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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
May 29, 2017;	2017_621547_0002 (A1)	000668-17	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.4) GP Inc. as general partner of CVH (No.4) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Inc. CAMBRIDGE ON N3H 5L8

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

LISA KLUKE (547) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Director of Care and Administrator of the home have requested an extension for this order CO #001-related to skin care program in order to complete the education requirements in the home. Extension request authorized as requested to June 23, 2017 as the new compliance date.

Issued on this 29 day of May 2017 (A1)

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

Original report signed by the inspector.

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Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 23, 24, 25, 26, 27, 30, 31 and February 1, 2, 3, 6, 7, 8, 9, 10, 13, 2017

The following critical incidents and complaints were conducted concurrently during this inspection.

log # 024422-16 related to alleged resident to resident abuse

log # 027103-16 related to alleged staff to resident neglect

log # 027204-16 related to continence care not provided to a resident

log # 028474-16 related to pain and skin care management of a resident

log # 033423-16 related to an incident that caused an injury to a resident

log # 000282-17 and # 000892-17 related to alleged staff to resident abuse

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the home's Resident Assessment Instrument (RAI) Coordinator, Housekeeping and Laundry attendants, the Office Manager, the Program Manager, the Nutritional Manager, the Registered Dietitian, the Physiotherapist (PT) and Physiotherapy Assistant (PTA), the Director of Care (DOC), the Extendicare Assist Nursing Consultant and the acting Administrator.

The inspectors toured the home, reviewed resident health care records, the resident's mobility equipment cleaning schedule, the resident and family general meeting minutes and the licensee's documents related to investigations for critical incidents. The following policy and procedures were reviewed related to Pain, Skin care, Continence care, Abuse, Medication destruction, Infection Control and Restraints. Pest Control documentation and nursing staff training records regarding Skin and Wound care. The Inspectors observed resident to resident and staff to resident interactions on both home units. The Inspectors observed medication administration passes, several meal services as well as infection prevention and control practices during this inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

17 WN(s)
10 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

The licensee has failed to ensure the implementation of the skin and wound care program that the licensee developed to promote skin integrity and provide effective skin and wound care interventions.

The licensee's policy and procedure #03-01 dated June 2010 regarding skin care program was reviewed by Inspector #547. To summarize, the program gives directions to nursing care staff regarding the following areas:

- On hire and annually care staff will receive education in preventative skin care as well as wound care for Registered Staff.

- The program's overall goals for preventative skin care to prevent and address dryness, protect the skin from damage from friction, shear, tears, etc. and observe for changes that may require further treatment.

- Residents at moderate to high risk for skin breakdown are assessed informally on a daily basis. Any concerns are then reported to the registered nursing staff who are then responsible for further assessing the area, documenting the assessment and completing any follow up required.

- This procedure indicated a plan of care related to preventative and active skin care based on the information observed, assessed for and collected will be developed by registered nursing staff.

- Comprehensive skin care assessments will be completed and documented by registered staff.

- Registered nursing staff are responsible for keeping the plan of care up to date at all times, thus reflecting the care needs with respect to skin care.

- If physician orders are required for care of the skin issue, the physician will be contacted to obtain these orders.

- Monthly statistics related to skin care will be collected and analyzed by the skin care coordinator or designate. This data will be reviewed, and where required, an action plan will be implemented to address any trends.

- The documentation requirements indicated the care plan is used to document all care needs and interventions related to skin, that includes active treatment as well as preventative skin care interventions.

The Program Manager indicated to Inspector #547 on February 13, 2017 that the home provides training to nursing care staff by surge electronic learning system. The Program Manager further indicated skin and wound care is required as a mandatory training to nursing staff annually. The Program Manager began in the education role as of October 2016 and noted that a large percentage of nursing staff had not completed their mandatory annual training for skin and wound. Upon review of the skin and wound care training, 61.7% of care staff and 58% of the registered nursing staff had completed this training for 2016. The Program Manager indicated that the Director of Care was made aware of staff that had not completed their mandatory training.

-The skin and wound care program for care staff and registered care staff indicated for proactive measures to prevent skin breakdown to ensure residents wear long sleeves and pants for warmth as well as prevention of skin tears, pad sharp edges of wheelchairs, use therapeutic and pressure offloading surfaces as necessary, use pillows and wedges for positioning, and to elevate heels by placing pillows lengthwise under legs or use heel pressure redistribution devices.

-The skin and wound care program for registered staff indicated the home's wound assessment tool is initiated when a resident has any open area/wound. One tool for each open area/wound will be completed with every dressing change, but minimum every seven days.

-Notify the physician and refer to members of the interdisciplinary Skin and Wound care team or external consultant if skin breakdown/healable wound is not improving in three weeks.

-The treatment regimen is recorded on the Medication Administration Records MAR and or Treatment Administration Record TAR.

-Wounds will be photographed initially and at least monthly as per best practice.

-The home's interdisciplinary wound and skin care team will have a process in place to review and document the resident's wound care status and plan of treatment on a regular and as needed basis.

-Treatment orders should include: location of wound, treatment and dressing required, how often the dressing is to be changed, include PRN (as required), and include monitor daily.

During the course of this inspection, the following residents were reviewed for skin and wound care:

RE: Resident #006

Resident #006 was admitted to the home on a specified date with several medical diagnoses. Resident was observed by Inspectors #551 and #547 to have several skin integrity issues to a specified area on the resident that triggered a review of the resident's skin care during this resident quality inspection.

Inspector #547 reviewed resident #006's health care records and the current care plan indicated that the resident's skin is very fragile. Interventions identified to protect fragile skin and PSW's are to apply moisturizing lotion daily. Resident's transfers is mechanical lift related to poor weight bearing ability and several skin issues. The resident is seated in a wheelchair during the day and intervention identifies to ensure proper seating to prevent sliding and shearing.

Resident #006's care plan or PSW flow sheets did not identify repositioning needs for this resident every two hours, as issues with skin and positioning as part of their preventative measures. Resident #006 requires extensive assistance of two staff members for repositioning while in bed or in a wheelchair. Two altered skin integrity areas was identified and specified treatments for each required as per protocol and Treatment Administration Record (TAR).

On February 8, 2017 Inspector #547 reviewed resident #006's TARs for two specified months that indicated the following:

1. Two specified areas required specified treatments every three days for dressing changes that started on a specified date over three months earlier.

2. One specified skin alteration required to be cleaned with normal saline and covered with a specified dressing and changed every 21 days and as required that started on a specified date over two months ago.

3. One specified skin alteration required to be cleaned with normal saline and covered with a specified dressing and changed every 21 days and as required that started on a specified date over four months ago.

4. Cut to a specified area to be cleaned with normal saline and covered with a specified dressing and changed every 24 hours and as required that started nine days earlier.

On February 8, 2017 Inspector #547 reviewed resident #006's progress notes and noted that resident #006 also had another ulcer to a specified area that was identified a month ago. As per Bates-Jansen assessment completed on the day it was discovered, resident #006 had a specified ulcer to this specified area. There is no further documentation in the progress notes, or assessments regarding resident #006's skin integrity to this area to date.

The licensee's skin care program indicated that PSW's are to perform a skin assessment on the first bath of the week and document on a flow sheet. The weekly skin observation for resident #006 for a specified month indicated a specified alteration in skin integrity by PSW for the four weeks in this specified month and no other issues. The DOC reviewed this weekly skin observation sheet and indicated that these assessments are not completed properly. The DOC indicated the purpose of these assessments with bathing is to identify all skin

alterations for residents and resident #006 had a specified number of open areas as well as an alteration of skin integrity identified a month earlier that were not documented.

RPN #103 observed resident #006's specified dressing on the resident and indicated to Inspector #547 that this dressing is only done every 21 days, and not due to be changed today. RPN #103 reviewed the physician's orders on resident #006's chart, which indicated another specified area required to be cleaned with normal saline and covered with a specified dressing and changed every 21 days and as required (PRN). RPN #103 indicated that the location of this wound was not properly identified in the TAR. This specified order was also not incorrectly transcribed for frequency of dressing changes as the TAR indicated this dressing was to be changed every 24 hours and not every 21 days.

Observations of resident #006:

On February 8, 2017 resident #006 was observed by Inspector #573 to be sliding out of the wheelchair. RPN #114 and RN #100 repositioned the resident by pulling the resident up from under the resident’s axilla and thighs in the chair. The resident returned to a slouched position. The resident's feet do not stay on the foot rest. The resident does not use a seat belt or have any other Personal Assistance Services Devices (PASD). The residents chair has capacity for tilt, however this has not been observed by the Inspection team since we arrived in the home on January 23, 2017. Resident #006 has been observed up in this large wheelchair daily after breakfast in the resident care hallways, in the same slouched position.

On February 8, 2017 PSW #108 indicated to Inspector #547 that he had just returned resident #006 to bed after lunch, and that the resident no longer had any pressure ulcer to a specified area.

RPN #103 and Inspector #547 went to evaluate the resident's wounds, as the TAR was unclear.

1. A specified area remained open and no dressing was observed to be covering the resident's ulcer.

2. Inspector #547 and RPN #103 observed that resident #006 no longer had any dressing to a specified area as identified in the resident's TAR. An alteration in skin integrity remained present from previous open area however this was not

documented.

3. Resident continued to have redness to a specified area that was not elevated, and the resident was in bed. RPN #103 indicated that the resident's clothing item was too tight and not good for circulation. It was noted that the resident's skin to this specified area remained impaired and would need to be kept elevated and under close observation.

4. Resident had a dressing to a specified area, not the area identified in the TAR. It was noted that the resident's skin around the wound was reddened, and that drainage to the wound was present.

5. The resident had a dressing to a specified area that was dated. RPN #103 indicated this date was when the dressing was last changed. RPN #103 indicated this area was an old skin tear and that it was not due to be changed as it is only changed every 21 days. They follow the TAR for dressing changes. This date was 22 days old on the dressing. The TAR actually indicated that this dressing was not due until three days after the present date. Dates for dressing is not clear.

6. No dressings were observed to specified areas identified in TAR, where a specified treatment was required.

On February 9, 2017 RPN #103 indicated to Inspector #547 that he completed a skin assessment on resident #006 on February 8, 2017 however identified the wrong location for the pressure ulcer and that he will complete another assessment that day. It was further noted that RPN #103 did not write any order for pharmacy to add this dressing treatment plan and he indicated to Inspector #547 that he was not the first person to initiate this wound and that he is not required to add this. The lead for skin and wound care program in the home, RPN #114 was also present, indicated that RPN #103 should have obtained an order for dressings to a specified area in order to add this treatment to the TAR and the resident plan of care.

RPN #114 indicated to Inspector #547 that skin assessments should be documented for each wound with each dressing change. If a wound is only changed every 21 days, he indicated they expect the registered staff to document their assessment of the dressing and the status of the wound beneath the clear dressing weekly. RPN #114 was aware that registered staff are required to assess wounds weekly and that they would have to review their process on how the TAR is written for appropriate staff direction.

Skin assessments were not completed for every wound/ulcer weekly as required by this program.

Orders were not transcribed properly for staff direction.

Orders were not obtained for pressure ulcer to a new specified area.

Treatments were not ordered or added to the plan of care or provided to the resident who was high risk for skin impairment.

Preventative skin breakdown measures were not in place as identified in the resident plan of care.

No documented pictures for initial or monthly wound assessments were obtained.

RE: Resident #016

Resident #016 returned to the home from hospital on a specified date. Upon return from hospital, the resident's head to toe skin assessment identified an ulcer to a specified area. An assessment of the ulcer was conducted by the Extendicare Assist consultant, the Director of Care and RPN #103 whereby the ulcer was cleansed and a protective dressing was applied.

Inspector #547 interviewed RPN #103 who indicated that he did observed the resident's ulcer on this specified date and completed the required skin assessments however did not contact the physician to inform or add any treatment plan to the resident plan of care.

No documented pictures for initial or monthly wound assessments were obtained.

Upon review of resident #016's health care records on February 13, 2017, no documented weekly assessment of resident #016's specified skin area was documented since the original assessment on this specified date of this ulcer.

RE: Resident #038

Resident #038 was admitted to the home on a specified date with several medical diagnoses. Resident #038 was considered high risk for impaired skin integrity

related to mobility and cognitive impairments.

On February 10, 2017 Inspector #547 interviewed resident #038's Substitute Decision Maker (SDM) who indicated the resident has had such trouble with fragile skin. The resident sits in a wheelchair for long periods of time in the morning, often moving specified body parts and skin tears occur. The SDM indicated that resident #038's skin is always so dry and flaky and that the resident did not have any moisturizing cream.

Resident #038 was observed by Inspector #547 to be seated daily in a wheelchair. Resident #038 is transferred to this wheelchair early in the morning as per PSW #105 when the resident wakes up due to high risk of falls from bed. Resident #038's wheelchair had two metal foot rests. It was observed that resident #038 now had a fresh open wound to a specified body part that morning. RPN #106 indicated this resident should have some padding or different wheelchair supports, to help prevent injury to the resident with movement. RPN #106 indicated that resident #038's skin is so dry, that it would also be helpful to have the resident's skin moisturized. The SDM indicated that the resident has not had any moisturizer for a long time now. RPN #106 went to get a large bottle of body moisturizer for the resident.

On February 10, 2017 RPN #106 indicated that she has done an assessment of a specified wound for the resident. The resident also has another specified ulcer now to another specified area that the dressing was not due to be changed that day. RPN #106 indicated that this resident now had a specified amount of wounds that required dressings at different times as identified in the TAR. RPN #106 indicated that she was not aware that each wound required a skin assessment to be documented, as she thought she only needed to do an assessment with the worst wound.

On February 10, 2017 Inspector #547 reviewed the resident #038's care plan and no documentation of the resident's skin tear to two specified areas for any preventative measures, positioning or protective interventions for these areas. RPN #106 indicated that they will have to add the new wound to a specified area that developed that day to the plan of care. Currently the care plan only identified one specified ulcer with interventions. No other interventions were noted related to two other specified areas for the resident.

The skin and wound care program indicated that PSW's are to complete a weekly

skin assessment document with the first bath of the week for every resident.

Inspector #547 reviewed resident #038's skin assessment documents for a specified month and no weekly assessment was documented for two specified weeks that month.On Two other specified weeks this month, PSW's identified a dressing to one specified area only. No documentation of any wound or dressing to a specified area on the resident that was identified during this specified month. Inspector #547 reviewed resident #038's skin assessment documents for the following month and no weekly assessment was documented for three weeks in this specified month and completed once that identified the resident’s skin was intact.

Inspector #547 reviewed resident #038's progress notes that indicated the resident was sent to hospital during this recent specified month from an injury related to a fall, and returned with skin laceration to a specified area. A head to toe skin assessment was completed upon return from hospital and this new skin issue was not added to the plan of care for resident #038.

For a specified two month period, the resident did not receive weekly skin assessments by registered nursing staff whereby one of the wounds became infected on specified date at the beginning of this period.

On February 9, 2016 the lead for the skin and wound care program, RPN #114 indicated to Inspector #547 that a skin assessment tool is to be documented after each dressing change, for each wound or area on the resident. If dressing are to be completed less than weekly such as those due every 21 days, they still expect an assessment of the dressing and wound beneath these clear dressings weekly to be documented. Upon review of resident #038’s health care records, RPN #114 indicated that each wound did not have a wound assessment completed as required. No documented pictures for initial or monthly wound assessments were obtained for each of this resident's wounds.

RE: Resident #048

Resident #048 was admitted to the home on a specified date with several medical diagnoses. The resident's care plan for a specified month indicated the resident had chronic leg pain related to specified medical diagnoses. The documented interventions were to monitor the resident’s pain level and describe, prescribed cream to be applied three times daily, and prescribed treatment for infection and to

monitor side effects. Impaired skin identified with wounds with documented interventions to cleanse with normal saline and then apply prescribed ointment twice daily and monitor.

Resident #048's skin assessments were documented as follows:

On a specified date, resident #048 skin assessment documented that infection present and plan was updated.

The next skin assessment was not completed until over two weeks later as resident #048's skin wounds were not improving.

Two days later, resident #048 was sent to hospital and diagnosed with a specified infection and returned with treatment prescribed.

Head to toe skin assessment was documented upon the resident's return from hospital two days later,which indicated no areas of impairment to skin integrity at this time.

No further documented weekly assessment of resident #048's skin to specified infected areas by registered nursing staff until ten days after the resident returned from hospital.

Two days later, the resident's progress notes documented an ulcer was identified, cleaned and dressed but no assessment tool was completed for this ulcer and this ulcer was not added to the residents plan of care.

Resident was sent to hospital two days after this ulcer appeared, as the resident's specified infected areas were swollen and painful and returned same date with physician orders for increased pain medication and dressings to ulcers daily.

It was noted that the specified treatment dressing orders were not added to the plan of care or to the TAR.

Progress notes documented resident #048's dressings were changed every two days and not daily as ordered.

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #014 and resident #020's plans of care set out clear directions to care staff regarding changing of the specified personal care equipment.

Resident #014 was admitted to the home on a specified date with several medical diagnoses.

On January 26, 2017 Inspector #547 interviewed resident #014 and a family member who indicated that they were not satisfied with the care for the resident's specified personal care equipment. The resident's family member indicated that the resident's specified personal care equipment are to be switched every morning and night and often this is not done. The resident's family member indicated for infection prevention, that the specified personal care equipment are suppose to be cleaned every time they switch them, and that these devices are changed weekly to a new system. These new devices are to be dated on the day they are provided to a resident. The resident's family member indicated that this is not done for resident #014 as old dates are seen on these specified personal care equipment.

On February 1, 2017 Inspector #547 observed resident #014's labelled day and night specified personal care equipment to be over a week old.

On February 1, 2017 RPN # 114, the lead for the continence care program in the home indicated to Inspector #547 that this specified personal care equipment are suppose to be labelled and changed weekly as per the licensee's policy and procedure. RPN #114 asked PSW #104 what day of the week the specified personal care equipment system is suppose to be changed for resident #014, PSW#114 indicated that he was not sure. PSW #114 is one of the primary PSW's that provides direct care to resident #014 on day shift.

On February 2, 2017 PSW#116 indicated to Inspector #547 that the process in the home has always been to change the specified personal care equipment on Mondays for all residents since initiating the new specified personal care equipment procedure put in to place by the Director of Care (DOC) on a specified date. RPN #114 indicated that he could not recall what day of the week had been decided and would have to verify in the resident's plan of care.

Resident #014 plan of care does not identify what day of the week the specified personal care equipment is to be changed. RN #102 indicated that she thought it was Mondays as well, but would verify. RN #102 indicated that upon review of the resident's plan of care, it was noted that this information was missing, and that PSW's did not have clear direction as to when the specified personal care equipment were to be changed. [s. 6. (1) (c)]

2. Resident #020 was admitted to the home on a specified date, with several medical diagnoses. RPN #114 indicated to Inspector #547 that resident #020 is alert and oriented and able to direct their own care.

Resident #020 indicated to Inspector #547 that he/she switches the resident's own specified personal care equipment independently every morning and night.The resident indicated that the home had not shown the resident how to wash or store the specified personal care equipment.

Inspector #547 observed resident #020's specified personal care equipment rolled up on a wooden table in the resident's room. The resident's specified personal care equipment contained yellow fluid. Resident #020 indicated to Inspector #547 that he/she had trouble cleaning it, and that the specified personal care equipment appeared very dirty. The specified personal care equipment was noted to be cloudy with white sediments along the inside of the device. The resident further indicated that he/she had no idea when the home changed the specified personal care equipment as there was no date on the devices.

Upon review of the resident's care plan, it was noted that there was no indication regarding the process of changing of the resident's specified personal care equipment and when.

On February 2, 2017 the charge RN for the unit indicated that she has updated every resident care plan, for residents with this type of specified personal care equipment, to ensure that cleaning, storage and changing of these items was clear for direct care staff. Resident #020 still preferred to keep the specified personal care equipment stored in the resident's own room, and the RN will make sure this is updated to the resident's plan of care as different than the home's current process. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care based on an assessment of resident #012 and the resident's needs and preferences.

Critical Incident Report was submitted to the Director by the home on a specified date detailing an allegation of staff to resident verbal abuse involving resident #012 and PSW #108. The resident reported to RPN #103 that the PSW had called the resident inappropriate names.

Resident #012 has resided at the home since a specified date with several medical

diagnoses including physical limitations requiring assistance with eating.

According to the Director of Care (DOC), following this allegation, resident #012 indicated that he/she preferred that PSW #108 would no longer provide the resident personal care.

On February 3, 2017 resident #012 indicated to Inspector #551 that PSW #108 continued to feed the resident at meals. Resident #012 indicated that this felt odd as the resident preferred to not have this PSW provide care, as discussed previously with the DOC.

On February 7, 2017 PSW #108 was observed by Inspector #551 to be feeding resident #012 the entree and dessert from the resident's lunch while in the dining room.

PSW #108 indicated to Inspector #551 that he was assigned to feed resident #012's table, and routinely fed this resident during meals.

Inspector #551 reviewed resident #012's plan of care, and noted that there was no information regarding the resident's needs and preferences to not have care provided by PSW #108.

The DOC indicated to Inspector #551 that as part of resident #012's needs and preferences to not receive care from PSW #108, that this care also included feeding assistance and that this should have been added to the resident's plan of care when it was discussed on that specified date. [s. 6. (2)]

4. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated in the assessment of the resident so that their assessments were integrated and were consistent with and complimented each other.

Resident #041 was admitted to the home several years ago, with several medical diagnoses. The resident ambulated using a wheelchair and was known to attempt to transfer self independently.

Between two specified dates over a three month period, resident #041 fell several times.On a specified date, the resident was found on the floor in the corridor.

Inspector #551 reviewed the resident's health care records and observed that on this specified date of the fall incident, resident #041 was assessed by the physiotherapist (PT) whereby the resident did not weight bear due to pain and tenderness in the specified body part. The PT recommended a physician opinion to rule out fracture. The progress note indicated that the RN was informed of this assessment.

Eight days later, resident #041 was assessed by the physiotherapist (PT), in relation to the fall on the specified date. During this assessment, the resident complained of pain in the same specified body part and rated the intensity of pain as 7/10.

In an interview with the PT on February 2, 2017, he indicated to Inspector #551 that on this specified assessment date eight days after the fall, he strongly believed that it was possible that the resident had fractured a specified body part based on his assessment, as noted above, and because the resident had fallen numerous times in the past and had not complained of pain. The PT indicated that he followed-up with the nurse the next week and indicated that a physician's opinion was recommended to rule out fracture on the previous assessment, and that it had not been completed. The PT stated that he was told that an x-ray of another specified body part had been completed. A progress note written by the PT on a specified date, 16 days after the fall, that indicated that he had informed the RN and the RAI co-ordinator that he was recommending a physician's opinion to rule out the cause of pain to this same specified part and resident #041 was changed to a full mechanical lift with two person assist. The PT further indicated to Inspector #551 that this change in transfer was made as the resident complained of pain so he did not want the resident to weight bear.

The PT indicated to Inspector #551 that on a specified date 23 days after the fall, he followed-up with nursing staff regarding resident #041's specified body part and he was told that his recommendations for physician assessment from two specified assessment dates on day eight and day 16 after the fall had not been followed. The PT indicated that following a discussion with the nurse, she called the physician to arrange for an x-ray of resident #041’s specified body part.

RPN #106 charted in the resident's progress notes 23 days after the fall, that the resident’s body part was painful, yellow, swollen, and the resident was unable to move it, and that the physician had been contacted and an x-ray of the specified body part was ordered.

The x-ray was taken via mobile x-ray the next day and the result were going to be available four days later.

The x-ray imaging showed a fracture of a specified body part identified 27 days after the resident fell.

Resident #041 fell on a specified date and was assessed by the PT on three specified dates whereby recommendations were not implemented until 23 days after the resident fell when an x-ray was ordered. Results of this x-ray returned 27 days after the resident fell, and the resident was transferred to hospital for a fractured specified body part that required surgical intervention. Inspector #551 reviewed the resident's post-operative report dated a specified date 29 days after the fall, that indicated despite several attempts, the physician was unable to repair this fracture since it occurred quite a time ago and that the muscles had shortened in this area preventing any possible repair. [s. 6. (4) (a)]

5. The licensee has failed to ensure that the care set out in the plan was provided to resident #011 as specified in the plan.

According to the Acting Administrator, on a specified date and time, the home was managing an enteric outbreak and the PSW assignment was changed to attempt to limit the spread of this outbreak. In the south unit, PSW #112 and #116 were assigned to provide care to the eight residents on isolation precautions and PSW #108 and #104 were assigned to provide care to the twenty two residents remaining who were not. Resident #011 lives in the south unit and was not on isolation precautions.

Resident #011 has resided at the home for several years. According to the resident's written plan of care, the resident is reliant on staff for toileting, is to be toileted routinely, and is not to be left unattended on the toilet.

On this same specified date at a later specified time, resident #011 was observed sitting in a wheelchair outside of the resident's room, and reported to Inspector #547 the need to be toileted and had been waiting a long time.

This was brought to the attention of PSW #112, #116 and #104. PSW #112 and #116 reported to Inspector #547 that they were aware the resident is normally toileted between specified times, but due to a change in the PSW assignment on

that day, the staff had not had the time to toilet the resident as part of the resident's normal routine.

Inspector #551 observed PSW #112 and #116 assist resident #011 to the toilet 75 minutes after the resident originally requested to be toileted. Resident #011 was then left unattended on the toilet when PSW #116 came out of the resident's room and into the hallway. PSW #116 checked on the resident five minutes later, who was not ready. PSW #104 and #116 then went to provide care to resident #006. Resident #011 remained on the toilet unattended on the toilet for at least ten minutes. [s. 6. (7)]

6. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, specifically related to fall prevention interventions.

Resident #038's health care record identified that the resident was at high risk for falls. Resident #038 had a fall on a specified date, that resulted in transfer to hospital with a fracture. Resident #038's current written plan of care included the use of safety alarm in the bed and wheelchair as a fall prevention intervention.

On January 27 and 30, 2017, Inspector #573 observed resident #038 lying in the bed without any safety alarm attached to the resident's bed. Inspector #573 spoke with RPN #106 who indicated that resident #038 is at high risk for falls and confirmed with the inspector that the use of safety alarm in the bed and wheelchair was one of the fall prevention interventions.

On January 30, 2017, RPN #106 observed resident #038 in the presence of the inspector and indicated that staff members are supposed to apply the safety alarm for resident #038 while the resident is in the bed. The RPN #106 further confirmed with Inspector #573 that the PSW staff members did not apply the safety alarm to the resident #038 as specified in the plan of care. [s. 6. (7)]

7. The licensee failed to ensure that when the plan of care is being revised because the care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the care plan.

A Critical Incident Report (CIS) was submitted to the Director by the home that indicated, on a specified date, resident #043 was found on the floor near the resident's washroom. The CIS report indicated that resident #043 was sent to the

hospital for further assessment and was diagnosed with fracture to a specified body part, which resulted in significant change in condition.

Inspector #573 reviewed resident #043's care plan at the time of incident, which identified that the resident #043 was at high risk for falls related to resident's unawareness towards safety needs and unsteady gait. Resident #043 had history of multiple falls.

Inspector #573 reviewed resident #043's health care records (progress notes/ post fall assessment/ fall risk management assessment) which indicated that resident #043 had fall incidents on three specified dates. Further review of resident's records, it was documented that the fall incident on two specified dates, were related to resident toileting needs.

Resident #043's health care records identified the following:

Fall incident (1) - on a specified date, resident lost balance while getting out of a chair and found on the floor. Immediate Actions: - vitals assessed, No injury observed. Fall prevention intervention at the time of fall – (a) Ensure environment is free of clutter (b) Make sure floor is dry (c) Call bell within reach/ Reinforce need to call for assistance (d) mobility device within reach.

Fall incident (2) - one day after fall incident (1), PSW staff reports that the resident is lying on the floor near the toilet door. Immediate Actions vitals assessed, No injury. Fall prevention intervention at the time of fall – (a) Ensure environment is free of clutter (b) Make sure floor is dry (c) Call bell within reach/ Reinforce need to call for assistance (d) mobility device within reach.

Fall incident (3) - two days after fall incident (1), PSW staff reports that the resident on the floor by the bathroom. Immediate Actions resident #043 was sent to the hospital for further assessment. Fall prevention intervention at the time of fall – (a) Ensure environment is free of clutter (b) Make sure floor is dry (c) Call bell within reach/ Reinforce need to call for assistance (d) poesy alarm.

A review of nursing fall progress notes on a specified date, for root causes analysis indicated that resident #043 falls highly related to toileting needs / episodes of some confusion and impaired gait.

On February 13, 2017, Inspector #573 spoke with RN #102 , who indicated that

resident #043 was not placed on any specific toileting program. RN #102 further indicated that following the resident's fall which resulted in a fracture to a specified body part, fall prevention interventions and frequent resident monitoring for falls were to be included for resident #043.

On February 13, 2017, Inspector #573 reviewed resident #043's written plan of care/ post fall assessment related to resident's falls in the presence of the DOC. Upon review, the DOC indicated to inspector that resident #043's falls prior to the specified date of fall incident (3), were related to toileting needs. The DOC further indicated that other than the fall preventions interventions identified in the resident's written plan of care, other different approaches were not considered in mitigating resident falls. [s. 6. (11) (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 regarding staff and others involved in the different aspects of care of the resident collaborated in the assessment of the resident so that their assessments were integrated and were consistent with and complimented each other with regarding to a resident plan of care, and that the care set out in these plans shall be provided to residents, to be implemented voluntarily.

WN #3: 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 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 they are complied with.

In accordance with O.Reg.79/10,s.30(1)1. the licensee is required to have relevant policies, procedures and protocols for the home's organized programs. O.Reg. 79/10, S.48(1) indicates that the pain management program is developed and implemented in the home to identify pain in residents and manage pain.

The licensee's policy titled Pain Management (RESI-10-03-01) stated that each resident, regardless of cognition, must be assessed for pain with a change in condition associated with the onset of pain, and that the paper or electronic Pain Assessment Tool is to be used. Indicators for completing a pain assessment include: when the resident states they have new pain 4 out of 10 or greater, taking new pain-related medication for > 72 hours and family/staff/volunteer indicate pain is present.

Resident #041 was admitted to the the home on a specified date with several medical diagnoses. The resident ambulated using a wheelchair and was known to transfer self.

Between a three month specified period, resident #041 fell sixteen times.

On a specified date and time, the resident was found on the floor in the corridor. Resident #041 was assessed by the physiotherapist (PT) and the resident

complained of pain to a specified body part and rated the intensity of pain as 7/10.

Resident #041 was assessed by the physiotherapist (PT) on a specified date, in relation to the fall eight days earlier, and the resident did not weight bear due to pain, and the PT noted tenderness to a specified body part. The PT recommended a physician opinion to rule out fracture, and PT treatment was put on hold until the specified body part pain was cleared. The progress note indicated that the RN was informed of this assessment.

The resident was assessed by the PT on a specified date and the physiotherapist assistant (PTA), in relation to the fall16 days prior. In his assessment, the PT noted that the resident complained of pain to a specified body part. The PT charted that he discussed the resident's pain with the RN and the RAI co-ordinator (RPN #114) and was informed that an x-ray had been performed. The PT recommended a physician opinion to rule out the cause of pain to this specified body part and that the resident be monitored more frequently.

Resident #041 complained of pain to a specified area 18 days after the fall incident and the area was described as being yellow in color. The physician was notified and pain medication was prescribed for five days.

23 days after the resident's fall, a progress note entry indicated that the resident's same specified body part was painful, yellow, swollen, and the resident was unable to move it. The physician ordered an x-ray of the specified body part.

The x-ray was taken via mobile x-ray the next day and the result returned on a specified date, 27 days after the resident's fall that showed a fracture to this specified body part. The resident was transferred to hospital and returned to the home seven days later.

Completed Pain Assessments Tools could not be located for the following:

A Pain Assessment Tool was not completed on both dates the physiotherapist identified to the nursing staff when resident #041 reported pain (rated 7/10) and tenderness to the a specified body part and could not weight bear.

A Pain Assessment Tool was not completed on a specified date when resident #041 was ordered pain medications for five days for new pain.

A Pain Assessment Tool was not completed on a specified date when the resident's left leg was painful, yellow, swollen, the resident was unable to move it, and a mobile x-ray was ordered.

Following the resident's fall, and subsequent reports of pain, a Pain Assessment Tool was not completed until the resident returned from hospital for a fractured specified body part. [s. 8. (1) (a),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 the home's policies and procedures related to Pain Management and Falls Prevention and Management Program are complied by care staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Critical Incident Report (CIR) was submitted to the Director by the home on a specified date, detailing an allegation of staff to resident abuse involving resident #050 and PSW #125 that occurred on a specified date one day earlier. According to the CIR, on the night shift of a specified date and time, resident #050 was following PSW #125 out of a bedroom in a wheelchair to return a brief that the PSW had left in the resident's room. The PSW then hit the resident with the brief and resident #050 slid to the floor hurting a specified body part.

According to the DOC, RN #124 who was in charge of the building at the time of the incident, wrote a progress note detailing the events and left it on the DOC's desk. The DOC saw the note when she came to work, the following day, over 24 hours from the RN becoming aware of this incident. The progress note written by RN #124 at a specified time and date of the incident, stated that the resident was harmed as a result of being hit with a brief by PSW #125 and falling to the floor.

According to the DOC, the RN should have called the DOC to report the allegation of abuse immediately.

The Director under the LTCHA, was notified of the suspected abuse a specified date, which was not notified immediately as required by this section. [s. 24. (1)]

2. On January 24, 2017, resident #039's Substitute Decision Maker (SDM) indicated to Inspector #573 concern about resident #039 altered skin integrity to a specified body part. The SDM reported suspicion the injury on the resident's specified body part may have resulted during care that was provided by a PSW staff member. Further the SDM indicated to Inspector #573 that a specified date, to have reported these concerns to charge RN #102.

A review of resident #039's progress note for a specified date, indicated "SDM was worried, therefore a report was filled and DOC made aware of situation".

On February 01, 2017, Inspector #573 spoke with RN #102, who indicated that on this specified date, resident #039's SDM reported concerns related to resident #039 altered skin integrity to a specified body part. RN #102 indicated to the inspector that on this specified date, she reported resident #039 SDM's concerns to the DOC and conducted an immediate investigation.

The Director under the LTCHA, was notified of the suspected abuse on a specified date five days after becoming aware of the alleged, suspected abuse, which was not reported immediately as required by this section. [s. 24. (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 a person who had reasonable grounds to suspect that abuse of a resident by anyone has or may occur immediately reported the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident may be restrained by a physical device, if the restraining of the resident was included in the resident's plan of care.

On January 30 and 31, 2017, resident #038 was observed seated in a wheelchair with a specified physical device. When Inspector #573 requested resident #038 to undo this specified physical device, resident #038 could not undo it.

On January 30, 2017, during an interview, PSW #107 stated that he applied the specified physical device for resident #038's safety while in the wheelchair to prevent falls and that the resident was physically incapable of removing the specified physical device.

Resident #038's current written plan of care was reviewed by Inspector #573, and there was no documentation that indicated resident #038 required a wheelchair specified physical device as a restraint.

On January 31, 2017, Inspector #573 observed resident #038 seated in a wheelchair with a specified physical device in the presence of RN #102. RN #102 indicated to Inspector #573 that the resident did not require this restraint as required by this section. [s. 31. (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 a resident may be restrained by a physical device if the restraining of the resident was included in the resident's plan of care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Personal Assistance Services Device (PASD) described in subsection (1) is used to assist a resident with a routine activity of living, only if the use of the PASD is included in the resident's plan of care.

In accordance with LTCHA 2007, s. 33 and O. Reg 79/10, s.111, a PASD is a device used to assist a person with a routine activity of living that limits/ inhibits freedom of movement and which the resident is unable to physically or cognitively remove.

Resident #002 was admitted to the home on a specified date. Resident #002's current plan of care identified that the resident was at high risk for falls.

On January 23, 2017 at 1317 hours, Inspector #551 observed resident #002 seated in a wheelchair with a specified PASD.

On January 27, 2017 at 1040 hours, Inspector #573 observed resident #002 seated in a wheel chair with a specified PASD.

Inspector #573 interviewed PSW #115 and RPN #101, who both indicated that the PASD was used for resident #002 to prevent the resident from sliding from the wheelchair and that at times resident #002 would try to stand up from the wheelchair if the wheelchair was not placed with this PASD.

On January 27, 2017 RN #100 indicated to Inspector #573 that the PASD is used to assist with resident #002's positioning while in the wheelchair.

On January 27, 2017 resident #002's heath care records including current written plan of care was reviewed by Inspector #573. The inspector was not able to locate any information that indicated the resident required the use of the PASD as required by this section. [s. 33. (3)]

2. Inspector #573 reviewed resident #038's health care records that identified that the resident was at high risk for falls. It was noted that on a specified date, resident #038 had a fall that resulted in transfer to hospital with a fracture.

On January 26 and 27, 2017 Inspector #573 observed resident #038 seated in a wheelchair with a PASD in place.

On January 27, 2017 Inspector interviewed RPN #106 in relation to resident #038's wheelchair PASD. RPN #106 indicated that resident #038's wheelchair PASD is used to assist with the resident positioning.

On January 31, 2017 RN #102 indicated to Inspector #573 that the wheelchair PASD was used for resident #038 and that the resident is cognitively and physically not able to remove the PASD.

Resident #038's heath care records including current written plan of care were reviewed by Inspector #573 and RN #102, and noted there was no documentation that indicated the resident required the use of the wheelchair PASD as required by this section. [s. 33. (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 a Personal Assistance Services Device (PASD) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 received fingernail care, including cutting of finger nails.

Resident #002 has resided at the home since a specified date, with several medical diagnoses. According to the written plan of care, resident #002 requires extensive assistance from two staff for personal hygiene and staff are to clean and trim the resident's nails on the first bath of the week. According to RN #102, resident #002's bath days are on two specified days of the week.

On January 23, 2017, resident #002's nails were observed to be long and discolored. On January 27, 30, 31 and February 1 and 2, 2017, the resident's nails were noted to be long with brown colored matter embedded underneath each of the resident's finger nails on both hands, and the tip of the right pinky nail was noted to be sharp and jagged.

The flow sheets from specified dates over the last three months were reviewed by Inspector #551. In a specified month, the residents nails were coded as C (cleaned) weekly. During this twelve week period, there is no documentation on the flow sheet to indicate that the resident's nails had been cut.

On January 30, 2017, RN #102 stated that the resident could be resistive to care, and that staff should report to the registered staff if the resident refused nail care. RN #102 further indicated, the registered staff should document this refusal of care in the progress notes. On January 30, 2017, RN #102 asked RPN #103 to check resident #002's nails.

On February 1, 2017, the progress notes from a specified date to the most recent were reviewed by inspector #551, and there was no documentation indicating that the resident refused nail care.

On February 2, 2017, the DOC and the inspector observed the resident's nails which as described above were long with brown matter embedded underneath each of the finger nails, and the DOC stated that the nails should be cut and that the brown matter in the nail bed should be cleaned. [s. 35. (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 every resident receives fingernail care, including cleaning and cutting of finger nails, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal.

Lunch meal service was observed by Inspector #551 in the south dining room on two specified dates.

According to the menu soup and bread are to be offered at lunch.

On two specified dates, it was noted that bread was not offered to any resident during both meal services.

On one of these specified dates, it was noted that resident #010 received an entrée without having been offered soup.

On another specified date, it was noted that resident #006 and resident #002 received their entrees without having being offered soup.

The dietary kardex and written plans of care for resident #010, #006 and #002 were reviewed, and there is no indication that these residents are not to be offered soup at lunch.

The dietary kardex for the south dining room was reviewed, and no residents were restricted from receiving bread at lunch. [s. 71. (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 planned menu items are offered to every resident and available at each meal, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (8) Every licensee shall ensure that every use of a physical device to restrain a resident pursuant to the common law duty referred to in section 36 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (8).
2. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (8).
3. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (8).
4. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (8).
5. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (8).
6. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (8).

Findings/Faits saillants :

1. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and the licensee shall ensure that the following are documented:
3. The person who applied the device and the time of application.
4. All assessment, reassessment and monitoring, including the resident's response.
5. Every release of the device and all repositioning.

On January 23 and 30, 2017, resident #014 was observed seated in a wheelchair with a specified physical device. When Inspector #573 requested resident #014 to undo the wheelchair specified physical device, resident #014 could not undo it.

Resident #014's plan of care related to the use and application of a specified physical device indicated that resident #014 requires this physical device in the wheelchair for safety. Inspector #573 reviewed the resident's health care records and noted that a physician's order was obtained for the use of wheelchair physical device as a restraint.

On January 30, 2017, RN #102 indicated to Inspector #573 that the physical device is considered as a restraint for resident #014 and that the resident is monitored hourly by the PSWs who document the application, release and repositioning of the resident on the form titled: Restraint Record. RN #102 indicated that the registered nursing staff are to record the resident's response and the effectiveness of the restraint every eight hours on this form.

On January 30, 2017, Inspector #573 reviewed resident #014 health care records with RN#102. RN #102 was unable to locate any Restraint Records for resident #014. [s. 110. (8)]

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 use of a physical device to restrain a resident is documented regarding:
3. The person who applied the device and the time of application.
4. All assessment, reassessment and monitoring, including the resident's response.
5. Every release of the device and all repositioning., to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

A. On January 25, 2017 Inspector #573 observed a container of prescribed cream next to resident #032's bed on top of the resident's bedside table. Inspector #547 observed this same prescribed cream that resident #032 indicated to Inspector #547 staff apply to a specified area and time.

Inspector #547 interviewed PSW #127 responsible for resident #032 on this specified date, who indicated that PSW's are not to apply prescription cream as registered nursing staff do this task. Inspector #547 interviewed RPN #106 responsible for resident #032, who indicated that this prescribed cream container should be stored in the unit's locked treatment cart and not at the bedside. RPN # 106 indicated to Inspector #547 that there are no residents in the home that have physician orders to self administer medications or keep medications at their bedside at this time.

B. On January 26, 2017 Inspector #547 observed several boxes, some folded and some open with items inside located outside resident room #133. Inside one of these boxes, it was noted that several unopened individual boxes of prescribed government stock medication in this box in the resident care hallway.

Inspector #547 informed the DOC who indicated she had no idea why these medications would be stored next to the recycling and garbage bins in the resident care hallway. The DOC indicated that these medications were previously stored in the locked drug storage room yesterday for this wing as they had expired and needed to be disposed of in the appropriate manner via the drug expiry pails used in the home.

C. On January 30 2017 at 1125 hours, Inspector#547 attempted to interview RPN #103 in the home's main nursing station however the home's Dietitian was working at the desktop computer in the nursing station. Inspector #547 knocked on the medication storage room door inside this main nursing station and noted that the medication room door was not locked. On the front of this medication storage room door, there was a red sign that indicated to always keep this door locked. No registered nursing staff were inside the medication storage room or nursing station room. The medication storage room door is equipped with a deadbolt style lock that requires a key to lock. This medication storage room contained an unlocked treatment cart that contained all the prescribed creams and ointments for the East wing residents. This room also contained the unlocked fridge with insulin medication for all residents in the East wing. This room contained the government stock in an unlocked cupboard and accessible to anyone on this wing including the Dietitian seated inside the nursing station room.

Inspector #547 waited till 1143 hours, RPN #103 returned to the main nursing station from the end of the East wing hallway and indicated that he was called away and must have closed the door and forgot to lock it. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs that are stored in an area of the nursing stations is kept secured and locked when unattended by Registered Nursing staff, to be implemented voluntarily.

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that PSW staff participate in the implementation of the infection prevention and control program related to specified personal care equipment storage.

The home's procedure for cleaning of these specified personal care equipment dated January 2016 by the Director of Care posted inside the dirty utility rooms for staff to follow indicated that nursing staff are to wash these specified personal care equipment as per protocol and ensure that a specified cleaning procedure of these specified personal care equipment is required for infection control purposes. This procedure further indicated to ensure that a specified piece is applied to these specified personal care equipment devices is on, when they are done washing the devices and if the specified piece is missing, please advise registered nursing staff immediately.

On January 31, 2017 Inspector #547 observed resident #014's specified personal care equipment inside the dirty utility room labelled with: resident #014's name and a specified date. It was noted that the specified personal care equipment was not stored as required, exposed and rubbing against the wall in the soiled utility room. On February 1, 2017 Inspector #547 observed the same labelled specified personal care equipment in the soiled utility room that was not properly stored.

On February 1, 2017 PSW #114 indicated that this specified piece for the specified personal care equipment for residents are often missing. PSW#114 indicated that he has reported this concern to RPN #114 in the past and that the process on the wall inside the soiled utility room was clear.

On February 1, 2017 RPN #114, the lead for the continence care program in the home observed the specified personal care equipment for resident#014 inside the soiled utility room that was not properly stored. RPN #114 indicated to Inspector #547 that this specified personal care equipment needs to be replaced for infection control purposes. [s. 229. (4)]

2. The licensee has failed to ensure that registered nursing staff participated in the implementation of the infection prevention and control program for resident #020 related to specified personal care equipment.

On February 2, 2017 resident #020 indicated to Inspector #547 to be responsible to care for his/her own specified personal care equipment, and changed these specified personal care equipment devices on his/her own. The resident indicated that he/she has had this specified personal care equipment for approximately a year now and was not shown how to wash or store the specified personal care equipment and figured out to do this on his/her own.

On February 2, 2017 Inspector #547 observed resident #020's specified personal care equipment stored inside the resident's room. The resident's specified personal care equipment was missing a specified piece and resident #020 indicated that he/she threw out these specified pieces when the specified personal care equipment was received, as he/she did not know to keep them. The resident further indicated to the Inspector that he/she does not use a specified cleaning method when changing these specified personal care equipment. Resident #020 indicated to Inspector #547 that he/she does have trouble with specific types of infections.

On February 6, 2017 Inspector #547 reviewed resident #020's health care records and noted that resident #020 has had specified types of infections in the last six months. The DOC indicated that the resident's cleaning and methods used with these specified personal care equipment possibly contributed to the resident's infections, and that the resident required training by the Registered Nursing staff. The registered nursing staff did not participate with the infection, prevention and control program by not teaching resident #020 the home's cleaning procedure regarding these specified personal care equipment. [s. 229. (4)]

3. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program regarding donning the proper Personal Protective Equipment (PPE) with an outbreak that affected residents in the home.

On a specified date, eight residents in a specified area of the home where on droplet isolation precautions for an unidentified organism. Posted signage was located on doors to eight specified rooms. The signs directed all persons to follow droplet precautions and to apply gloves, a gown and a mask upon entering these rooms.

On this specified date, Inspector #547 observed the following staff not wear any PPE as required by the home's infection, prevention and control program.

- Laundry staff #119 and #120 were not wearing PPE while going in and out of rooms three specified rooms that were identified as required droplet outbreak precautions.

- Housekeeping staff #121 was cleaning inside a specified room, that also was identified with signage on the door as droplet precautions and PPE required at the point of entry to this room.

Housekeeping staff #121 and Laundry staff #119 indicated to Inspector #547 that they were not aware these rooms were in droplet precautions, as they did not look at the signage on the doors before entering these rooms. Affected residents were inside each of these rooms as isolated for droplet precautions. [s. 229. (4)]

4. On a specified date and time, Activity Assistant #109 was observed in a specified room with the resident at the resident's bedside. This specified resident

room was currently in droplet outbreak precautions. The Activity Assistant was wearing a gown, but she had not applied gloves or a mask.

On the same day approximately 50 minutes later, PSW #112 left the dining room with show plates and entered into each of the eight rooms identified above without donning any PPE. These rooms were isolated for droplet outbreak precautions.

30 minutes later, PSW #112 and #116 left the dining room with trays for the residents who were on droplet isolation precautions as identified above as they were eating inside their rooms. Trays were delivered to each of the rooms by PSW #112 and #116 who did not apply any PPE upon entering the residents' rooms.

PSW #116 was then observed by Inspector #551 to be feeding resident #049 wearing a gown and gloves but not wearing a mask as directed by the posted signage for droplet precautions.

PSW #111 was observed at a specified time, coming out of a specified room with the resident's lunch tray. The tray was placed uncovered on the trolley, then the PSW went into another specified room. Both of these rooms were on droplet precautions as identified above. The PSW had not donned any PPE and was not observed to wash their hands upon leaving one room and entering another. Hand sanitizer dispensers were observed in resident care hallways as well as inside resident rooms for point of care.

The DOC indicated to Inspector #551 that the dining trays should be removed from the residents' rooms in bags and that for any close contact with the resident affected by this outbreak, such as tray delivery and set-up, staff should be donning full PPE as per posted signage.

The Administrator indicated to Inspector #547 when this was brought to her attention that she would follow up with staff in both areas as they are trying to contain this outbreak to prevent further spread. The Administrator further indicated that any person entering these rooms are required to wear the PPE indicated on the signs located on the doors. [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 care staff, including Nursing, Housekeeping, Laundry, Recreation staff or others that come in contact with residents who are isolated for infection, prevention and control (IPAC) reasons, participate in the implementation of this IPAC program, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

In accordance with O.Reg 31(1) the licensee is required to have an organized program of nursing and personal support services. This program further requires oral care to be provided as identified in O.Reg 34(1) whereby each resident of the home receives oral care to maintain the integrity of the oral tissue that includes mouth care in the morning and evening.

Resident #016 has resided at the home for several years. According to the written plan of care, the resident requires extensive assistance with personal hygiene.

A family member for resident #016 reported to Inspector #551 that they did not believe that resident #016 received adequate mouth care.

Inspector #551 reviewed the documented flow sheets for a specified two week period, which showed that the provision of mouth care was not documented on nine occasions (four times in the evening, once on the day shift, and the provision of mouth care was not documented at all on two specified dates). [s. 30. (2)]

WN #13: 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. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were served their meals only when someone was available to provide the assistance required by the resident.

On a specified date, Inspector #547 observed the meal service on a specified wing for resident's on isolation precautions for an unidentified organism. Six specified resident rooms were observed to have lunch trays located inside their rooms at 1235 hours. RPN #128 indicated to Inspector #547 that she began delivering meal trays to resident rooms, to help out the two PSW's feeding or assisting these residents for lunch at approximately 1230 hours.

Resident in a specified room was provided a tray for lunch but was not assisted with the lunch meal until 1300 hours when PSW #129 arrived to assist with the meal, approximately 25 minutes after the tray was served. PSW #129 indicated to Inspector #547 that this resident required assistance to eat the lunch meal.

Resident in another specified room was provided a tray for lunch but was not assisted with the lunch meal until 1325 hours when PSW #127 arrived to assist with the meal, approximately 55 minutes after the tray was served. PSW #127 indicated to Inspector #547 that this resident required assistance to eat the lunch meal.

Resident in another specified room was provided a tray for lunch but was not assisted with the lunch meal until 1320 hours when PSW #129 arrived to assist with the meal, approximately 50 minutes after the tray was served. PSW #129 indicated to Inspector #547 that this resident required assistance to eat the lunch meal.

On this specified date, Inspector #551 observed that resident #044 ate a meal in the resident's room due to being on outbreak precautions. Resident #044 received a meal tray at approximately 1300 hours, and PSW #116 told the resident that she would be back. The resident did not attempt to feed self. PSW #112 and #116 assisted the resident with positioning at 1320 hours and PSW #116 assisted the resident to eat the meal, approximately twenty minutes after the resident's tray was served. The written plan of care for resident #044 directs staff to provide limited to extensive assistance for eating. [s. 73. (2) (b)]

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually relating to Resident's Bill of Rights and the licensee's policy to promote zero tolerance of abuse and neglect of residents.

In accordance with LTCHA 2007, s.76 (1),(2),(4) and O.Reg 79/10, s. 219(1), all staff at the home shall receive training on the Resident's Bill of Rights and licensee's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities and annually thereafter.

A critical incident report (CIR) was submitted by the home regarding an alleged staff to resident #042 abuse and neglect that occurred on a specified date. The CIR indicated that PSW#122 and PSW#123 were disciplined following an investigation related to this incident. The analysis and follow-up actions in the CIR indicated to ensure all staff completed education on the Resident's Bill of Rights and the licensee's policy to promote zero tolerance of abuse and neglect of residents.

On February 09, 2017, Inspector #573 spoke with the DOC, who indicated that the home is using an on line staff training program called Surge Learning to educate all staff on the Resident's Bill of Rights and the licensee's policy to promote zero tolerance of abuse and neglect of residents. The DOC revealed upon review of the training reports that PSW #123 did not receive retraining annually for a two year period, including the year of this incident, relating to the Resident's Bill of Rights and the licensee's policy to promote zero tolerance of abuse and neglect of residents. [s. 76. (4)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of any alleged, suspected or witnessed abuse of resident #050.

Critical Incident Report (CIR) was submitted by the home on a specified date, detailing an allegation of staff to resident abuse involving resident #050 and PSW #125.

According to the CIR, on a specified date and time, resident #050 was following PSW #125 out of a bedroom in a wheelchair to return a brief that the PSW had left in the resident's room. PSW #125 then hit the resident with the brief, and resident #050 slid to the floor hurting a specified body part.

According to the DOC, RN #124 who was in charge of the building at the time of the incident, wrote a progress note and left it on the DOC's desk. The DOC saw the note when she came to work the following day. The progress note written by RN #124 at a specified time and date about this incident, stated that the resident was harmed as a result if being hit with a brief by PSW #125 and falling to the floor.

The resident's SDM was not notified of the alleged incident of abuse until a specified date, more than 24 hours after the licensee became aware of this incident of alleged staff to resident abuse that resulted in physical injury and pain to resident #050. [s. 97. (1) (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the long-term actions planned to correct the situation and prevent recurrence.

Critical Incident Report (CIR) was submitted to the Director by the home on a specified date, detailing an allegation of staff to resident abuse involving resident #012 and PSW #108.

In the section of the CIR that asked the long-term actions planned to correct the situation and prevent recurrence, the DOC who completed the report, wrote that the actions would be determined pending the home's investigation.

According to the DOC, the resident and the PSW mutually agreed that PSW #108 would no longer provide the resident's care, and that this was implemented immediately. This was the only action taken.

The Director was not notified of the long-term action to correct the situation and prevent recurrence of abuse. [s. 104. (1) 4.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

On January 31, 2017 RPN's #103,#106 and RN #102 indicated to Inspector #547 that they were not aware of the need to destroy drugs, that were not controlled substances in the surplus pails located in the nursing stations. The registered nursing staff interviewed indicated they were informed to place drugs in their original packages or containers, into these surplus pails in whole state for later pick-up from the delivery company.

Inspector #547 observed the surplus pails in both the west and south nursing stations on January 31, 2017. The surplus pail in the south wing was observed to not have a sealed lid. Inspector #547 lifted this surplus pail lid, that exposed a full pail of wrapped up labelled resident medication packages, bottles containing liquid medications, in their original packaging provided by the home's pharmacy. Inspector #547 observed the surplus pail in the west wing and the lid to the surplus pail was attached however the medications were inside there packages inside this pail in their original packaging in whole form. It was noted that there was a white powder in the bottom of this pail under all the medication packages and bottles. RPN #106 indicated to Inspector #547 that she had no idea what this substance was or why this substance was at the bottom of the pail. RPN #106 further indicated to the Inspector that she was not aware to add any fluid to these pails.

The DOC indicated to Inspector #547 that the home's process was to remove the medications from their original packages and place the prescribed medications inside the destruction surplus pails. The DOC further indicated that water or other liquid is required to be added after medication is dropped into these pails as per the home's pharmacy Record of Medication Designated for Destruction instructions, for non-narcotic and non-controlled drugs in the home. The drugs inside these surplus pails were not altered or denatured to such an extent that its consumption is rendered impossible or improbable. [s. 136. (6)]

Issued on this 29 day of May 2017 (A1)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LISA KLUKE (547) - (A1)

Inspection No. / No de l'inspection : 2017_621547_0002 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 000668-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : May 29, 2017;(A1)

Licensee / Titulaire de permis : CVH (No.4) GP Inc. as general partner of CVH (No.4) LP
766 Hespeler Road, Suite 301, c/o Southbridge Care Homes Inc., CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : MANOIR MAROCHEL
949 MONTREAL ROAD, OTTAWA, ON, K1K-0S6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Paul Beverley

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

To CVH (No.4) GP Inc. as general partner of CVH (No.4) LP, 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. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

(A1)
The licensee is ordered to prepare, submit and implement a plan to ensure that the licensee's Skin and Wound Care Program #03-01 dated June 2010 is fully understood and implemented by all registered nursing staff.

Specifically by the established compliance due date, through a combination of performance management interventions, clinical bedside teaching, interactive case-based discussions, directed reading for individualized nursing staff learning needs including a review of the Licensee's Skin and Wound Care program, every registered nursing staff shall demonstrate the knowledge and skill to:

1. identify residents at risk for skin and wound complications/problems

2. ensure care staff provide preventative measures to promote resident skin integrity based on the resident's individualized care needs

3. ensure care staff conduct skin care assessments and ensure these assessments are communicated to registered nursing staff

4. review resident flow sheets regarding documented daily and weekly skin assessments by care staff at the end of each shift

5. carry-out the prescribed treatment plan if and when skin and wound problems develop and devise effective strategies to resolve complex skin and wound problems, including referrals as required.

6. document the skin care assessment accurately including: assessments, interventions, treatments, evaluations and re-evaluations and that this assessment is updated in the resident's plan of care

The licensee shall maintain a detailed written account of all the steps taken and the results achieved during each of the planning, implementation and evaluation phases of this plan.

Furthermore the licensee shall ensure that the Skin Care Program is monitored, reviewed and analyzed on an ongoing basis to determine the need for further corrective actions as part of the licensee's quality improvement program.

Grounds / Motifs :

1. The licensee has failed to ensure the implementation of the skin and wound care program that the licensee developed to promote skin integrity and provide effective skin and wound care interventions.

The licensee's policy and procedure #03-01 dated June 2010 regarding skin care program was reviewed by Inspector #547. To summarize, the program gives directions to nursing care staff regarding the following areas:

- On hire and annually care staff will receive education in preventative skin care as

well as wound care for Registered Staff.

- The program's overall goals for preventative skin care to prevent and address dryness, protect the skin from damage from friction, shear, tears, etc. and observe for changes that may require further treatment.

- Residents at moderate to high risk for skin breakdown are assessed informally on a daily basis. Any concerns are then reported to the registered nursing staff who are then responsible for further assessing the area, documenting the assessment and completing any follow up required.

- This procedure indicated a plan of care related to preventative and active skin care based on the information observed, assessed for and collected will be developed by registered nursing staff.

- Comprehensive skin care assessments will be completed and documented by registered staff.

- Registered nursing staff are responsible for keeping the plan of care up to date at all times, thus reflecting the care needs with respect to skin care.

- If physician orders are required for care of the skin issue, the physician will be contacted to obtain these orders.

- Monthly statistics related to skin care will be collected and analyzed by the skin care coordinator or designate. This data will be reviewed, and where required, an action plan will be implemented to address any trends.

- The documentation requirements indicated the care plan is used to document all care needs and interventions related to skin, that includes active treatment as well as preventative skin care interventions.

The Program Manager indicated to Inspector #547 on February 13, 2017 that the home provides training to nursing care staff by surge electronic learning system. The Program Manager further indicated skin and wound care is required as a mandatory training to nursing staff annually. The Program Manager began in the education role as of October 2016 and noted that a large percentage of nursing staff had not completed their mandatory annual training for skin and wound. Upon review of the

skin and wound care training, 61.7% of care staff and 58% of the registered nursing staff had completed this training for 2016. The Program Manager indicated that the Director of Care was made aware of staff that had not completed their mandatory training.

-The skin and wound care program for care staff and registered care staff indicated for proactive measures to prevent skin breakdown to ensure residents wear long sleeves and pants for warmth as well as prevention of skin tears, pad sharp edges of wheelchairs, use therapeutic and pressure offloading surfaces as necessary, use pillows and wedges for positioning, and to elevate heels by placing pillows lengthwise under legs or use heel pressure redistribution devices.

-The skin and wound care program for registered staff indicated the home's wound assessment tool is initiated when a resident has any open area/wound. One tool for each open area/wound will be completed with every dressing change, but minimum every seven days.

-Notify the physician and refer to members of the interdisciplinary Skin and Wound care team or external consultant if skin breakdown/healable wound is not improving in three weeks.

-The treatment regimen is recorded on the Medication Administration Records MAR and or Treatment Administration Record TAR.

-Wounds will be photographed initially and at least monthly as per best practice.

-The home's interdisciplinary wound and skin care team will have a process in place to review and document the resident's wound care status and plan of treatment on a regular and as needed basis.

-Treatment orders should include: location of wound, treatment and dressing required, how often the dressing is to be changed, include PRN (as required), and include monitor daily.

During the course of this inspection, the following residents were reviewed for skin and wound care:

RE: Resident #006

Resident #006 was admitted to the home on a specified date with several medical diagnoses. Resident was observed by Inspectors #551 and #547 to have several skin integrity issues to a specified area on the resident that triggered a review of the resident's skin care during this resident quality inspection.

Inspector #547 reviewed resident #006's health care records and the current care plan indicated that the resident's skin is very fragile. Interventions identified to protect fragile skin and PSW's are to apply moisturizing lotion daily. Resident's transfers is mechanical lift related to poor weight bearing ability and several skin issues. The resident is seated in a wheelchair during the day and intervention identifies to ensure proper seating to prevent sliding and shearing.

Resident #006's care plan or PSW flow sheets did not identify repositioning needs for this resident every two hours, as issues with skin and positioning as part of their preventative measures. Resident #006 requires extensive assistance of two staff members for repositioning while in bed or in a wheelchair. Two altered skin integrity areas was identified and specified treatments for each required as per protocol and Treatment Administration Record (TAR).

On February 8, 2017 Inspector #547 reviewed resident #006's TARs for two specified months that indicated the following:

1. Two specified areas required specified treatments every three days for dressing changes that started on a specified date over three months earlier.

2. One specified skin alteration required to be cleaned with normal saline and covered with a specified dressing and changed every 21 days and as required that started on a specified date over two months ago.

3. One specified skin alteration required to be cleaned with normal saline and covered with a specified dressing and changed every 21 days and as required that started on a specified date over four months ago.

4. Cut to a specified area to be cleaned with normal saline and covered with a specified dressing and changed every 24 hours and as required that started nine days earlier.

On February 8, 2017 Inspector #547 reviewed resident #006's progress notes and noted that resident #006 also had another ulcer to a specified area that was identified a month ago. As per Bates-Jansen assessment completed on the day it was discovered, resident #006 had a specified ulcer to this specified area. There is no further documentation in the progress notes, or assessments regarding resident #006's skin integrity to this area to date.

The licensee's skin care program indicated that PSW's are to perform a skin assessment on the first bath of the week and document on a flow sheet. The weekly skin observation for resident #006 for a specified month indicated a specified alteration in skin integrity by PSW for the four weeks in this specified month and no other issues. The DOC reviewed this weekly skin observation sheet and indicated that these assessments are not completed properly. The DOC indicated the purpose of these assessments with bathing is to identify all skin alterations for residents and resident #006 had a specified number of open areas as well as an alteration of skin integrity identified a month earlier that were not documented.

RPN #103 observed resident #006's specified dressing on the resident and indicated to Inspector #547 that this dressing is only done every 21 days, and not due to be changed today. RPN #103 reviewed the physician's orders on resident #006's chart, which indicated another specified area required to be cleaned with normal saline and covered with a specified dressing and changed every 21 days and as required (PRN). RPN #103 indicated that the location of this wound was not properly identified in the TAR. This specified order was also not incorrectly transcribed for frequency of dressing changes as the TAR indicated this dressing was to be changed every 24 hours and not every 21 days.

Observations of resident #006:

On February 8, 2017 resident #006 was observed by Inspector #573 to be sliding out of the wheelchair. RPN #114 and RN #100 repositioned the resident by pulling the resident up from under the resident's axilla and thighs in the chair. The resident returned to a slouched position. The resident's feet do not stay on the foot rest. The resident does not use a seat belt or have any other Personal Assistance Services Devices (PASD). The residents chair has capacity for tilt, however this has not been observed by the Inspection team since we arrived in the home on January 23, 2017. Resident #006 has been observed up in this large wheelchair daily after breakfast in the resident care hallways, in the same slouched position.

On February 8, 2017 PSW #108 indicated to Inspector #547 that he had just returned resident #006 to bed after lunch, and that the resident no longer had any pressure ulcer to a specified area.

RPN #103 and Inspector #547 went to evaluate the resident's wounds, as the TAR was unclear.

1. A specified area remained open and no dressing was observed to be covering the resident's ulcer.

2. Inspector #547 and RPN #103 observed that resident #006 no longer had any dressing to a specified area as identified in the resident's TAR. An alteration in skin integrity remained present from previous open area however this was not documented.

3. Resident continued to have redness to a specified area that was not elevated, and the resident was in bed. RPN #103 indicated that the resident's clothing item was too tight and not good for circulation. It was noted that the resident's skin to this specified area remained impaired and would need to be kept elevated and under close observation.

4. Resident had a dressing to a specified area, not the area identified in the TAR. It was noted that the resident's skin around the wound was reddened, and that drainage to the wound was present.

5. The resident had a dressing to a specified area that was dated. RPN #103 indicated this date was when the dressing was last changed. RPN #103 indicated this area was an old skin tear and that it was not due to be changed as it is only changed every 21 days. They follow the TAR for dressing changes. This date was 22 days old on the dressing. The TAR actually indicated that this dressing was not due until three days after the present date. Dates for dressing is not clear.

6. No dressings were observed to specified areas identified in TAR, where a specified treatment was required.

On February 9, 2017 RPN #103 indicated to Inspector #547 that he completed a skin assessment on resident #006 on February 8, 2017 however identified the wrong

location for the pressure ulcer and that he will complete another assessment that day. It was further noted that RPN #103 did not write any order for pharmacy to add this dressing treatment plan and he indicated to Inspector #547 that he was not the first person to initiate this wound and that he is not required to add this. The lead for skin and wound care program in the home, RPN #114 was also present, indicated that RPN #103 should have obtained an order for dressings to a specified area in order to add this treatment to the TAR and the resident plan of care.

RPN #114 indicated to Inspector #547 that skin assessments should be documented for each wound with each dressing change. If a wound is only changed every 21 days, he indicated they expect the registered staff to document their assessment of the dressing and the status of the wound beneath the clear dressing weekly. RPN #114 was aware that registered staff are required to assess wounds weekly and that they would have to review their process on how the TAR is written for appropriate staff direction.

Skin assessments were not completed for every wound/ulcer weekly as required by this program.

Orders were not transcribed properly for staff direction.

Orders were not obtained for pressure ulcer to a new specified area.

Treatments were not ordered or added to the plan of care or provided to the resident who was high risk for skin impairment.

Preventative skin breakdown measures were not in place as identified in the resident plan of care.

No documented pictures for initial or monthly wound assessments were obtained.

RE: Resident #016

Resident #016 returned to the home from hospital on a specified date. Upon return from hospital, the resident's head to toe skin assessment identified an ulcer to a specified area. An assessment of the ulcer was conducted by the Extendicare Assist consultant, the Director of Care and RPN #103 whereby the ulcer was cleansed and a protective dressing was applied.

Inspector #547 interviewed RPN #103 who indicated that he did observed the resident's ulcer on this specified date and completed the required skin assessments however did not contact the physician to inform or add any treatment plan to the resident plan of care.

No documented pictures for initial or monthly wound assessments were obtained.

Upon review of resident #016's health care records on February 13, 2017, no documented weekly assessment of resident #016's specified skin area was documented since the original assessment on this specified date of this ulcer.

RE: Resident #038

Resident #038 was admitted to the home on a specified date with several medical diagnoses. Resident #038 was considered high risk for impaired skin integrity related to mobility and cognitive impairments.

On February 10, 2017 Inspector #547 interviewed resident #038's Substitute Decision Maker (SDM) who indicated the resident has had such trouble with fragile skin. The resident sits in a wheelchair for long periods of time in the morning, often moving specified body parts and skin tears occur. The SDM indicated that resident #038's skin is always so dry and flaky and that the resident did not have any moisturizing cream.

Resident #038 was observed by Inspector #547 to be seated daily in a wheelchair. Resident #038 is transferred to this wheelchair early in the morning as per PSW #105 when the resident wakes up due to high risk of falls from bed. Resident #038's wheelchair had two metal foot rests. It was observed that resident #038 now had a fresh open wound to a specified body part that morning. RPN #106 indicated this resident should have some padding or different wheelchair supports, to help prevent injury to the resident with movement. RPN #106 indicated that resident #038's skin is so dry, that it would also be helpful to have the resident's skin moisturized. The SDM indicated that the resident has not had any moisturizer for a long time now. RPN #106 went to get a large bottle of body moisturizer for the resident.

On February 10, 2017 RPN #106 indicated that she has done an assessment of a specified wound for the resident. The resident also has another specified ulcer now

to another specified area that the dressing was not due to be changed that day. RPN #106 indicated that this resident now had a specified amount of wounds that required dressings at different times as identified in the TAR. RPN #106 indicated that she was not aware that each wound required a skin assessment to be documented, as she thought she only needed to do an assessment with the worst wound.

On February 10, 2017 Inspector #547 reviewed the resident #038's care plan and no documentation of the resident's skin tear to two specified areas for any preventative measures, positioning or protective interventions for these areas. RPN #106 indicated that they will have to add the new wound to a specified area that developed that day to the plan of care. Currently the care plan only identified one specified ulcer with interventions. No other interventions were noted related to two other specified areas for the resident.

The skin and wound care program indicated that PSW's are to complete a weekly skin assessment document with the first bath of the week for every resident.

Inspector #547 reviewed resident #038's skin assessment documents for a specified month and no weekly assessment was documented for two specified weeks that month.On Two other specified weeks this month, PSW's identified a dressing to one specified area only. No documentation of any wound or dressing to a specified area on the resident that was identified during this specified month. Inspector #547 reviewed resident #038's skin assessment documents for the following month and no weekly assessment was documented for three weeks in this specified month and completed once that identified the resident's skin was intact.

Inspector #547 reviewed resident #038's progress notes that indicated the resident was sent to hospital during this recent specified month from an injury related to a fall, and returned with skin laceration to a specified area. A head to toe skin assessment was completed upon return from hospital and this new skin issue was not added to the plan of care for resident #038.

For a specified two month period, the resident did not receive weekly skin assessments by registered nursing staff whereby one of the wounds became infected on specified date at the beginning of this period.

On February 9, 2016 the lead for the skin and wound care program, RPN #114 indicated to Inspector #547 that a skin assessment tool is to be documented after

each dressing change, for each wound or area on the resident. If dressing are to be completed less than weekly such as those due every 21 days, they still expect an assessment of the dressing and wound beneath these clear dressings weekly to be documented. Upon review of resident #038's health care records, RPN #114 indicated that each wound did not have a wound assessment completed as required. No documented pictures for initial or monthly wound assessments were obtained for each of this resident's wounds.

RE: Resident #048

Resident #048 was admitted to the home on a specified date with several medical diagnoses. The resident's care plan for a specified month indicated the resident had chronic leg pain related to specified medical diagnoses. The documented interventions were to monitor the resident's pain level and describe, prescribed cream to be applied three times daily, and prescribed treatment for infection and to monitor side effects. Impaired skin identified with wounds with documented interventions to cleanse with normal saline and then apply prescribed ointment twice daily and monitor.

Resident #048's skin assessments were documented as follows:

On a specified date, resident #048 skin assessment documented that infection present and plan was updated.

The next skin assessment was not completed until over two weeks later as resident #048's skin wounds were not improving.

Two days later, resident #048 was sent to hospital and diagnosed with a specified infection and returned with treatment prescribed.

Head to toe skin assessment was documented upon the resident's return from hospital two days later,which indicated no areas of impairment to skin integrity at this time.

No further documented weekly assessment of resident #048's skin to specified infected areas by registered nursing staff until ten days after the resident returned from hospital.

Two days later, the resident's progress notes documented an ulcer was identified, cleaned and dressed but no assessment tool was completed for this ulcer and this ulcer was not added to the residents plan of care.

Resident was sent to hospital two days after this ulcer appeared, as the resident's specified infected areas were swollen and painful and returned same date with physician orders for increased pain medication and dressings to ulcers daily.

It was noted that the specified treatment dressing orders were not added to the plan of care or to the TAR.

Progress notes documented resident #048's dressings were changed every two days and not daily as ordered. (547)

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

Jun 23, 2017(A1)

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
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 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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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 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
Inspection 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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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
Inspection 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

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 29 day of May 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA KLUKE - (A1)

Service Area Office /
Bureau régional de services : Ottawa