Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 15, 2014	2014_283544_0028	S-000349-14	Resident Quality Inspection

Licensee/Titulaire de permis

584482 ONTARIO INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

MANITOULIN LODGE
3 MAIN STREET P. O. BOX 648 GORE BAY ON P0P 1H0

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

FRANCA MCMILLAN (544), MARGOT BURNS-PROUTY (106), MARINA MOFFATT (595), MONIKA GRAY (594)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 15, 16, 17, 18, 19, 22, 23, 24, 25, 26, 2014 related to

Log # S-000282-14
Log # S-000349-14
Log # S-000421-14
Log # S-000593-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Staff, Health Care Aides (HCAs), Personal Support Workers (PSWs), Maintenance/ Housekeeping/Laundry Staff, Food Service Supervisor, Dietary Staff, RAI/MDS/Staff Education/Resident Admissions Co-ordinator, Activity/Volunteer Co-ordinator, President of Residents' Council, Chairperson of Family Council, Residents and Families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

11 WN(s)
3 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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. Inspector # 594 reviewed a Complaint Log.

A previous compliance order related to the Long-Term Care Home Act, s. 19 (1) was issued in Inspection # 2014_376594_0005 with a compliance date of July 25, 2014.

The licensee was ordered to prepare, submit and implement a plan for achieving compliance to ensure that residents are protected from abuse by staff.

The licensee had written that Staff # 120 would meet with Staff # 101 on a weekly basis for four weeks to discuss work performance. Staff # 120 was also to create a learning plan. Inspector # 594 reviewed Staff # 120's personnel file and found only two documented meetings to discuss Staff # 120's work performance. Staff # 101 confirmed that only two meetings occurred with Staff # 120 and they were documented. Staff # 120 has still refused to submit a learning plan.

The compliance order was re-issued during a Complaint Inspection with a compliance date of September 17, 2014.

The order stated that "the licensee shall ensure a criminal reference check is completed and provided to the home prior to the licensee hiring a staff member or accepting a volunteer and shall ensure that education on the home's abuse policy is provided to all staff."

The order stated that "the licensee shall ensure all staff be trained on the home's abuse policy by September 17, 2014. Inspector #594 reviewed staff education/training attendance records and identified 16 staff did not complete the mandatory Prevention of Abuse Policy prior to the compliance date of September 17, 2014. This was confirmed

by Staff # 100.

Inspector # 594 completed a follow-up Log which was conducted during this Resident Quality Inspection.

Despite the home's attempt to address the abuse issues with Staff # 120 and ensure all staff were educated/trained in regards to the home's abuse policy, the staff education and the plan submitted by the home was not completed by the compliance date.

Resident # 985 brought forward a new incident of Abuse to Inspector # 594 during the Resident Quality Inspection.

Inspector # 594 interviewed Resident # 985 twice. Resident #985 told Inspector # 594 that Staff # 120 was "being loud and rude" and "gets me worked up." Resident #985 also confirmed and stated that, "I felt intimidated, belittled and Staff # 120 diminished my dignity."

Inspector # 594 reported this immediately to Staff # 100.
Staff # 120 was immediately sent home pending the completion of an investigation by the home.
A Critical Incident Report was sent to the Director by the home and was reviewed by Inspector # 594.

Staff # 100 told Inspector # 544 that Staff # 120 may be terminated at this time since another complaint had now come forward. Staff # 120 still has refused to submit a learning plan to the home.

The licensee has failed to ensure that Residents are protected from abuse by staff in the home. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. Inspector #106 reviewed the Kardex and the written care plan document for Resident #934. They both had the following interventions, "Porter Resident #934 to meals. Take their walker to the dining room as well so they can use it to walk to the bathroom and back to their room if they choose to walk by themselves." Under mobility, it is written, "MOBILITY - totally dependent in wheelchair for all mobility needs." These interventions contradict each other and do not provide clear direction regarding the mobility requirements for Resident #934.

The licensee failed 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. [s. 6. (1) (c)]

2. Inspector # 595 identified in the RAI/MDS assessment that Resident # 964 required assistance with bed mobility. It was noted that there was no focus, goals or interventions identified specifically on bed mobility in either Resident # 964's care plan or kardex. It was confirmed by Staff #116 and Staff #119 that Health Care Aides (HCAs), use the Kardex to find information on Resident health care needs. There was no direction in regards to Resident # 964's bed mobility.

The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to Resident #964. [s. 6. (1) (c)]

3. Inspector #594 reviewed the health care record for Resident # 978 which identified the

presence of a wound that required clinical intervention. The Treatment Administration Record (TAR), included an order for registered staff to provide wound care treatment once per day and on an as required basis (prn). However, the care plan outlined that treatment for this wound was to be provided every three days and on an as required basis. Inspector # 594 interviewed Staff # 108 who confirmed that the wound care treatment was completed every three days or on an as required basis

Resident # 978's care plan also identified the presence of another wound. Inspector # 594 interviewed Staff # 121, 108 and Staff # 101 and they confirmed that Resident # 978 did not have a wound on the area that was indicated. Inspector # 594 interviewed Resident # 978 and could not find a wound on the area that was indicated.

It was identified in Resident # 978's progress notes that Resident # 978 had another new wound that had developed. There was no focus, goals or intervention regarding this new wound. There was no clear direction on the care plan in regards to the treatment of this new wound for Resident # 978.

The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the Resident # 978. [s. 6. (1) (c)]

4. Inspector # 106 asked four (4) Personal Support Workers (PSWs) if they could access the Residents' plans of care and have convenient and immediate access to them. All four (4) PSWs indicated, to the Inspector, that they only have access to the Residents' Kardex through Point of Care (POC), in Point Click Care (PCC).
Inspector # 106 reviewed Resident # 934's Kardex and written plan of care and found that there were many areas of the written plan of care that were not captured in the Kardex. In the section regarding risk of falls, in the written plan of care document, only one (1) of the four (4) interventions listed, was found in the Kardex document.

The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. [s. 6. (8)]

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. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. Inspector # 595 interviewed Residents and families. They told Inspector # 595 that many times there was insufficient staffing to care for Residents in the home. Inspector # 595 interviewed Staff # 100 and Staff # 101 who confirmed that the home did not have a formal plan or a written plan outlining the home's process for a back-up plan when the home is short staffed and staff call in sick.

The licensee has failed to ensure that the staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector # 594 reviewed Resident # 978's health care record and identified a progress note in which the Resident complained that they had pain due to a wound. It was noted that in the morning, 11 days after the initial identification of the wound, staff provided treatment to the wound without documentation of an assessment. Later that day, staff conducted an assessment of the wound and physician orders were implemented.

Review of policy Resident Rights, Care and Services – Required Programs – Skin and

Wound Care - Point Click Care (PCC)- Wound Assessment and Treatment dated September 16, 2013 stated, "The Wound Assessment and Treatment assessment shall be completed for a resident at the time of any impairment of skin integrity including pressure ulcer, vascular ulcer, bruising , skin tear, scar, surgical incision, burn, rash, subcutaneous or IV port, blister, etc. It will also be completed for any change in treatment for that impairment."

The licensee has failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound. [s. 50. (2) (b) (i)]

2. Inspector # 594 reviewed Resident # 978's health care record for the period of six (6) months and identified the onset of three different wounds.
The onset of one wound was not reassessed again until three weeks later and then again a reassessment was not completed until two weeks later. Another reassessment was not completed until three weeks later.
In a continual pattern, to the present time, the wound was not reassessed until a further two weeks had elapsed.

Resident # 978 developed another wound. Inspector # 544 could not find any documentation on Resident # 978's health care record of re-assessments that were completed after the initial wound was assessed.

Resident # 978 developed a third new wound that was identified. Inspector # 544 could not find any further documentation of re-assessments on Resident # 978's health care record or treatment administration record of this wound.

Inspector # 594 reviewed the home's policy, Resident Rights, Care and Services – Required Programs – Skin and Wound Care – Program dated September 16, 2013 which stated, "the skin and wound care program shall ensure that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated."

The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2)

(b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity receives a skin assessment by a member of the registered staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Inspector # 595 and Inspector # 544 observed for several days that the incorrect Weekly menu was posted near the dining room. The posted Weekly menu was for Week 4. The next week, the posted Weekly menu was for Week 1. Staff # 115 confirmed that these Weekly menu cycles were incorrect and had not been changed. They also confirmed that they are the only person who changes the Weekly menus on the menu board.

The licensee has failed to ensure that weekly menus are communicated to residents. [s. 73. (1) 1.]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector # 544 observed two (2) computer monitors, on which the Health Care Aides document, were left opened and were not in the locked position. Several Residents names were visible on both screens. These monitors were located between Resident's rooms. Anyone could access any Resident's personal health information simply by touching the screen. Residents and families were walking down the hall to the dining room to prepare for the dinner meal. This was confirmed by Staff # 117.

Inspector # 544 again observed, on another day, a computer monitor was not in the locked position in the hallway. Resident names were visible on the screen. Residents and families were walking in the hallways at this time.

The licensee did not ensure that rights of residents were fully respected and promoted. Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act. [s. 3. (1) 11. iv.]

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. Inspector # 594 reviewed the home's "Medication Administration Records (MAR), Treatment Administration Records (TAR) and Policy # 4.1, Revision date March 2009." It is written, "all medications which are administered to a resident must appear on that Resident's MAR/TAR sheet and be supported with a physician's order and that a MAR/TAR is a legal document which represents a record of all medications administered to a Resident within a one month period of time."

Inspector # 594 reviewed Resident #978's progress notes in Point Click Care. It was identified that staff documented wound care treatments in the progress notes however, it was not documented in the MAR/TAR. There were several days, during the month, a note was documented in Resident # 978's progress notes but there were no sign-off initials in the MAR/TAR. It was confirmed by Staff # 101 that staff should sign-off in the TAR whenever a wound care treatment was completed.

Inspector # 594 reviewed the home's policy titled, "Resident Rights, Care and Services – Required Programs – Skin and Wound Care – Program Effective Date September 16, 2013." It is written, "Registered Staff will ensure that all residents receive a head to toe skin assessment (on Point Click Care under assessments) as part of completion of section L and M of RAI-MDS." Health care record review for Resident # 978, on Point Click Care under assessments, identified two head to toe assessments completed, one in 2011 and the other in 2012. Resident # 978's most recent RAI-MDS assessment was completed two months ago.

Review of the home's policy titled Resident Rights, Care and Services – Required Programs – Skin and Wound Care – Program Effective Date September 16, 2013 stated, "with actual alteration in skin integrity registered staff are to complete wound assessment and treatment record in Point Click Care (PCC), under assessments, completed with initiation of impaired skin integrity and any change in treatment." Review of Resident # 978's health care record identified a wound. Inspector # 594 was unable to locate a wound care assessment record in PCC. Review of Skin Care Referral Summary failed to indicate a date or confirm a date of the wound assessment and treatment completion.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with. [s. 8. (1) (a),s. 8. (1) (b)]

WN #8: 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. Inspector # 595 observed for several days that Resident # 964 and Resident # 985 had one or two bed rails in the "up" position on their bed.
Inspector # 595 interviewed Staff # 101 and Staff # 100 who confirmed that the home did not use a formal bed rail assessment tool to assess Resident bed rail needs.

Inspector # 595 spoke with Staff # 104 who confirmed that they would use the Restorative Assessment tool to assess the need for bed rails however, the tool does not have a specific section for bed mobility or bed rails. It was confirmed by Staff # 104 that it was used as a vague guideline to determine the need for bed rails. Staff # 104 would also observe the Resident's bed mobility, including lying-sitting, sitting-lying, rolling left/right and moving up in bed. It was confirmed by Staff # 104 that these assessments were not documented. The home was now started implementing a Bed Mobility Assessment Tool however, only four Residents have been assessed at this time.

Inspectors # 106 and # 595 spoke to Staff # 100 who confirmed that the home has not used a formal assessment for bed rail use until recently and only four Residents have been assessed using the Bed Mobility Assessment Tool.

The licensee has failed to ensure that where bed rails are used, the resident 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. [s. 15. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. Inspector # 595 reviewed the home's air temperature audits from December 2013, January, February, June, July and August 2014. Temperatures are checked on each wing, each shift in a resident room. The following number of audits were below 22 degrees Celcius:

Dec 2013 - 98 audits, 1 audit not completed
Jan 2014 - 92 audits, 2 audits not completed
Feb 2014 - 66 audits
June 2014 -77 audits
July 2014 -87 audits
Aug 2014 - 74 audits, 3 audits not completed

Inspector # 595 spoke with Staff # 100 who confirmed that when staff were checking the room temperatures, they were expected to ask the Resident if they were comfortable. If the Resident was uncomfortable with the temperature, staff were to adjust the thermostat and recheck the room temperature in one hour. If the Resident stated that they were comfortable with the temperature, regardless if it was below 22 degrees Celcius, staff were to document this. It was confirmed by Staff # 100 that no documentation was available in the audits to determine if any interventions were implemented to correct low or uncomfortable temperatures.

The licensee has failed to ensure that the temperature in the home is maintained at a minimum of 22 degrees Celsius. [s. 21.]

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

Specifically failed to comply with the following:

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

s. 87. (3) The licensee shall ensure that a sufficient supply of housekeeping equipment and cleaning supplies is readily available to all staff at the home. O. Reg. 79/10, s. 87 (3).

Findings/Faits saillants :

1. A tour of the home was conducted by Inspector # 544 on the initial day of the Inspection and Inspector # 544 also conducted a daily walk- through the home during the course of the Inspection. It was identified that the home exhibited signs of offensive odours that were not being managed.

Inspector # 544 also toured the home with Staff # 111 and it was identified by Inspector # 544 and confirmed by Staff # 111, that several rooms had strong offensive odours of urine. These odours could also be detected in the hallway before entering the rooms.

One room had a strong offensive odour of urine in the bathroom. The bottom of the toilet bowl, in this room, was wet with urine and the urine was seeping under the laminate flooring. A black ring of debris was noted around the base of the toilet bowl, the laminate flooring was discoloured and lifting slightly.

Staff # 111 confirmed that the home's chemical supplier had suggested a powder that could be purchased to assist with these odours. Staff # 111 was going contact the supplier in regards to this powdered chemical. Staff # 111 was also going to ask Maintenance staff to assist with cleaning the black debris and apply a new bead of caulking around the toilet bowl to stop the seepage of urine under the laminate flooring.

In a family interview, Resident # 940's family member confirmed that when the family would visit, the urine odour could be detected in the hallway before entering Resident # 940's room. The odour was more pronounced in the room. The family member confirmed that this urine odour had been present for a long period of time.

The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours [s. 87. (2) (d)]

2. Inspector # 544 observed that privacy curtains, in Resident's rooms, were stained. Inspector # 544 interviewed Staff # 118 who stated that there were no extra privacy curtains in the home to replace the ones that were dirty or stained. Staff # 118 told Inspector that, privacy for the Residents became an issue when the privacy curtains were to be removed for washing.

Privacy curtains in another room were soiled and stained with grease and black marks. According to Staff # 118, these privacy curtains needed to be replaced.
Staff # 118 stated replacement curtains were needed in order to perform their duties better and maintain the Resident's privacy when care was being provided.

The licensee has failed to ensure that there is sufficient supply of housekeeping equipment readily available to all staff of the home. [s. 87. (3)]

WN #11: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

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

Findings/Faits saillants :

1. Inspector # 544 observed Staff # 117 administering a medication pass to five (5) Residents.
Inspector identified that Staff # 117 did not sanitizing or wash their hands in between Residents contact who were receiving medications.
Staff # 117 was also re-positioning Residents, giving them extra fluids to drink and raising and lowering the head of Resident's beds during this medication administration pass. Inspector # 544 observed that Staff # 117 did not wash their hands once during these activities.

Inspector # 544 again observed a medication pass on on the afternoon shift by Staff # 117 and identified the administration of medications to five (5) different Residents.
Staff # 117 did not wash their hands or sanitizing their hands after administering medications to three (3) Residents
After the third Resident, Staff # 117 stated that they was allergic to the hand sanitizer and washed their hands at the sink.
Staff # 117 then prepared a Residents' insulin pen dosage, took the Resident's glucose level with a glucometer (put gloves on for this task) and then gave the Resident their insulin dosage via an insulin pen. Staff # 117 then used the hand sanitizer, after they

stated to the Inspector, they was allergic to the the sanitizer.
During one task, to a Resident, Staff # 117 put on gloves and did not wash or sanitize their hands after removing the gloves.

The licensee failed to ensure that all staff participate in the implementation of the Infection Control and Prevention Program. [s. 229. (4)]

2. Inspector # 595 reviewed Resident # 949 and Resident # 3016's health care record for immunization status. It was noted that Resident # 949 did not receive Step 1 of TB skin test for eleven (11) months after their admission and Step 2 was completed a month later.

It was noted that Resident # 3016 did not receive any TB skin testing or a chest x-ray before or after their admission. This was confirmed by Staff # 101.

The licensee has failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission. [s. 229. (10) 1.]

3. Inspector # 595 reviewed Resident # 3016's health care record. It was noted that Resident # 3016 did not receive immunization against tetanus or diphtheria, nor was it indicated that the immunization was offered. This was confirmed by Staff # 101.

The licensee has failed to ensure that residents are offered immunizations against tetanus and diphtheria. [s. 229. (10) 3.]

Issued on this 15th day of December, 2014

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	FRANCA MCMILLAN (544), MARGOT BURNS-PROUTY (106), MARINA MOFFATT (595), MONIKA GRAY (594)
Inspection No. / No de l'inspection :	2014_283544_0028
Log No. / Registre no:	S-000349-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 15, 2014
Licensee / Titulaire de permis :	584482 ONTARIO INC 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	MANITOULIN LODGE 3 MAIN STREET, P. O. BOX 648, GORE BAY, ON, P0P-1H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DEBBIE WRIGHT

To 584482 ONTARIO 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) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_376594_0008, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. Inspector # 594 reviewed a Complaint Log

A previous compliance order related to the Long-Term Care Home Act, s. 19 (1) was issued in Inspection # 2014_376594_0005 with a compliance date of July 25, 2014.

The licensee was ordered to prepare, submit and implement a plan for achieving compliance to ensure that residents are protected from abuse by staff.

The licensee had written that Staff # 120 would meet with Staff # 101 on a weekly basis for four weeks to discuss work performance. Staff # 120 was also to create a learning plan. Inspector # 594 reviewed Staff # 120's personnel file and found only two documented meetings to discuss Staff # 120's work performance. Staff # 101 confirmed that only two meetings occurred with Staff # 120 and they were documented. Staff # 120 still refused to create and submit a learning plan.

The compliance order was re-issued in Inspection # 2014_376594_0008 on September 10, 2014 during a Complaint Inspection with an order compliance date.

The order stated that "the licensee shall ensure a criminal reference check is completed and provided to the home prior to the licensee hiring a staff member or accepting a volunteer and shall ensure that education on the home's abuse policy is provided to all staff."

The order stated that "the licensee shall ensure all staff be trained on the home's abuse policy ." Inspector #594 reviewed staff education/training attendance records and identified 16 staff did not complete the mandatory training on the Prevention of Abuse Policy prior to the compliance date. This was confirmed by Staff # 100.

Inspector # 594 completed the Follow-up Inspection which was conducted during this Resident Quality Inspection.

Despite the home's attempt to address the abuse issues with Staff # 120 and to ensure all staff were educated/trained in regards to the home's abuse policy, the staff education and the plan submitted by the home was not completed by September 17, 2014 (the compliance date).

A new incident of Abuse was brought forward to Inspector # 594 by Resident # 985, during the Resident Quality Inspection.

Inspector # 594 interviewed Resident # 985 twice. Resident # 985 told Inspector # 594 that Staff # 120 was "being loud and rude" and "gets me worked up." Resident # 985 also confirmed and stated that, "I felt intimidated, belittled and Staff # 120 diminished my dignity."

Inspector # 594 reported this immediately to Staff # 100.
Staff # 120 was immediately sent home pending the completion of an investigation by the home.

A Critical Incident Report # 2667-000013-14/Log # S-000593-14 was sent to the Director by the home and was reviewed by Inspector # 594.

Staff # 100 told Inspector # 544 that Staff # 120 may be terminated at this time since another complaint had now come forward. Staff # 120 still has refused to submit a learning plan to the home.

The licensee has failed to ensure that Residents are protected from abuse by

staff in the home. (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 16, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident.

Grounds / Motifs :

1. Inspector # 594 reviewed the health care records for Resident # 978 which identified Resident # 978 had a wound which required clinical intervention. The Treatment Administration Record (TAR) included an order for registered staff to provide wound care treatment once per day and on an as required basis. However, the plan of care outlined that treatment for the wound was to be provided every three days and on a as a required basis. Inspector # 594 interviewed Staff # 108 who confirmed that the wound care treatment was to be completed every three days or on as a required basis.

Resident # 978's care plan also identified the presence of another wound. Inspector # 594 interviewed Staff # 108, 101, and Staff # 121, who all stated that Resident # 978 did not have a wound on the area that was indicated. Inspector # 594 interviewed Resident # 978 and could not find a wound on the area that was indicated.

It was identified in Resident # 978's progress notes that Resident # 978 had another new wound that had developed. There was no focus, goals or intervention regarding this new wound. There was no clear direction on the care plan in regards to the treatment of Resident # 978's new wound.

The licensee has failed to ensure that the care plan set out clear directions to staff and others who provide direct care to Resident # 978.
(594)

2. Inspector # 595 identified, through an MDS trigger, that Resident # 964 required assistanmce with bed mobility. It was noted that there was no focus, goals or interventions identified specifically regarding bed mobility, in either Resident # 964's most recent care plan or kardex. It was identified by Staff # 116 and #119, that Health Care Aides (HCAs) use the kardex to find information on Resident health care needs. There was no direction to staff and others who provide direct care to Resident # 964, in regards to Resident # 964's bed mobility.

The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to Resident #964. (595)

3. Inspector # 106 reviewed the Kardex and the written plan of care for Resident # 934. They both have the following interventions, "Porter to meals. Take their walker to the dining room as well so they can use it to walk to the bathroom and back to their room if they choose to walk themself." Under the focus mobility, it is written, "MOBILITY - totally dependent in wheel chair for all mobility needs." These interventions contradict each other and do not provide clear direction regarding the mobility requirements for Resident # 934.

The licensee has failed 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. (106)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 16, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 15th day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Franca McMillan

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