further record review of the resident's weight history identified missing weights for four different months.

Review of resident #005 and #006's progress notes and assessments revealed that the RD did not receive a dietary referral for their significant weight changes.

Interviews with RNs #105 and #113 revealed that the RD assesses resident weights and the weight variance on his/her own, and that registered staff do not refer residents to the

RD for significant weight changes.

Interview with the DOC revealed that weight management meetings have become part of the home's high risk rounds.

Interview with the RD revealed that he/she assesses weight variances on his/her own, and had to investigate the reason for the weight change on his/her own. The RD further revealed that the high risk rounds and monthly weight management meetings had not been helpful as they were done after significant weight changes had already occurred, and was done with management rather than with direct care staff who had a better idea of what was going on with the residents.

Interview with the DOC revealed that review of past weight management meetings revealed that the notes were only from the RD's assessments and did not include any nursing assessment, and that dietary referral was not completed when residents #005 and #006 experienced significant weight changes. He/she further revealed that the home did not assess residents' weight changes using an interdisciplinary approach for residents with significant weight changes. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. During stage one of the RQI, resident #002 was triggered related to eating decline since the resident's admission to the home.

Record review of resident #002's weight history revealed he/she experienced significant weight changes.

Review of the home's policy titled, 'Monthly weights and weight variance report' (revised date 2014-11-04) indicated that the weight monitoring system shall ensure that actions are taken and outcomes evaluated for:
-A change of 5% of body weight, or more, over one month
-A change of 7.5 % of body weight, or more, over three months
-A change of 10 % of body weight, or more, over 6 months.

The policy further stated that the registered staff will ensure that monthly weights are completed and documented by the 10th of each month, and will complete dietary referral for those residents with significant weight changes.

The policy also revealed that the DOC or delegate, lead a monthly weight management meeting to facilitate interdisciplinary assessment, action and outcome of residents with

significant weight change, as detailed above.

Review of the weight variance assessment in resident #002’s progress notes revealed the RD’s assessment, but did not reveal any assessment from nursing or other disciplines, and there were no referrals for resident #002’s significant weight change.

Interviews with RNs #105 and #113 revealed that the RD assesses resident weights and the weight variance on his/her own, and that registered staff do not refer residents to the RD for significant weight changes.

Interview with the DOC revealed that weight management meetings have become part of the home’s high risk rounds.

Interview with the RD revealed that he/she assesses weight variances on his/her own, and had to investigate the reason for the weight change on his/her own. The RD further revealed that the high risk rounds and monthly weight management meetings had not been helpful as they were done after significant weight changes had already occurred, and was done with management rather than with direct care staff who had a better idea of what was going on with the residents.

Interview with the DOC revealed that review of past weight management meetings revealed that the notes were only from the RD's assessments and did not include any nursing assessment, and that dietary referral was not completed when resident #002 experienced significant weight change. He/she further revealed that the home did not assess residents’ weight changes using an interdisciplinary approach for residents with significant weight changes.

The severity of the non-compliance was potential for actual harm.

The scope of the non-compliance was widespread.

A review of the home's compliance history revealed one or more unrelated non-compliances in the last three years. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were schedules and procedures in place for routine, preventive and remedial maintenance.

During stage one of the RQI, residents #005 and #006 were triggered related to having low BMI and weight loss.

Review of the home's policy titled "Acquiring Maintenance: Repair Books and Software" (Revised date: October 2016), revealed that the repair books are for the use of all employees. Furthermore, the policy revealed that when a worker notices a needed repair they should list as much information as possible in the appropriate repair book; maintenance workers are to check the repair books daily as a part of their regular routine; and repairs are to be completed and documented as soon as possible.

Review of the checklist of routine checking of lifts included checking of sit-stand lifts and tub lifts, but did not specify which lifts had scales. Review of the ESS' Daily Recording, Preventative Maintenance tasks, and the Monthly Preventive Maintenance checklist did not include checking of the wheelchair scale.

Interviews with PSW #122 and RN #105 and #113 revealed that the scales in the home had been broken in December 2016. Registered Practical Nurse (RPN) #120 further revealed that the wheelchair scale had been broken since September 2017, but it was

not written in the repair book for the ESS, and that he/she did not notify the ESS. PSWs #121 and #122 revealed that one new wheelchair scale had been shared by all home areas. RPN #120 revealed that the staff did not use the tub scale, but only use the two wheelchair scales, to minimize weight variations.

Interview with Co-DOC #116 revealed the home's tub lift scales had been broken following November 2016, but the new tub lifts that were purchased did not have scales. He/she further revealed that one wheelchair scale that had been purchased, was shared among residents on all five home areas. Co-DOC #116 also stated that the tub lift scale had been broken prior to August 2017, and that the one wheelchair scale was in disrepair in August 2017. He/she further indicated that the home was without a scale to use for a couple of weeks before a new scale had been obtained for the home. Co-DOC #116 further stated that the use of different scales may have contributed to the weight variations. Co-DOC #116 further stated that the home currently uses two wheelchair scales for all residents, and one tub lift scale could be used, but staff mainly use the two wheelchair scales. He/she further indicated that it was unacceptable to have the limited number of scales in the home, as this impacted nursing care, where not all residents had been weighed by the 10th of the month.

Interview with the ESS revealed he/she did not do any scheduled routine, preventive, or remedial services on the wheelchair scale, and was not sure who was responsible for doing the services on the wheelchair scale. He/she further indicated that he/she was not aware that all but one tub lift scale had been working in the home, or that the staff were only using the two wheelchair scales to weigh the residents. The ESS further revealed that staff did not consistently write repair issues in the repair book, but may tell him/her verbally, or put a tag on the item and bring the item to him/her to fix. The ESS further revealed that he/she did not receive any messages verbally or in the repair book regarding any broken wheelchair scales.

Interview with the Administrator revealed that the ESS is responsible for performing scheduled routine, preventive, or remedial services for the wheelchair scales. The Administrator further indicated that the wheelchair scale was purchased in the beginning of 2017, and since then, there had been no schedule or procedure in place for servicing the wheelchair scale.

Interview with the DOC revealed that there were no schedules and procedures in place for routine, preventive and remedial maintenance of the two wheelchair scales in the home. The DOC further indicated that it was the home's expectation for staff to write any

repair issues in the repair book for the ESS, and that the home did not ensure that there was a procedure in place for routine, preventive, and remedial maintenance.

The severity of the non-compliance was potential for actual harm.

The scope of the non-compliance was widespread.

A review of the home's compliance history revealed one or more unrelated non-compliances in the last three years. [s. 90. (1) (b)]

Additional Required Actions:

CO # - 004 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. 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 has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

During stage one of the RQI, resident #001 was triggered related to incidence of continence decline since admission from the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment.

Review of resident #001's written plan of care indicated how the identified care was to be provided to the resident.

An observation conducted on an identified time and day, revealed resident #001 had been provided the identified care by an identified number of PSWs in his/her bedroom. Care was provided contrary to the written plan of care.

Following the above-mentioned observation, interviews with PSW #106 and RPN #107 confirmed that resident #001 had been receiving the identified care with an identified number of staff due to his/her responsive behaviours. RPN #107 further acknowledged that resident #001's written plan of care did not provide clear directions to staff, as it did not reflect the resident's current care needs.

Interview with the DOC acknowledged that resident #001's written plan of care did not set out clear directions to staff and others who provided direct care to the resident. He/she further indicated that the written plan of care should have been reflective of what the resident care was. [s. 6. (1) (c)]

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

During stage one of the RQI, resident #004 was triggered related to abuse.

Interview with resident #004 revealed that an identified staff member was rough with him/her during care and would say shut up and behave yourself. When asked if there was one or two staff assisting, the resident stated just one.

Record review of the resident's current written plan of care revealed that the resident exhibits identified responsive behaviours during care.

Interventions identified to manage the behaviour included having an identified number of staff present during care at all times.

Interview with PSW #125 revealed awareness of the written plan of care intervention of the identified number of staff being present during care and revealed the resident often exhibited responsive behaviours during an identified activity. PSW #125 stated that he/she asks a co-worker to assist in those instances.

PSWs #123 and #118 along with RPN #117, who had provided the resident's care when short staffed, revealed that they provided care to the resident in an identified manner, and had not encountered any recent allegations from him/her.

Interview with the Co-DOC #116 revealed that resident #004's responsive behaviours were still present and that the intervention to provide care with an identified number of staff should have been implemented, and that the care set out in resident's written plan of care had not been provided. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with.

According to O. Reg. 79/10, s. 229 (9), The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.

Review of the home's policy titled "Operation of Homes – Infection Control – Hand Hygiene Program" dated February 16, 2013, indicated the following:

"The Lead for Infection Prevention and Control will:
-Audit the hand hygiene program with use of Just Clean Your Hands (JCYH) observation tool for long term care and use on the spot feedback forms.
-Establish an auditing schedule with key managers and other hand hygiene champions to ensure that hand hygiene is audited on a sample of staff on all shifts in all departments at least monthly using JCYH tools.
-Compile statistics related to hand hygiene program to report at Infection Prevention and Control meeting quarterly".

Interview with the Infection Prevention and Control (IPAC) lead confirmed that he/she had not established an auditing schedule in the home to ensure that hand hygiene had been audited at least monthly. The IPAC lead further indicated that the records of previous audits had been shredded, and he/she had not been compiling statistics related to the hand hygiene program to report at the Professional Advisory Committee (PAC) quarterly meetings. The IPAC lead confirmed that the home's policy on hand hygiene program had not been complied with. [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 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 is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure residents were bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

This inspection had been inspector initiated as a result of staff interviews on an identified HA.

Interviews with PSWs #118, #123 and #124 identified an equipment had been broken since November–December 2016, and that resident #005 had been receiving an identified activity since this time.

Interview with the ESS, revealed he/she was unable to confirm the date when the equipment was broken and removed from use, but identified a time frame of November–December 2016.

Record review of resident #005's current written plan of care indicated he/she was to be assisted to do an identified activity on two identified days of the week.

Interview with PSW #123 revealed that it was well known that resident #005 loved the identified activity, but that staff switched a few residents from their preferences of the identified activity to an alternative activity because they could not accommodate with only one equipment from the other home area.

Interview with PSW #124 stated that resident #005 was fidgety and tried to stand up when the alternative activity was provided, and that it was not his/her preference.

Interview with PSW #118 stated that from offering resident #005 both activities, when the equipment was not broken over the past year, he/she knew resident #005 enjoyed the identified activity. PSW #118 stated he/she could tell that the resident enjoyed the identified activity and was more relaxed.

Interview with RPN #117, revealed when asked what was resident #005's preference, that the resident did not have a preference but that his/her wife would say he/she preferred the identified activity because he/she did it at home.

Interview with resident #005's Substitute Decision-Maker (SDM) confirmed that resident #005 loved the identified activity and always did it at home. The SDM stated he/she was unaware and not informed that the identified equipment in the home had been broken and that the staff were providing an alternative activity to resident #005 since at least December 2016.

Interview with Co-DOC #116 confirmed that resident #005 was not provided the identified activity, at a minimum, twice a week by the method of his or her choice. [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving the Residents' Council advice related to concerns or recommendations

Interview with the Life Enrichment Co-ordinator (LEC)/residents' council assistant, stated that when concerns and recommendations were raised at the residents' council meeting, he/she documented them in the residents' council meeting minutes. He/she revealed that once the minutes were finalized he/she provided a copy of the minutes to each department manager who was to review and provide a response to any department specific concern or recommendation. After a few days if the residents' council assistant did not hear back from the department manager he/she would follow up. At that point the minutes and the written responses would be taken to the president of the residents' council all within 10 days.

Review of the residents' council meeting minutes on three identified dates, revealed concerns and recommendations related to the following: nursing, pharmacy, staffing, laundry, food services, and housekeeping.

Interviews with the ESS, FSS, and the Co-DOC confirmed that responses had not been provided related to the concern or recommendation of their departments.

The LEC/residents' council assistant confirmed that a written response had not been provided within 10 days of receiving Residents' Council advice related to concerns and recommendations. [s. 57. (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 if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction had been: (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's SDM, if any, and the resident's attending physician.

As part of the RQI, the home's medication incidents within the last three months from the first date of the inspection had been reviewed.

Review of the home's policy titled "Resident Rights, Care and Services – Medication Management" dated July 20, 2017, indicated that "Upon identification of a medication error, the individual identifying the error will:
-Assess the resident for any signs and symptoms of reaction to the error.
-Notify the physician of the error, and prepare for transfer to hospital for further assessment if warranted.
-Notify the resident and the resident's SDM of the medication incident.
-Report the identified medication incident to the Attending Physician, Director of Care, Pharmacist, Resident and SDM.
-Initiate and complete the internal medication incident report.
-Forward the completed internal medication incident report to the Director of Care, Attending Physician and Pharmacist.
-Document in the progress notes the status of the resident, actions taken and further follow up action to be taken".

Interview with RPN #100 stated that when a medication incident occurred, the registered

staff who discovered the error would assess and monitor the resident, notify the resident and/ or the SDM, and the physician. The registered staff would fill out the medication incident report, fax it to the pharmacy and give the form to the DOC. He/ she further indicated that all of the details surrounding the medication incident would be documented in the progress notes and on the medication incident form.

A review of the home’s medication incidents from July to September 2017, did not identify any documentation of the immediate actions taken to assess and maintain the resident's health, for medication incidents involving the following residents: Residents #002, #004, 010, #016, #017, #018, #019, #020, #021, #022, #025, #027, and #028.

Review of the following medication incident reports and progress notes did not identify any documentation that the resident and/ or SDM and/ or the physician had been notified of the medication incidents involving the following residents: Residents #016, #018, #024, #025, #026, #027, and #028.

There was no information obtained to indicate that the above mentioned medication incidents resulted in adverse effects.

During an interview, the inspector and the DOC reviewed the above mentioned medication incident reports. The DOC acknowledged the discrepancies and the lack of documentation of the immediate actions taken to assess and maintain the residents' health and records of notification to the appropriate individuals, following the medication incidents. The DOC further acknowledged that assessments should have been documented on the medication incident report or the progress notes, and that the residents and/ or their SDM, and the attending physician should have been notified of the medication incidents as required. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #10: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A medication administration observation was carried out on an identified time and day, on an identified HA. Inspector #653 observed RPN #100 administer medications to residents #008, #009, and #010 consecutively. The inspector observed that RPN #100 did not perform hand hygiene before and after administering resident #008 and #009's medications and in-between resident #009 and #010's medication pass. Interview with RPN #100 confirmed the above mentioned observations, and he/she confirmed that the home's expectation was for registered staff to perform hand hygiene before and after administering medications to each resident.

Interview with the DOC confirmed that the home's expectation was for registered staff to perform hand hygiene in-between residents when administering medications, as part of the implementation of the infection prevention and control program in the home. [s. 229. (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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 16th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROMELA VILLASPIR (653), DIANE BROWN (110), IVY LAM (646)
Inspection No. / No de l'inspection :	2017_486653_0019
Log No. / No de registre :	022979-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 3, 2017
Licensee / Titulaire de permis :	ORILLIA LONG TERM CARE CENTRE INC. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	LEACOCK CARE CENTRE 25 MUSEUM DRIVE, ORILLIA, ON, L3V-7T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracy Muchmaker

To ORILLIA LONG TERM CARE CENTRE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Order / Ordre :

Upon receipt of this order the licensee shall: prepare, submit, and implement a plan that includes the following requirements and the person responsible for completing the tasks:

1. Within 10 days of receiving this order, the Licensee shall conduct a review and include appropriate disciplines to identify the type and number of scales required in the home to meet the home's policy of accurately weighing residents by the 10th of each month. Minutes from the meeting shall be available to the inspector upon request.

2. The Licensee shall provide for the type and number of scales identified as being required and onsite by the date of compliance.

3. The home shall develop a policy and procedure for preventive maintenance (PM) of all scales in the home. The policy shall include identification of who is responsible for PM and how often scales are serviced and calibrated.

The plan is to be submitted to ivy.lam@ontario.ca by November 17, 2017, and implemented by February 2, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that supplies, equipment and devices were readily available to meet the nursing and personal care needs of the residents.

During stage one of the Resident Quality Inspection (RQI), residents #005 and #006 were triggered related to having low body mass index (BMI) and weight loss.

Record review of resident #005's weight history revealed he/she experienced significant weight changes. Further record review of the resident's weight history identified missing weights for three identified months.

Record review of resident #006's weight history revealed he/she experienced significant weight changes. Further record review of the resident's weight history identified missing weights for four different months.

Interviews with Personal Support Worker (PSW) #122 and Registered Nurses (RNs) #105 and #113 revealed that the scales in the home had been broken in December 2016. PSWs #121 and #122 revealed that one wheelchair scale had been shared by all home areas, which limited the days on which residents had been weighed, and some residents had not been weighed by the 10th of the month, as per the home's expectation.

Interview with Co-Director of Care (Co-DOC) #116 revealed that the home's tub lift scales had been broken following November 2016, and that the new tub lifts that were purchased did not have scales. He/she further revealed that one wheelchair scale that had been purchased, was shared among residents on all five home areas. Co-DOC #116 also stated that the tub lift scale had been broken prior to August 2017, and that the one wheelchair scale was in disrepair in August 2017. He/she further indicated that the home was without a scale to use for a couple of weeks before a new scale had been obtained for the home. Co-DOC #116 further stated that the use of different scales may have contributed to the weight variations.

Interview with the Food Service Supervisor (FSS) revealed that since the weight had not been always completed by the 10th of the month, this did not consistently provide a 30-day gap to determine if it was an accurate significant weight change from month to month.

Interview with the RD revealed that he/she could not depend on the accuracy or reliability of the weights done in the home. The RD further revealed that weight was an important factor for the assessment of residents, and was used to determine if additional nutrition and nursing interventions were needed for the residents. He/she further indicated that due to the inaccurate weights, he/she was unable to determine the effectiveness of nutrition interventions in place, or whether additional interventions were required for residents, and this affected

the care of the residents.

Interview with the DOC revealed that weight management meetings have become part of the home's high risk rounds. Review of the home's monthly weight exception meeting report form for the weight exception meetings attended by the RD, FSS, and DOC in January, February, and April, 2017, revealed that the RD has commented that the scales have not been taking residents' weights properly, that he/she queried the accuracy of weight records for residents, and that different scales have been used to take the residents' weights.

Interview with Co-DOC #116 revealed that the home currently uses two wheelchair scales for all residents, and one tub lift scale could be used, but staff mainly use the two wheelchair scales. He/she further indicated that it was unacceptable to have the limited number of scales in the home, as this impacted nursing care, where not all residents had been weighed by the 10th of the month.

Interview with the Director of Care (DOC) revealed weight management was part of the high risk meetings in the home, and that the home needed to tighten the weight management process to ensure that weight scale equipments and devices were readily available in the home to meet the nursing and personal care needs of the residents. (646)

2. This inspection had been inspector initiated as a result of staff interviews on an identified Home Area (HA).

Interviews with PSWs #118, #123 and #124 identified an equipment had been broken since November–December 2016, and that resident #005 had been receiving an identified activity since this time.

Interview with the Environmental Service Supervisor (ESS), revealed he/she was unable to confirm the date when the equipment was broken and removed from use, but identified a time frame of November–December 2016.

The ESS revealed that prism medical is the company and service provider for the home's identified equipments. Record review revealed a checklist dated May 9, 2017, indicating that the equipment did not pass inspection and the notes revealed that it was to be replaced and the client was waiting for a quote from

prism medical. The checklist was signed by the DOC.

Interview with front line staff confirmed that the broken equipment for approximately 10 months had a negative impact on meeting resident's personal care needs.

Interview with Co-DOC #116 revealed that a new equipment for the identified HA was on the capital equipment budget for 2016, as it was old. He/she stated that once the equipment had been broken, the process took longer than it should have and confirmed that the broken equipment impacted care for some residents.

The severity of the non-compliance was potential for actual harm.

The scope of the non-compliance was a pattern.

A review of the home's compliance history revealed one or more unrelated non-compliances in the last three years. (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 02, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

Upon receipt of this order the licensee shall: prepare, submit, and implement a plan that includes the following requirements and the person responsible for completing the tasks:

1. Within 30 days of receiving this order, all PSWs and registered staff shall be provided education on the home's weight monitoring policy and the importance of weight monitoring for an accurate nutrition assessment.

2. The Licensee shall maintain a record of staff names and signatures acknowledging their attendance at the training, and understanding of the home's weight monitoring policy.

3. Within 10 days of all required scales being on site, all residents should have a new baseline weight taken, along with weighing of any equipment that would affect the residents' weights (e.g., wheelchair, walker), in addition to their monthly weight.

The plan is to be submitted to ivy.lam@ontario.ca by November 17, 2017, and implemented by February 2, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that the nutrition care and hydration program included a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

During stage one of the RQI, residents #005 and #006 were triggered related to having low BMI and weight loss.

Record review of resident #005's weight history revealed he/she experienced significant weight changes. Further record review of the resident's weight history identified missing weights for three identified months.

Record review of resident #006's weight history revealed he/she experienced significant weight changes. Further record review of the resident's weight history identified missing weights for four different months.

Interviews with PSW #122 and RNs #105 and #113 revealed that the scales in the home had been broken in December 2016. PSWs #121 and #122 revealed that one wheelchair scale had been shared by all home areas, which limited the

days on which residents had been weighed, and some residents had not been weighed by the 10th of the month, as per the home's expectation.

Interview with Co-DOC #116 revealed that the home's tub lift scales had been broken following November 2016, and that the new tub lifts that were purchased did not have scales. He/she further revealed that one wheelchair scale that had been purchased, was shared among residents on all five home areas. Co-DOC #116 also stated that the tub lift scale had been broken prior to August 2017, and that the one wheelchair scale was in disrepair in August 2017. He/she further indicated that the home was without a scale to use for a couple of weeks before a new scale had been obtained for the home. Co-DOC #116 further stated that the use of different scales may have contributed to the weight variations.

Interview with the DOC revealed that the home's expectation was for residents' weights to be done monthly, and that residents #005 and #006 should have been weighed every month.

The severity of the non-compliance was potential for actual harm.

The scope of the non-compliance was a pattern.

A review of the home's compliance history revealed one or more unrelated non-compliances in the last three years. (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 02, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. 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.

Order / Ordre :

Upon receipt of this order the licensee shall: prepare, submit, and implement a plan that includes the following requirements and the person responsible for completing the tasks:

1. Within 10 days of receiving this order the Licensee shall conduct a review and include the appropriate disciplines to determine the home's process for ensuring that nursing staff, as part of an interdisciplinary approach, have clear roles and responsibilities in assessing residents with the following weight changes 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.

2. A copy of the meeting minutes shall be available upon request by the inspector.

3. Modify the home's policy titled, 'Monthly weights and weight variance report' (revised date 2014-11-04) to ensure that the nursing role and responsibilities are clearly identified.

4. The Licensee shall provide education to all registered nursing staff on their role and responsibilities for assessing residents with weight changes.

5. The Licensee shall maintain a record of registered nursing staff names and signatures acknowledging their understanding of their role in assessing residents with weight changes.

6. Upon reweighs of all residents the RD shall identify ALL residents who have experienced an unplanned weight change as follows:
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.

The home shall reassess the changes in weight using an interdisciplinary approach, with a nursing assessment, including actions taken and outcomes monitored.

7. The home shall maintain a record of the residents who were identified with weight changes and had been reassessed.

The plan is to be submitted to ivy.lam@ontario.ca by November 17, 2017, and implemented by February 2, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were 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.

During stage one of the RQI, resident #002 was triggered related to eating decline since the resident's admission to the home.

Record review of resident #002's weight history revealed he/she experienced significant weight changes.

Review of the home's policy titled, 'Monthly weights and weight variance report' (revised date 2014-11-04) indicated that the weight monitoring system shall ensure that actions are taken and outcomes evaluated for:
-A change of 5% of body weight, or more, over one month
-A change of 7.5 % of body weight, or more, over three months
-A change of 10 % of body weight, or more, over 6 months.

The policy further stated that the registered staff will ensure that monthly weights are completed and documented by the 10th of each month, and will complete dietary referral for those residents with significant weight changes.

The policy also revealed that the DOC or delegate, lead a monthly weight management meeting to facilitate interdisciplinary assessment, action and outcome of residents with significant weight change, as detailed above.

Review of the weight variance assessment in resident #002's progress notes revealed the RD's assessment, but did not reveal any assessment from nursing or other disciplines, and there were no referrals for resident #002's significant weight change.

Interviews with RNs #105 and #113 revealed that the RD assesses resident weights and the weight variance on his/her own, and that registered staff do not refer residents to the RD for significant weight changes.

Interview with the DOC revealed that weight management meetings have become part of the home's high risk rounds.

Interview with the RD revealed that he/she assesses weight variances on his/her own, and had to investigate the reason for the weight change on his/her own. The RD further revealed that the high risk rounds and monthly weight management meetings had not been helpful as they were done after significant weight changes had already occurred, and was done with management rather than with direct care staff who had a better idea of what was going on with the residents.

Interview with the DOC revealed that review of past weight management meetings revealed that the notes were only from the RD's assessments and did not include any nursing assessment, and that dietary referral was not completed when resident #002 experienced significant weight change. He/she further

revealed that the home did not assess residents' weight changes using an interdisciplinary approach for residents with significant weight changes. (646)

2. During stage one of the RQI, residents #005 and #006 were triggered related to having low BMI and weight loss.

Record review of resident #005's weight history revealed he/she experienced significant weight changes. Further record review of the resident's weight history identified missing weights for three identified months.

Record review of resident #006's weight history revealed he/she experienced significant weight changes. Further record review of the resident's weight history identified missing weights for four different months.

Review of resident #005 and #006's progress notes and assessments revealed that the RD did not receive a dietary referral for their significant weight changes.

Interviews with RNs #105 and #113 revealed that the RD assesses resident weights and the weight variance on his/her own, and that registered staff do not refer residents to the RD for significant weight changes.

Interview with the DOC revealed that weight management meetings have become part of the home's high risk rounds.

Interview with the RD revealed that he/she assesses weight variances on his/her own, and had to investigate the reason for the weight change on his/her own. The RD further revealed that the high risk rounds and monthly weight management meetings had not been helpful as they were done after significant weight changes had already occurred, and was done with management rather than with direct care staff who had a better idea of what was going on with the residents.

Interview with the DOC revealed that review of past weight management meetings revealed that the notes were only from the RD's assessments and did not include any nursing assessment, and that dietary referral was not completed when residents #005 and #006 experienced significant weight changes. He/she further revealed that the home did not assess residents' weight changes using an interdisciplinary approach for residents with significant weight changes.

The severity of the non-compliance was potential for actual harm.

The scope of the non-compliance was widespread.

A review of the home's compliance history revealed one or more unrelated non-compliances in the last three years. (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 02, 2018

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

Upon receipt of this order the licensee shall: prepare, submit, and implement a plan that includes the following requirements and the person responsible for completing the tasks:

1. The Administrator has expressed that the ESS is responsible for scheduled routine, preventative, or remedial services for the wheelchair scales. The Licensee shall confirm that the contracted service for environmental services includes the scheduled routine, preventative, or remedial services for the wheelchair scales. Confirmation shall be provided by way of a written agreement of understanding or contract.

2. Education training shall be provided to all PSWs and registered staff on the home's expectation and policy for staff to write any repair issues in the repair book for the ESS. The Licensee shall maintain a record of staff names and signatures acknowledging their understanding of the process.

3. Training and identified resources for technical support shall be provided to the ESS on the routine, preventative, or remedial services for the specific wheelchair scales used by the home.

4. A record of the training and resources shall be available to the inspector.

The plan is to be submitted to ivy.lam@ontario.ca by November 17, 2017, and implemented by February 2, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that, as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were schedules and procedures in place for routine, preventive and remedial maintenance.

During stage one of the RQI, residents #005 and #006 were triggered related to having low BMI and weight loss.

Review of the home's policy titled "Acquiring Maintenance: Repair Books and Software" (Revised date: October 2016), revealed that the repair books are for the use of all employees. Furthermore, the policy revealed that when a worker notices a needed repair they should list as much information as possible in the appropriate repair book; maintenance workers are to check the repair books

daily as a part of their regular routine; and repairs are to be completed and documented as soon as possible.

Review of the checklist of routine checking of lifts included checking of sit-stand lifts and tub lifts, but did not specify which lifts had scales. Review of the ESS' Daily Recording, Preventative Maintenance tasks, and the Monthly Preventive Maintenance checklist did not include checking of the wheelchair scale.

Interviews with PSW #122 and RN #105 and #113 revealed that the scales in the home had been broken in December 2016. Registered Practical Nurse (RPN) #120 further revealed that the wheelchair scale had been broken since September 2017, but it was not written in the repair book for the ESS, and that he/she did not notify the ESS. PSWs #121 and #122 revealed that one new wheelchair scale had been shared by all home areas. RPN #120 revealed that the staff did not use the tub scale, but only use the two wheelchair scales, to minimize weight variations.

Interview with Co-DOC #116 revealed the home's tub lift scales had been broken following November 2016, but the new tub lifts that were purchased did not have scales. He/she further revealed that one wheelchair scale that had been purchased, was shared among residents on all five home areas. Co-DOC #116 also stated that the tub lift scale had been broken prior to August 2017, and that the one wheelchair scale was in disrepair in August 2017. He/she further indicated that the home was without a scale to use for a couple of weeks before a new scale had been obtained for the home. Co-DOC #116 further stated that the use of different scales may have contributed to the weight variations. Co-DOC #116 further stated that the home currently uses two wheelchair scales for all residents, and one tub lift scale could be used, but staff mainly use the two wheelchair scales. He/she further indicated that it was unacceptable to have the limited number of scales in the home, as this impacted nursing care, where not all residents had been weighed by the 10th of the month.

Interview with the ESS revealed he/she did not do any scheduled routine, preventive, or remedial services on the wheelchair scale, and was not sure who was responsible for doing the services on the wheelchair scale. He/she further indicated that he/she was not aware that all but one tub lift scale had been working in the home, or that the staff were only using the two wheelchair scales to weigh the residents. The ESS further revealed that staff did not consistently

write repair issues in the repair book, but may tell him/her verbally, or put a tag on the item and bring the item to him/her to fix. The ESS further revealed that he/she did not receive any messages verbally or in the repair book regarding any broken wheelchair scales.

Interview with the Administrator revealed that the ESS is responsible for performing scheduled routine, preventive, or remedial services for the wheelchair scales. The Administrator further indicated that the wheelchair scale was purchased in the beginning of 2017, and since then, there had been no schedule or procedure in place for servicing the wheelchair scale.

Interview with the DOC revealed that there were no schedules and procedures in place for routine, preventive and remedial maintenance of the two wheelchair scales in the home. The DOC further indicated that it was the home's expectation for staff to write any repair issues in the repair book for the ESS, and that the home did not ensure that there was a procedure in place for routine, preventive, and remedial maintenance.

The severity of the non-compliance was potential for actual harm.

The scope of the non-compliance was widespread.

A review of the home's compliance history revealed one or more unrelated non-compliances in the last three years. (646)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 02, 2018

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 3rd day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Romela Villaspir

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