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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 17, 20, 2014	2014_198117_0028	O-001157-14 & 2 OTHER INSPECTIONS	Complaint

Licensee/Titulaire de permis

1663432 ONTARIO LTD.
2212 GLADWIN CRESCENT UNIT A-9, SUITE 200 OTTAWA ON K1B 5N1

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

MANOIR MAROCHEL
949 MONTREAL ROAD OTTAWA ON K1K 0S6

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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 27, 28 and 29, 2014

It is noted that two (2) critical incident inspections were also conducted as part of this inspection : Logs # O-000729-14 and Log # O-001025-14

During the course of the inspection, the inspector(s) spoke with the home's administrator, the acting Director of Care/ Clinical Care Nurse, the RAI Coordinator, a Registered Nurse (RN), a Registered Practical Nurse (RN), to several Personal Support Workers (PSW), a Personal Support Services student, an Extendicare Nursing Consultant, the office manager, the maintenance manager, and to several residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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).

Findings/Faits saillants :

1. 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. [Log # O-001157-14]

Resident #3 is identified as being at risk of falls. On October 27 and 28, 2014, Resident #3 was observed by Inspector #117 to have a wheelchair lap belt with front buckle closure in place, a wheelchair lap tray with rear frog clip closure in place as well as a personal tab alarm clipped from the wheelchair to the resident's clothing. In the resident's room, there is a hi-lo bed with quarter side rails and a fall mat. At the resident's bedside is a note indicating that the personal tab alarm is to be applied when the resident is up in his/her wheelchair and also when he/she is in bed.

Interviewed staff members RN S#101, RPN S#102, PSWs S# 104, S#105, S#106 and PSW student S#107, all stated to Inspector #117 that the above mentioned fall prevention interventions are always applied as the resident does try to get up from the wheelchair and bed and is at risk of falls. They stated that Resident #3 can occasionally undo the lap belt and will try to get up if the lap tray with rear clip is not in place.

A review of the resident's plan of care was conducted. The plan does identify that the resident has a tilt wheelchair, a lap tray table for safety reasons, a hi-lo bed with side-rails. It does not identify the use of a fall mat at the resident's bedside, the use of a lap belt, a lap tray with rear closure nor the use of a personal tab-alarm when either in bed or in the wheelchair as fall prevention interventions.

The plan of care was reviewed with home's acting DOC and RPN S#102 . They stated that these interventions have been in place for several weeks but could not identify when these were implemented. The acting DOC also stated that she was not aware that the resident's lap tray had a rear closure restraint as the resident had been assessed for a regular lap tray, with no rear closure. Nor was she aware that the resident had a lap belt with his wheelchair.

Resident #3's written plan of care does not set out clear direction to staff and others who provide care to the resident as it relates to the use of wheelchair lap tray with rear closure, wheelchair lap belt, personal tab-alarms and fall mats. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Resident #3's written plan of care sets out clear direction to staff in regards to fall prevention interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is an order by the physician or the registered nurse in the extended class for the use of a restraint and failed to ensure that there is a consent by the resident's SDM for the use of a restraint. [Log # O-001157-14]

Resident #3 is identified as being at risk of falls. The plan of care does identify that the resident has a tilt wheelchair and a lap tray table for safety reasons. On October 27 and

28 2014, Resident #3 was observed by Inspector #117 to have a wheelchair lap belt with front buckle closure in place, a wheelchair lap tray with rear frog clip closure in place as well as personal tab alarm clipped from the wheelchair to the resident's clothing. Interviewed staff members RN S#101, RPN S#102, PSWs S# 104, S#105, S#106 and PSW student S#107, all stated to Inspector #117 that the above mentioned items are restraints as the resident does try to get up from the wheelchair and is at risk of falls. They stated that Resident #3 can occasionally undo the lap belt and will try to get up if the lap tray with rear clip is not in place. Inspector #117, in the presence of the home's acting DOC, asked Resident #3 on several occasions to undo the wheelchair lap belt. Resident #3 was unable to do so; therefore the lap belt was a restraint.

A review of Resident #3's chart was conducted with the acting DOC and RPN S#102. No medical order from an attending physician or a registered nurse from an extended class for the use of the lap tray with rear closure and lap belt as restraints were identified in the resident's chart. No consent from the resident's substitute decision maker related to the use of a lap tray with rear closure and a lap belt as restraints was found in the resident's chart. [s. 31. (2) 4.]

2. The licensee failed to comply with LTCH s. 31. (3) (b) in that if a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that the resident is monitored while restrained, in accordance with the requirements provided for in the regulations. [Log #O-001157-14]

Resident #3 is identified as being at risk of falls. On October 27 and 28 2014, Resident #3 was observed by Inspector #117 to have a wheelchair lap belt with front buckle closure in place, a wheelchair lap tray with rear frog clip closure in place as well as personal tab alarm clipped from the wheelchair to the resident's clothing. At the resident's bedside there is a note indicating that the personal tab alarm is to be applied when the resident is up in his/her wheelchair and also when he/she is in bed.

Interviewed staff members RN S#101, RPN S#102, PSWs S# 104, S#105, S#106 and PSW student S#107, report that the above mentioned items are restraints as the resident does try to get up from the wheelchair is at risk of falls. They stated that Resident #3 can occasionally undo the lap belt and will try to get up if the lap tray with rear clip is not in place.

Resident #3's health care record and plan of care were reviewed with the home's RPN

S#102. The plan of care states that when the resident is up in the tilt wheelchair the lap tray is to be applied. It also states that staff are to conduct hourly safety checks and reposition the resident every two hours. The RPN S#102, PSWs S# 104, S#105 and S#106 stated that these interventions have been in place for several weeks but could not identify when these were implemented. They also stated to the Inspector that they did not document anything related to the application, repositioning of the resident, monitoring and removal of these restraining devices in the resident's chart.

Resident #3's health care record was reviewed with the acting DOC. The acting DOC stated that she was not aware that the resident's lap tray had a rear closing restraint as the resident had been assessed for a regular lap tray, with no rear closure. Nor was she aware that the resident had a lap belt with his/her wheelchair. The acting DOC stated that as these are restraints and that staff should have been documenting the application of the restraints, the resident's response to the restraints, when the resident was being repositioned and when the restraints were being removed, as well as registered staff assessing and documenting the effectiveness of the restraints, at least every 8 hours.

No information was found in the resident's chart, as required under O.Reg. 79/10, s. 110 (2) (4, 5 and 6) and under O.Reg. s. 110 (7) (5,6 and 7) as to the application of the restraints, the resident's response to the restraints, when the resident was being repositioned and when the restraints were being removed. Nor was there any information found related to the resident's condition being reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. [s. 31. (3) (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 there is a physician order for the use of wheelchair lap tray and lap belt restraints for Resident #3 ; to ensure that Resident #3's substitute decision maker gives consent to the use of the wheelchair lap belt and lap tray restraints; and to ensure that the resident is monitored while restrained, in accordance with the requirements provided for in the regulations, to be implemented voluntarily.

WN #3: 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. The licensee failed to ensure that O.Reg. 79/10, s. 50. (2) (b) (i,ii,iv) in that 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, and (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [Log # O-001157-14]

Resident #3 was admitted to the home in late August 2014. At the time of his/her admission the resident had a rash to both lower legs which was treated with a medicated cream. On October 27, 2014, Inspector #117 noted that Resident #3 had a dry and intact dressing on a lower leg and the presence of discoloured spots where the rash had been located. Staff members PSW S#104 and student PSW S#107 stated that they did not recall when the resident developed a wound requiring a dressing on the identified lower leg. They were also not aware of when the dressing was last changed.

A review of Resident #3's health care record was conducted with the home's acting DOC and unit RPN S#102 on October 27 and 28 2014. Chart documentation indicates that the resident developed an open area on the identified lower leg on a specific day in October 2014. The wound was assessed, cleansed and a dressing applied. The next day, in private nursing agency records, kept at the resident's bedside, is an entry from the agency's nursing supervisor indicating that the resident's dressing had a smell and the presence of yellowish /green discharge. It is noted that the dressing was changed by the agency RN at the request of the resident's family. It also notes that the resident had a large stage 1 pressure ulcer to a lower buttock close to perineum. Resident #3's health care record documents that the agency nursing supervisor did report to the home's registered staff the dressing change. No other information related to the resident's leg wound and dressing was found in the resident's health care record until 14 days later. Documentation indicates that the resident's dressing was changed 14 days later, that the wound was healing, that it was cleansed and a new dressing applied. No other information related to the presence of a stage 1 pressure ulcer was noted in the resident's chart or in any other skin/wound assessment tools on the nursing unit.

On October 27 2014, Resident #3's wound and skin was assessed by the RPN S#102, PSW S#104 and Inspector #117. The resident's dressing was noted to be dry and intact and the wound was pinkish red in colour with no open areas. It was noted that resident's perineum was red and inflamed with the presence of a stage 1 pressure ulcer, on a lower buttock, approximately 1cm in diameter. Unit RPN S#102 and PSW S#104 stated that they were not aware of the presence neither of the stage 1 pressure ulcer nor of the redness of the resident's perineum. The unit RPN immediately contacted the attending physician who prescribed a medicated cream for the resident's perineum. On October 28 2014, RN S#101 and PSWs S#105 and S#106 also stated to the Inspector that they did

not know when the resident's leg wound dressings were changed or assessed and that they were also not aware of the presence of a stage 1 ulcer at the resident's lower buttock.

On October 28 2014, the home's Acting DOC, RN S#101 and RPN S#102 stated to Inspector #117 that all staff who provide direct care to the resident are to report any changes in resident skin condition to registered staff. They also report that when a resident has a wound and or pressure ulcer, these are to be identified, assessed weekly or more often as needed by registered staff, treatments are to given as per medical orders and documented. Neither registered staff members could say if the resident's leg wound had been assessed and the dressing changed more then on the 3 identified days in October 2014. They also could not give any information as it relates to any assessments, treatments or monitoring of the stage 1 pressure ulcer located at the resident's lower buttock initially identified and reported by a private agency RN on a specific day in October 2014. [s. 50. (2) (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 Resident #3 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; that Resident #3 receives immediate treatment and interventions to promote healing of wounds and pressure ulcers as required; and that Resident #3's skin and wounds be reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident: has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint. [Log # O-001157-14]

On a specified day in October 2014, Resident #3's family member called and left a voice mail message to the home's administration. The family member expressed various concerns related to the resident's medication, care and services. The family member's concerns were documented in the home's "Complaint Investigation Form". The home's RAI Coordinator followed up on the family member's concerns that same day. On October 29, 2014, the RAI Coordinator stated to Inspector #117 that he had contacted and spoken with Resident #3's family member via telephone regarding the identified concerns however he did not document his response and contact with the family member either in the resident's health care record or in the home's "Complaint Investigation Form".

On a specified day in October 2014, Resident #3's family member called and spoke to the home's office manager. The family member expressed concerns with the resident's personal hygiene and bathing. The family member's concerns were documented in the home's "Complaint Investigation Form". As per the office manager, the family member's concerns were forwarded to the home's Nursing Consultants for follow up. The home's Administrator was also notified of the family's new concerns. On October 29, 2014, the Nursing Consultant and Administrator stated to Inspector #117 that they had conducted a follow-up in regards to the family member's concerns. They had asked that either the charge RN or the RAI Coordinator contact and provide a response to Resident #3's

family member. The RAI Coordinator stated to Inspector #117 that he did not contact Resident #3's family member regarding with a response to the concerns raised on this specified day in October 2014. He stated that he was unaware if the charge RN had contacted the resident's family member related to the expressed concerns. No documentation was found in either in the resident's health care record or in the home's "Complaint Investigation Form" regarding a member of the home's staff responding to concerns raised by Resident #3's family member.

It is noted in Resident #3's chart, that the resident's family member did visit the resident during the evenings of both days on which concerns were reported to the home. No information was found in the chart related to nursing staff addressing concerns raised by the family member with the family member during these visits. On October 29, 2014, the office manager stated to Inspector #117 that when she was speaking with the family member on the day of the second report of concerns, she did inquire with the caller if nursing staff had contacted them in response to the concerns previously brought forward. The office manager stated, that the family member did not respond to the questions but stated that he/she had been at the home during the evening of their 1st reported concerns.

Nursing staff did not document their investigation and response to concerns raised by Resident #3's family member on two specified days in October 2014. [s. 101. (1) 1.]

Issued on this 20th day of November, 2014

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

Original report signed by the inspector.