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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Oct 06, 2015;	2015_261522_0005 (A3)	L-001836-15	Resident Quality Inspection

Licensee/Titulaire de permis

MAPLEWOOD NURSING HOME LIMITED
500 QUEENSWAY WEST SIMCOE ON N3Y 4R4

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

MAPLE MANOR NURSING HOME
73 BIDWELL STREET TILLSONBURG ON N4G 3T8

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

MELANIE NORTHEY (563) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance date extended to October 30, 2015 as requested by the home.

Issued on this 6 day of October 2015 (A3)

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

Original report signed by the inspector.

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MELANIE NORTHEY (563) - (A3)

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): February 9, 10, 11, 12, 13, 17, 18, 19 and 20, 2015.

During the course of the inspection, the inspector(s) spoke with the Operations Manager, Director of Care, Controller, Dietary Manager, Program Manager, RAI Co-ordinator, two Activity Program Assistants, two Registered Nurses, six Registered Practical Nurses, twelve Personal Support Workers, a Maintenance Person, a Housekeeping Aide, three Family Members and forty Residents.

The Inspectors toured all resident home areas, the medication room, observed dining service, medication pass, provision of resident care, recreational activities, staff/resident interactions, infection prevention and control practices, reviewed resident clinical records, posting of required information and relevant policies and procedures, as well as minutes of meetings pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

- **19 WN(s)**
- **11 VPC(s)**
- **7 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care included an order by the Physician or the Registered Nurse in the extended class.

A specific resident was observed sitting in a chair with a restraint in place.

Interview with a Personal Support Worker and Registered Nurse confirmed the resident uses a restraint for safety.

Review of the Resident's Quarterly MDS Assessment revealed the reasons for the use of the restraint.

Review of the Physician's Orders revealed the absence of an order for the use of the restraint. This was confirmed by the RAI Coordinator.

Interview with the Director of Care confirmed the home's expectation that a restraint is not included in the resident's plan of care unless there is a Physician's Order. [s. 31. (2) 4.]

2. A specific resident was observed on two occasions sitting in a chair with a restraint in place.

Interview with a Personal Support Worker and Registered Nurse confirmed the Resident uses a restraint for safety.

Review of the Resident's Plan of Care revealed the restraint is to be used at all times when the resident is in the chair.

Review of the Resident's Quarterly MDS Assessment revealed the Resident uses a restraint.

Review of the Physician's Orders revealed the absence of an order for the use of the restraint. This was confirmed by the RAI Coordinator.

Interview with the Director of Care confirmed the home's expectation that a restraint is not included in the resident's plan of care unless there is a Physician's Order. [s. 31. (2) 4.]

3. Review of a specific resident's flow sheet in Point of Care for a specified period revealed staff documented on eight occasions that the resident used a restraint. This was confirmed by the Registered Nurse.

Review of the residents plan of care revealed the restraint is to be used when the resident is in the chair.

Review of the Physician's Orders revealed the absence of an order for the use of the restraint. This was confirmed by a Registered Nurse.

Interview with the Director of Care confirmed the expectation that a restraint is not included in the resident's plan of care unless there is a physician's order. [s. 31. (2) 4.]

4. The licensee has failed to ensure that the restraint plan of care included the consent by the resident or if the resident was incapable, by the Substitute Decision Maker (SDM).

A specific resident was observed on two occasions sitting in a chair with a restraint in place.

Interview with a Personal Support Worker and Registered Nurse confirmed the resident uses a restraint for safety.

Review of the Resident's Plan of Care revealed the restraint is to be used at all times when in the resident is in the chair.

Review of the resident's clinical record and hard copy chart revealed the absence of consent for the use of the restraint. This was confirmed by the RAI Coordinator.

Interview with the Director of Care confirmed the home's expectation that a restraint is not included in the resident's plan of care unless there is consent by the resident or if the resident is incapable, by the SDM. [s. 31. (2) 5.]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 001

WN #2: 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 the home's Ordering and Receiving Medications policy is complied with.

Review of a specific resident's Physician's Orders and electronic Medication Administration Record (eMAR) with the Director of Care (DOC) revealed the resident was ordered a treatment for altered skin integrity on a specified area.

Review of resident’s plan of care revealed the absence of documentation related to altered skin integrity on the specified area. This was confirmed by the DOC.

Interview with a Registered Staff revealed the resident did not have altered skin integrity on the specified area rather the treatment was for altered skin integrity on a different area. The RN confirmed there was an error in the order and eMAR.

Review of Roulston's LTC Pharmacy Services policy Ordering and Receiving Medications, 3.1 Physician's Order Sheet revealed, "All new orders will be checked by two different nurses, by comparing the original order to the eMAR. Sign and date physician’s orders after all steps completed.”

Review of the resident’s hard copy chart revealed only one Registered Nurse reviewed and signed off on the Physician’s Orders. This was confirmed by a Registered Staff.

Interview with the Director of Care confirmed the home's expectation that the Ordering and Receiving Medication policy be complied with; that two different Registered Staff members are to double check orders for accuracy. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's Skin Care and Wound Management Program policy is complied with.

Interview with a Registered Nurse revealed a specific resident currently has altered skin integrity.

Review of the home's Skin Care and Wound Management Program policy NDM-III-239 dated March 30, 2011 revealed,"The Registered Staff upon discovery of a pressure ulcer, initiate a baseline assessment using the pressure ulcer wound assessment record; stage the pressure ulcer using the staging guidelines and make a referral to Enterostomal Therapist (ET) nurse or Wound Care Specialist if available (for stage 3, 4 and unstageable ulcers only).

Review of the resident’s clinical record revealed the absence of a baseline assessment. This was confirmed by a Registered Staff and the RAI Coordinator.

Review of the assessments completed by the Wound Care Specialist (WCS) revealed the resident had not been assessed by the WCS. This was confirmed by the Director

of Care.

Interview with the Director of Care confirmed the home's expectation that the Skin Care and Wound Management Program policy is complied with. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A)Observation on a specific date revealed the Emergency Drug Box contained four vials of Haloperidol 5 mg/ml ampules. Review of the Emergency Drug Box Audit List revealed the contents as having three vials of Haloperidol 5 mg/ml ampules. This was confirmed by two Registered Staff.

Review of Roulston's LTC Pharmacy Services policy Pharmacy Service Overview, 2.7 Emergency Drug Box revealed, "The pharmacist provides an Emergency Drug Box Audit list for the Home, which details its contents, and allows staff to monitor inventory levels and expiry dates on a regular basis."

Interview the Director of Care confirmed the home's expectation that the Emergency Drug Box Audit List should be an accurate account of the contents of the Emergency Drug Box and that the Emergency Drug Box policy is complied with.

B)Review of the "Maple Manor Nursing Home - 1st Floor Resident Narcotic Count" for a specified month revealed that the shift change Narcotic Count document for the month was undated and untimed. Observation revealed there were two staff signatures accounting for only the Evening/Night shift change narcotic count.

Interviews with two Registered Staff revealed that the home has one Registered Staff count and sign for the narcotics between shifts for the Night/Day and Day/Evening shift, and two Registered Staff count and sign the narcotic count sheets at the shift change for Evenings/Nights.

Interview with a Registered Staff confirmed that the "Maple Manor Nursing Home - 1st Floor Resident Narcotic Count" for for a specified month, is the only Narcotic Count sheet currently used for this month. The Registered Staff revealed that the Narcotic Count is completed between the Evening and the Night shift once daily.

Review of Roulston's LTC Pharmacy Services policy Narcotic and Controlled

Medications, 11.4 Shift Change Narcotic Count revealed, "When a Resident's narcotic medication is received, complete the top portion of the form. The outgoing and incoming nurses perform the count together: a)count the amount of medication remaining, b)confirm the actual quantity equals that on the Individual Resident Controlled Drug Administration/Count form, or Unit Narcotic and Controlled Drug Sheet (if utilized), c)Record the date, time, quantity of medication, and sign in the designated location on the Individual Resident Controlled Drug Administration Sheet."

Interview with the Director of Care (DOC) confirmed that the narcotics are counted and the Narcotic Count sheets are signed by one staff on the Days and Evenings shift change and the narcotics are counted and the Narcotic Count sheets are signed by two staff on the shift change between the Evening and Night shift.

The DOC confirmed the home's expectation that narcotic counts have double signatures at each shift change and the home's Shift Change Narcotic Count policy is complied with. [s. 8. (1) (b)]

4. The licensee has failed to ensure that the home's Resident Services-Weights policy is complied with.

Review of the home's Resident Services-Weights policy NDM-III-191 dated October 2008 revealed, "The bath person is responsible for weighing each resident a minimum of once a month."

Review of resident clinical records revealed the following:

Four Residents had not been weighed since December 2014.
One Resident had not been weighed in January 2015, October 2014, September 2014 and June 2014.
One Resident had not been weighed in January 2015.
One Resident had not been weighed in January 2015 and June 2014.

Interview with the RAI Coordinator confirmed the residents had not been weighed.

Interview with the Director of Care confirmed the home's expectation that the home's Resident Services-Weights policy is complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

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

Resident observations revealed the following:
Two residents' mattresses were sitting on top of the corner guards.
Three residents' mattresses fit the bed frame length wise but slid easily on the bed frame.

Tour with the Maintenance person confirmed the above mattresses were sitting on top of the corner guards.

Tour with the Director of Care confirmed the above mattresses slide in the bed frame and were not properly placed into the corner guards.

Review of the Home's Facility Entrapment Inspection Sheet dated January 2, 2012 revealed the following:
a) 93 bed frames, mattresses and side rails were reviewed out of a possible 106 beds
b) 64/93 beds (69%) of these beds received a failure rating in at least one zone between zone 1 and 4.
c) The home confirmed 18 new mattresses and bed frames were purchased and installed since 2012.
d) The home was unable to provide any documentation to confirm corrective action was implemented to correct the failures in zone 1-4.

Interview with the Operations Manager (OM) confirmed the absence of documentation to support corrective action was implemented post failure assessments in January 2012. The OM confirmed it is the home's expectation that all bed systems will be safe for residents residing in this home. [s. 15. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observation of a specific resident's room revealed that the call bell cord was behind the resident's wardrobe and was difficult to view or access.

The Controller confirmed the call bell was inaccessible to the resident and stated this would be addressed immediately.

Interview with the Controller confirmed the home's expectation that the call bell be accessible to the resident at all times. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the resident-staff communication and response system is available in every area accessible by residents.

Observations during the initial tour of the home revealed the absence of a resident-staff communication and response system in the first and second floor North Lounges, the Crow's nest, the second floor sitting area and the second floor common area. These home areas were located at the opposite end of the hallway from the nurses stations. This was confirmed by the Operations Manager.

Interview with the Operations Manager confirmed the home's expectation that a resident-staff communication and response system is available in every area accessible by residents and without one in place there is a safety risk for residents and staff. [s. 17. (1) (e)]

Additional Required Actions:

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

(A3)The following order(s) have been amended:CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that interdisciplinary programs required under section 48 of the Regulations are evaluated and updated at least annually in accordance with evidenced based practices and if there are none in accordance with prevailing practices.

Interview with the Operations Manager (OM) confirmed the home has not completed an annual evaluation of the required programs – skin and wound care, pain management, continence care and bowel management and falls prevention and management.

The OM confirmed the home is aware an evaluation of required programs is to be done annually. [s. 30. (1) 3.]

2. Review of the home's policy related to Personal Support Services documentation of the provision of resident care by Personal Support Workers (PSW's) revealed the home's policy had not been updated since June 2005.

Review of the home's Charting-Flow Sheets policy NDM-III-130 dated June 2005 revealed,"A daily record of actual care given to the resident by the Nurse Aide shall be made on the Flow Sheet and maintained in the permanent record."

Interview with the Director of Care (DOC) revealed the PSW's document the provision of resident care on Point of Care (POC). The DOC confirmed the electronic documentation system was implemented in the home the end of 2013.

Interview with the Operations Manager confirmed that the home had not reviewed and updated the policy to reflect that documentation is completed by Personal Support Workers on POC. [s. 30. (1) 3.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 005

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the home's Administrator works regularly in that position on site for at least the following amount of time per week: In a home with 97 or more licensed beds, at least 35 hours.

Upon entering the home for the start of the Resident Quality Inspection the Controller informed the Inspectors that the Administrator and Director of Care were on vacation and that the Controller would contact the Operations Manager who was off site.

Review of the list of the home's key personnel and their office locations provided as part of the Resident Quality Inspection revealed the absence of the name and location of an Administrator.

Interview with two members of the Resident's Council revealed the residents' were unaware of who the Administrator of the home was.

Interview with the Director of Care (DOC) revealed she worked 35 hours or more in the DOC role.

Interview with the Controller revealed she worked 35 hours or more in the Controller role and the Operations Manager worked 15 hours a week.

Interview with the Operations Manager confirmed he is on site two days per week and accessible by phone the remainder of the time.

Interviews with the Operations Manager, Director of Care and Controller confirmed that there is no Administrator on site 35 hours per week. [s. 212. (1)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain.

Interview with a Registered Staff revealed that a specific resident had altered skin integrity at the time of the interview.

Interview with a member of the Registered Staff revealed that pain assessments are not completed on residents as part of their skin and wound care program.

Review of the resident's clinical record revealed the absence of a documented pain assessment related to the resident's altered skin integrity. This was confirmed by a Registered Staff.

Interview with Director of Care confirmed the home's expectation that pain assessments will be completed using assessments for cognitively alert or cognitively impaired residents. [s. 50. (2) (b) (ii)]

2. Interview with a member of the Registered Staff revealed that pain assessments

are not completed on residents as part of their skin and wound care program.

Review of a specific resident's chart revealed the absence of pain assessments for the resident who has altered skin integrity.

Interview with Director of Care confirmed there were no pain assessments completed on the resident and it is the home's expectation that pain assessments will be completed using assessments for cognitively alert or cognitively impaired residents. [s. 50. (2) (b) (ii)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds have been assessed by a Registered Dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

Chart review revealed the Wound Care Specialist completed two assessments related to altered skin integrity on a specific resident.

Chart review revealed a referral was made to the home's Registered Dietitian.

Interview with a member of the Registered Staff revealed that he/she was unaware of any criteria related to when a referral to a Registered Dietitian would be made for altered skin integrity.

Interview with the Director of Care confirmed it is the home's expectation that a referral will be made to the Registered Dietitian when a resident has an alteration in skin integrity, as per the home's policy. [s. 50. (2) (b) (iii)]

4. Interview with a Registered Staff revealed that a specific resident currently has altered skin integrity.

Review of the resident’s clinical record revealed on a specified date the Registered Staff was alerted to the altered skin integrity.

Further record review revealed the absence of a referral to the home’s Registered Dietitian related to the altered skin integrity.

Interview with a member of the Registered Staff revealed a referral to the Dietitian

should have been made for the altered skin integrity.

Interview with the Director of Care confirmed it is the home's expectation that a referral will be made to the Registered Dietitian when a resident has an alteration in skin integrity, as per their home's policy. [s. 50. (2) (b) (iii)]

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

Chart review revealed two completed assessments of a specific resident's altered skin integrity by the Wound Care Specialist.

Review of the resident's electronic Treatment Administration Record revealed weekly skin assessments were not completed consistently. Also, there was no consistency in the contents of these assessments.

Interview with the Director of Care confirmed there were omissions and lack of information on the weekly skin assessments and it is the home's expectation that weekly assessments will be completed by a member of the Registered Staff weekly and not only by the Wound Care Specialist. [s. 50. (2) (b) (iv)]

6. Interview with a Registered Nurse revealed that a specific resident currently has altered skin integrity.

Review of the resident's clinical record revealed on a specified date the Registered Staff was alerted to the altered skin integrity.

Review of the resident's electronic Treatment Administration Record revealed weekly skin assessments were not completed consistently. Also, there was no consistency in the contents of these assessments.

Interview with Director of care confirmed there were omissions and lack of information on the weekly assessments and it is the home's expectation that weekly assessments will be completed by a member of the Registered Staff weekly. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

A) Observations made on a specific date during the medication pass revealed that the

medication cellophane packages containing resident personal health information (PHI) were placed directly into the garbage receptacle on the medication cart after use.

Interviews with two Registered Staff revealed the home has always placed the cellophane packages into the garbage without rendering them illegible. The Registered Staff confirmed the garbage receptacle containing the cellophane packages are then taken off of the medication cart and placed into the "regular" garbage.

Interview with the Director of Care (DOC) confirmed the cellophane packages containing PHI are currently placed in the garbage, and are not rendered illegible prior to disposal.

The DOC confirmed the home's expectation that residents' personal health information is kept confidential.

B) Observation of the first floor nurses station on a specific date revealed shift report was given at the nurses station and resident personal health information (PHI) was audible. The nurses station is located in a hallway which is frequented by residents, staff, and visitors.

Interview with the Director of Care (DOC) confirmed shift report occurs at the nurses station on the first floor and resident information is audible.

The DOC confirmed the home's expectation that residents' personal health information is kept confidential. [s. 3. (1) 11. iv.]

2. Observation of the first and second floor nurses station revealed resident's hard copy charts were kept behind the counter at the nurse's station. The nurses stations were not equipped with a locked door and residents' charts were completely accessible from the hallway.

Interview with the Director of Care confirmed residents' charts were accessible to the public and the nurse's station is often left unattended.

The DOC confirmed the home's expectation that residents' personal health information is kept confidential. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every residents' personal health information within the meaning of the Personal Health Information Protection Act is kept confidential, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Observation of the second floor Soiled Utility room beside room 230 revealed the door was unlocked and unattended.

The Soiled Utility room contained five hazardous cleaning products.

Interview with the Activity Program Assistant confirmed that the door should be locked when unattended.

Interview with the Operations Manager confirmed the home's expectation that all chemicals are to be securely stored. [s. 5.]

2. Observation of the first floor nurses station on a specific date revealed an unlocked and unattended treatment cart. The cart contained prescription creams, vitarub and hydrogen peroxide.

The Operations Manager (OM) confirmed the cart was unlocked and that the treatment cart should be locked at all times when unattended.

Interview with the OM confirmed the home's expectation that the home is a safe and secure environment for its residents. [s. 5.]

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 is a safe and secure environment for its residents, to be implemented voluntarily.

WN #10: 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. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) Observation of a specific resident‘s room revealed there was a falls mat in place at the side of the resident’s bed.

Interview with a Personal Support Worker and a Registered Staff revealed the falls mat is to be used when the resident is in bed as a falls prevention measure.

Review of the resident's plan of care revealed the absence of documentation related to the use of a falls mat as a falls prevention measure. This was confirmed by a Registered Staff.

Interview with the Director of Care confirmed the home's expectation that the plan of care sets out clear directions to staff that provide direct care to the resident.

B) Interview with a Registered Staff revealed that a specific resident currently has altered skin integrity.

Review of the resident's electronic Treatment Administration Record (eTAR) with the Director of Care (DOC) revealed there were conflicting treatment orders related to the altered skin integrity.

The DOC confirmed the eTAR does not provide clear direction as to the specific area the treatment is to be applied.

Interview with the Director of Care confirmed the home's expectation that the plan of care provide clear direction. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A) Review of a specific resident's clinical record revealed the following:

i) The Wound Care Consultant completed two assessments for altered skin integrity.
ii) The Physician completed the 2014 annual physical and did not reference the altered skin integrity.
iii) The Registered Dietitian completed a nutritional assessment and documented the resident had no skin concerns.

Interview with the home's Skin and Wound Care Nurse confirmed members of the multidisciplinary team usually discuss with the Registered Staff how a resident is

doing.

B) Interview with a Registered Staff revealed a specific resident currently has altered skin integrity.

Review of the resident's clinical record revealed altered skin integrity was noted on a specified date.

Review of the resident's Annual MDS assessment revealed the absence of documentation related to the altered skin integrity. Documentation in the MDS Assessment by the Registered Dietitian did not indicate the resident has altered skin integrity. This was confirmed by the Director of Care.

Interview with the Director of Care revealed it is the home's expectation that there will be an interdisciplinary team approach to ensure assessments are integrated, consistent and complement each other. [s. 6. (4) (a)]

3. 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.

Review of a specific resident's Plan of Care revealed a restraint is to be used when the resident is in the chair.

The resident was observed sitting in a chair and the restraint was not in place. This was confirmed by a Registered Staff.

Interview with the Registered Staff confirmed the resident is to have a restraint on at all times when in the chair.

Interview with the Director of Care confirmed that care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

4. The Licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A) Review of a specific resident's care plan revealed the resident is continent and staff are to encourage the resident to use the bathroom or call for assistance.

Review of resident's Flow Sheet in Point of Care for a specified period revealed the absence of documentation related to toileting observation on five shifts.

B) Review of a specific resident's care plan revealed that the resident is to be toileted regularly to maintain bowel and bladder continence.

Review of the resident's Flow Sheet in Point of Care for a specified period revealed the absence of documentation related to toileting observation on five shifts.

Review of the home's Charting-Flow Sheets policy NDM-III-130 dated June 2005 revealed, "A daily record of actual care given to the resident by the Nurse Aide shall be made on the flow sheet and maintained in the permanent record. Nursing staff on each shift will add appropriate information for those residents assigned to their care."

Review of the Flow Sheets with the Director of Care confirmed the provision of care is not documented consistently, or as per the Plan of Care.

Interview with the Director of Care confirmed the home's expectation that the provision of care as set out in the plan of care is documented, as per the home's policy.

C) Review of a specific resident's Flow Sheet in Point of Care (POC) for a specified period revealed the absence of documentation to support oral care was provided 9/36 occasions (25%).

D) Review of a specific resident's Flow Sheet in Point of Care for a specified period revealed the absence of documentation to support oral care was provided 16/36 occasions (44%).

E) Review of a specific resident's Flow Sheets for a specified period revealed the absence of documentation to support oral care was provided 4/38 occasions (10%).

F) Review of a specific resident's Flow Sheet in POC for a specified period revealed the absence of documentation to support oral care was provided 19/34 occasions (55 %).

Interview with the Director of care confirmed the omissions in the documentation of oral care and that it is the home's expectation that oral care will be provided every morning and evening, and as well, this care will be documented in the flow sheets

consistently.

G) Review of a specific resident's plan of care revealed a bed alarm is to be used when the resident is in bed.

Interview with a Personal Support Worker and Registered Nurse confirmed that a bed alarm is used when the resident is in bed.

Review of the resident's Flow Sheet on Point of Care for a specified period revealed the absence of documentation related to the use of a bed alarm when the resident was in bed on 16/19 occasions (84%). This was confirmed by the Director of Care.

Interview with the Director of Care confirmed the home's expectation that care set out in the plan of care is documented. [s. 6. (9) 1]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) Review of a specific resident's care plan revealed staff are to set up the resident and to encourage the resident to complete oral care.

Interviews with three Personal Support Workers revealed the resident no longer completes his/her own oral care.

Interview with the Director of Care confirmed the home's expectation that if the resident no longer completes their own oral care, this information should be communicated to the Registered Staff in order for the care plan to be revised.

B) Interviews with Personal Support Workers revealed, a falls mat is placed on the floor beside a specific resident's bed and two side rails are used as interventions to minimize the impact and or occurrence of another fall.

Review of the resident's care plan revealed one side rail is used when the resident is in bed; there is no reference to the use of a falls mat.

Interview with the Director of Care confirmed the home's expectation when care needs change and different interventions are implemented that the information is

communicated to the Registered Staff in order for the care plan to be revised. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident; that the care set out in the plan of care is provided to the resident as specified in the plan; that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary; and that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the home's Least-Restraints policy is complied with.

On three separate occasions a specific resident was observed sitting in a chair with a Personal Assistive Service Device (PASD) in place.

Review of the resident's clinical record revealed a physician's order for the use of a PASD.

Review of the resident's Flow Sheets in Point of Care revealed the absence of documentation related the monitoring and repositioning of the resident on the three separate occasions. This was confirmed by a Registered Staff.

Review of the home's Least-Restraints policy NDM-III-128 revealed, "Staff are required to monitor and reposition residents in restraints and PASD's."

Interview with the Director of Care confirmed the home's expectation that the Least-Restraints policy is complied with. [s. 29. (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 the home's Least-Restraints policy is complied with, to be implemented voluntarily.

WN #12: 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. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD to assist a resident with a routine activity of daily living is included in a resident's plan of care only if the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

On three separate occasions a specific resident was observed sitting in a chair with a Personal Assistive Service Device (PASD) in place.

Review of the resident's clinical record revealed a physician's order for the use of a PASD.

Review of the resident's clinical record revealed a consent form in the resident's hard copy chart for the use of the PASD. The consent form did not include the resident's name or the date the substitute decision maker signed the consent. This was confirmed by the RAI Coordinator.

Interview with the Director of Care confirmed the home's expectation that the use of a PASD must be consented to by the resident's substitute decision maker. [s. 33. (4) 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 the use of a PASD to assist a resident with a routine activity of daily living is included in a resident's plan of care only if the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Review of clinical records for two specific residents revealed the absence of a documented clinically appropriate Continence Assessment.

Interview with the Resident Assessment Instrument (RAI) Coordinator revealed that the MDS/RAPS assessment is the only form of assessment that is completed for continence.

Review of the residents' clinical record with the Director of Care (DOC) confirmed bowel and bladder assessments are not being completed consistently.

Interview with the Director of Care (DOC) confirmed the home's expectation that residents' receive a continence assessment which is conducted using a clinically appropriate assessment instrument. [s. 51. (2) (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 the resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A)Review of Residents' Council meeting minutes for a specified date revealed a concern from residents that there was no emergency lighting in the North lounge.

Further review revealed an email response was sent from the Operations Manager to the Program Manager after 10 days of receiving the concern. This response was read by the Program Manager at the Residents' Council meeting on the following month. This was confirmed by the Operations Manager and the Program Manager.

B)Review of Residents' Council meeting minutes for a specified date revealed a concern from residents that night staff were talking too loud in the halls during the night, waking residents and that residents would like staff to introduce themselves when they come on shift to let the resident know who will be taking care of them.

Interview with the Director of Care (DOC) revealed the DOC had not responded to the concern from the Residents' Council meeting.

Interview with the Operations Manager confirmed the home's expectation that a written response is given within 10 days of receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the licensee responds in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately informed of an outbreak of a reportable disease as defined in the Health Protection and Promotion Act.

Upon entering the home on February 17, 2014 Inspectors were informed by the Controller that the home went into outbreak on February 14, 2015 and had one confirmed case of Influenza A.

On February 19, 2015 a review of the Long Term Care Homes Critical Incidents Submissions revealed the home had not submitted a Critical Incident Report related to the outbreak of Influenza A.

Interview with the Director of Care (DOC) confirmed that a Critical Incident Report was not submitted on February 14, 2015 when the home declared an outbreak. The DOC submitted a Critical Incident Report on February 19, 2015.

The DOC confirmed the home's expectation that the Director is informed immediately when the home is in an outbreak of a reportable disease. [s. 107. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is immediately informed of an outbreak of a reportable disease as defined in the Health Protection and Promotion Act, to be implemented voluntarily.

WN #16: 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. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the documentation of a physical restraint includes the person who applied the device and the time of application.

On three separate occasions a specific resident was observed sitting in a chair with a restraint in place.

Review of the Resident's Flow Sheet on Point of Care revealed the absence of documentation related to the use of the restraint on those dates.

This was confirmed by a Registered Staff.

Interview with the Director of Care confirmed the home's expectation that documentation of a physical restraint include the person who applied the device and the time of application. [s. 110. (7) 5.]

2. On three separate occasions a specific resident was observed sitting in a chair with a restraint in place.

Review of the resident's Flow Sheet on Point of Care revealed the absence of documentation related to the use of the restraint.

Further review revealed on 15 out of 16 days (93%) Flow Sheet documentation indicated a restraint was used on the resident. Documentation was inconsistent on

which type of restraint was used.

Interview with a Registered Staff confirmed the use of the restraint was not documented consistently.

Interview with the Director of Care confirmed the home's expectation that documentation of a physical restraint include the person who applied the device and the time of application. [s. 110. (7) 5.]

3. The licensee has failed to ensure that the documentation of a physical restraint included every release of the device and repositioning.

On three separate occasions a specific resident was observed sitting in a chair with a restraint in place.

Review of the resident's Flow Sheet on Point of Care revealed the absence of documentation related to the release of the restraint and repositioning of the resident.

This was confirmed by a Registered Staff.

Interview with the Director of Care confirmed the expectation that documentation of a physical restraint include the release of the device and repositioning of the resident. [s. 110. (7) 7.]

4. On two separate occasions a specific resident was observed sitting in a chair with a restraint in place.

Review of the Resident's flow sheet on Point of Care revealed the absence of documentation related to the release of the restraint and repositioning of the resident.

This was confirmed by a Registered Staff.

Interview with the Director of Care confirmed the home's expectation that documentation of a physical restraint include the release of the device and repositioning of the resident. [s. 110. (7) 7.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the documentation of a physical restraint includes the person who applied the device and the time of application,and every release of the device and repositioning, to be implemented voluntarily.

WN #17: 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 that is used exclusively for drugs and drug related supplies.

Observation of the first floor Utility Room/Century Tub room revealed the presence of prescription medications.

A Personal Support Worker (PSW) confirmed the prescription medications were stored in the Utility Room/Century Tub room. The PSW confirmed the prescription medications should not be stored in this area.

Interview with the Operations Manager confirmed the home's expectation that prescription medications are required to be stored in an area exclusively for drugs. [s. 129. (1)]

2. The licensee has failed to ensure that 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.

Observation of the medication pass on a specific date revealed that the Emergency Narcotic container located in a keyed cupboard inside the Medication room, was unlocked.

Interviews with two Registered Staff confirmed that the cupboard door containing Emergency Narcotics was open and unlocked. The Registered Staff confirmed the cupboard door should be locked when not in use.

Interview with the Director of Care confirmed the home's expectation that the cupboard containing Emergency Narcotics must be locked at all times when not in use. [s. 129. (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 drugs are stored in an area that is used exclusively for drugs and drug related supplies; and that 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, to be implemented voluntarily.

WN #18: 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. (1) Every licensee of a long-term care home shall ensure that the infection prevention and control program required under subsection 86 (1) of the Act complies with the requirements of this section. O. Reg. 79/10, s. 229 (1).

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

Findings/Faits saillants :

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

Observation of the noon meal service in the basement dining room on a specific date revealed staff did not wash their hands between residents during the meal. The Inspector observed a Personal Support Worker (PSW) walk over to speak to a staff member, lean against the dining room wall with their right hand, and then proceed to assist a resident by placing their right hand on the residents hamburger and cut it in half.

The PSW confirmed they had washed their hands on the second floor before coming to the main dining room, but had not washed their hands during the meal service.

The Dietary Manager and the Operations Manager confirmed the home's expectation that staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

2. Observation of a eight shared resident bathrooms revealed numerous unlabelled personal care items. The unlabelled items were confirmed by a Personal Support Worker and Housekeeping Aide.

Interview with the Director of Care revealed it is the home's expectation that all personal care items will be labelled in both shared and private bathrooms. Each week a Personal Support Worker goes around and is to check, label or discard unlabelled personal care items, in both shared rooms and private rooms.

Interviews with the General Manager, Director of Care and the Dietary Manager confirmed that it is the home's expectation that staff participate in the implementation of the infection prevention and control program which includes proper hand washing by all staff and training has been provided to staff on hand hygiene. [s. 229. (4)]

3. Observation of a specific resident room revealed an infection control precautions sign on the entrance to the room. The Personal Protective Equipment (PPE) which was required to enter the room was located inside the bathroom of room.

Interview with a Personal Support Worker (PSW) confirmed the room was under infection control precautions and the PPE was located inside the bathroom. The PSW confirmed the PPE needs to be accessible prior to entering the room.

Interview with the Operations Manager confirmed the home's expectation that personal protective equipment is accessible prior to entering a resident room where infection control precautions are noted. [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, a course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

Observation of the lunch meal on a specific date revealed dessert was offered to the residents before the main course was finished.

Interview with a Personal Support Worker (PSW) revealed that meals are not served course by course. The PSW confirmed staff do this so that documentation can be completed at the end of the meal in order to determine resident intake and refusals.

Interview with the Dietary Manager and Operations Manager confirmed that it is the expectation of the home that the dining service include course by course service of meals for each resident. [s. 73. (1) 8.]

Issued on this 6 day of October 2015 (A3)

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
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Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MELANIE NORTHEY (563) - (A3)

Inspection No. / No de l'inspection : 2015_261522_0005 (A3)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : L-001836-15 (A3)

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

Report Date(s) / Date(s) du Rapport : Oct 06, 2015;(A3)

Licensee / Titulaire de permis : MAPLEWOOD NURSING HOME LIMITED
500 QUEENSWAY WEST, SIMCOE, ON, N3Y-4R4

LTC Home / Foyer de SLD : MAPLE MANOR NURSING HOME
73 BIDWELL STREET, TILLSONBURG, ON, N4G-3T8

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Kim Dance-Palermo

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To MAPLEWOOD NURSING HOME LIMITED, 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 :

LTCHA, 2007, s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Order / Ordre :

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

(A2)
The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 S. O. 2007, c.8, s. 31 (2) to ensure that restraining of a resident by a physical device is included in the residents plan of care only if there is an order approving the restraining by a physician or registered nurse in the extended class and a consent by the resident or the residents substitute decision maker.

The plan must include confirmation that Resident #47, Resident #48 and Resident #54 have a physician s order for the use of a restraint; and that consent has been obtained for Resident #48.

The plan must also identify how and when education will be provided to Registered Nursing staff related to the minimizing of restraining including obtaining consent and an order for the use of a restraint..

Please submit the plan, in writing, to Julie Lampman, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London, ON N6A 5R2, by email at julie.lampman@ontario.ca, by April 1, 2015.

Grounds / Motifs :

1. This area of noncompliance was issued previously as a WN on March 10, 2014 during a Resident Quality Inspection.

The licensee has failed to ensure that the restraint plan of care included an order by the Physician or the Registered Nurse in the extended class.

Review of a specific resident's flow sheet for a specified period in Point of Care revealed staff documented on eight occasions that a restraint was used on the resident. This was confirmed by the Registered Nurse.

Review of the residents Plan of Care revealed the restraint is to be used when the resident is in the chair.

Review of the Physician's Orders revealed the absence of an order for the use of the restraint. This was confirmed by a Registered Nurse.

Interview with the Director of Care confirmed the expectation that a restraint is not included in the resident's plan of care unless there is a physician's order. (522)

2. On three separate occasions a specific resident was observed sitting in a chair with a restraint in place.

Interview with a Personal Support Worker and Registered Nurse confirmed the resident uses the restraint for safety.

Review of the Resident's Plan of Care revealed the restraint is to be used at all times when in the resident is in the chair.

Review of the Resident's Quarterly MDS Assessment revealed the resident uses a restraint.

Review of the Physician's Orders revealed the absence of an order for the use of the restraint. This was confirmed by the RAI Coordinator.

Interview with the Director of Care confirmed the home's expectation that a restraint is not included in the resident's plan of care unless there is a Physician's Order. (522)

3. Observation of a specific resident revealed the resident was seated in a chair with a restraint in place.

Interview with a Personal Support Worker and Registered Nurse confirmed the resident uses a restraint for safety.

Review of the Resident's Quarterly MDS Assessment revealed the reason the resident uses the restraint.

Review of the Physician's Orders revealed the absence of an order for the use of the restraint. This was confirmed by the RAI Coordinator.

Interview with the Director of Care confirmed the expectation that a restraint is not included in the resident's plan of care unless there is a Physician's Order.
(522)

4. The licensee has failed to ensure that the restraint plan of care included the consent by the resident or if the resident was incapable, by the Substitute Decision Maker (SDM).

On three separate occasions a specific resident was observed sitting in a chair with a restraint in place.

Interview with a Personal Support Worker and Registered Nurse confirmed the Resident uses a restraint for safety.

Review of the Resident's Plan of Care revealed the restraint is to be used at all times when the resident is in the chair.

Review of the resident's clinical record and hard copy chart revealed the absence of consent for the use of the restraint. This was confirmed by the RAI Coordinator.

Interview with the Director of Care confirmed the expectation that a restraint is not included in the resident's plan of care unless there is consent by the resident or if the resident is incapable, by the SDM.
(522)

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

Jun 30, 2015(A2)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

(A2)
The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79 10, s. 8(1) to ensure the home s policies and procedures are complied with.

The plan must include how the policies and procedures will be reviewed, updated and implemented, how education will be provided to the appropriate staff and how compliance will be monitored for the following policies:

a) Skin Care and Wound Management Program policy
b) Ordering and Receiving Medications policy
c) Emergency Drug Box policy
d) Shift Change Narcotic Count
e) Resident Services-Weights policy
f) Charting-Flow Sheets policy

Please submit the plan in writing to Julie Lampman, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement
and Compliance Branch, 130 Dufferin Avenue, 4th floor, London, ON, N6A 5R2,
by email, at julie.lampman@ontario.ca, by April 1, 2015.

Grounds / Motifs :

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

1. The licensee has failed to ensure that the home's Skin Care and Wound Management Program policy is complied with.

Interview with a Registered Nurse revealed that a specific resident currently has altered skin integrity.

Review of the home's Skin Care and Wound Management Program policy NDM-III-239 dated March 30, 2011 revealed, "The Registered Staff upon discovery of a pressure ulcer, initiate a baseline assessment using the pressure ulcer wound assessment record; stage the pressure ulcer using the staging guidelines and make a referral to Enterostomal Therapist (ET) nurse or Wound Care Specialist if available (for stage 3, 4 and unstaegable ulcers only).

Review of the resident’s clinical record revealed the absence of a baseline assessment. This was confirmed by a Registered Staff and the RAI Coordinator.

Review of the assessments completed by the Wound Care Specialist (WCS) revealed the resident had not been assessed by the WCS. This was confirmed by the Director of Care.

Interview with the Director of Care confirmed the home's expectation that the Skin Care and Wound Management Program policy is complied with. DOC confirmed the home's expectation that there should have been an initial assessment of the wound on the resident’s left great toe, the wound should have been staged and a referral made to the WCS.
(522)

2. The licensee has failed to ensure that the home's Ordering and Receiving Medications policy is complied with.

Review of a specific resident's Physician's Orders and electronic Medication Administration Record (eMAR) with the Director of Care (DOC) revealed the resident was ordered a treatment for altered skin integrity on a specified area.

Review of the resident's plan of care revealed the absence of documentation related to altered skin integrity on the specified area. This was confirmed by the DOC.

Interview with a Registered Staff revealed the resident did not have altered skin integrity on the specified area rather the treatment was for the altered skin integrity on a different area. The RN confirmed there was an error in the order and eMAR.

Review of Roulston's Pharmacy policy Ordering and Receiving Medications 3.1 Physician's Order Sheet states, "All new orders will be checked by two different nurses, by comparing the original order to the eMAR. Sign and date physician's orders after all steps completed."

Review of the resident's hard copy chart revealed only one Registered Nurse reviewed and signed off on the Physician's Orders. This was confirmed by a Registered Staff.

Interview with the Director of Care confirmed the home's expectation that the Ordering and Receiving Medication policy be complied with; that two different Registered Staff members are to double check the order for accuracy.
(522)

3. The licensee has failed to ensure that the home's Resident Services-Weights policy is complied with.

Review of the home's Resident Services-Weights policy NDM-III-191 dated October 2008 revealed, "The bath person is responsible for weighing each resident a minimum of once a month."

Review of resident clinical records revealed the following:

Four resident had not been weighed since December 2014.
One resident had not been weighed in January 2015, October 2014, September 2014 and June 2014.
One resident had not been weighed in January 2015.
One resident had not been weighed in January 2015 and June 2014.

Interview with the RAI Coordinator confirmed the residents had not been weighed.

Interview with the Director of Care confirmed the home's expectation that the Resident Services-Weights policy is complied with.

4. Review of the home's Charting-Flow Sheets policy NDM-III-130 dated June 2005 revealed, "A daily record of actual care given to the resident by the Nurse Aide shall be made on the Flow Sheet and maintained in the permanent record."

Interview with the Director of Care (DOC) revealed the Personal Support Worker's (PSW's) document the provision of resident care on Point of Care (POC). The DOC confirmed the electronic documentation system was implemented in the home the end of 2013.

Interview with the Operations Manager confirmed that the home had not reviewed and updated the Charting Flow Sheets policy to reflect that documentation is completed by Personal Support Workers on PCC. (522)

4. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied.

A) Observation on a specific date revealed the Emergency Drug Box contained four vials of Haloperidol 5 mg/ml ampules. Review of the Emergency Drug Box Audit List revealed the contents as having three vials of Haloperidol 5 mg/ml ampules. This was confirmed by two Registered Staff.

Review of Roulston's LTC Pharmacy Services policy Pharmacy Service Overview, 2.7 Emergency Drug Box revealed, "The pharmacist provides an Emergency Drug Box Audit list for the Home, which details its contents, and allows staff to monitor inventory levels and expiry dates on a regular basis."

Interview with the Director of Care (DOC) confirmed the home's expectation that the Emergency Drug Box Audit List should be an accurate account of the contents of the Emergency Drug Box and that the Emergency Drug Box policy is complied with.

B) Observations of the medication pass on a specified date revealed that the Narcotic Count documents for a specified month had 2 staff signatures for one undated and untimed shift change.

Interview with two Registered Staff revealed that the home has one Registered Staff count and sign for the narcotics between shifts for the Night/Day and Day/Evening shift, and two Registered Staff count and sign the Narcotic Count sheets at the shift change for Evenings/Nights.

Interview with a Registered Staff confirmed that the "Maple Manor Nursing Home - 1st Floor Resident Narcotic Count" is the only Narcotic Count sheet currently used for this month. The Registered Staff revealed the Narcotic Count is completed between the Evening and the Night shift once daily.

Review of Roulston's LTC Pharmacy Services policy Narcotic and Controlled Medications, 11.4 Shift Change Narcotic Count revealed, "When a Resident's narcotic medication is received, complete the top portion of the form. The outgoing and incoming nurses perform the count together: a)count the amount of medication remaining, b)confirm the actual quantity equals that on the Individual Resident Controlled Drug Administration/Count form, or Unit Narcotic and Controlled Drug Sheet (if utilized), c)Record the date, time, quantity of medication, and sign in the designated location on the Individual Resident Controlled Dug Administration Sheet."

Interview with the Director of Care (DOC) confirmed that the narcotics are counted and the Narcotic Count sheets are signed by one staff on the Days and Evenings shift change and the narcotics are counted and the Narcotic Count sheets are signed by two staff on the shift change between the Evening and Night shift.

The DOC confirmed the home's expectation that narcotic counts have double signatures at each shift change and the home's Shift Change Narcotic Count policy is complied with.

(588)

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

Sep 30, 2015(A2)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

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

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s.15 (1)(b) to ensure that where bed rails are used steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The plan must include when the evaluation of the bed systems will occur, including who will evaluate the bed systems. The plan must include the corrective action implemented for bed systems that failed the bed entrapment assessments; including beds in five specific resident rooms.

Please submit the plan, in writing, to Julie Lampman, Long-Term Care Homes
Inspector, Ministry of Health and Long-Term Care, Performance Improvement
and Compliance Branch, 130 Dufferin Avenue, 4th floor, London, ON N6A 5R2,
by email at julie.lampman@ontario.ca, by April 1, 2015.

Grounds / Motifs :

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

Resident observations revealed the following:
Two resident mattresses were sitting on top of the corner guards.
Three resident mattresses fit the bed frame length wise but slid easily on the bed frame.

Tour with the maintenance person confirmed mattresses were sitting on top of the corner guards.

Tour with the Director of Care confirmed the mattresses slide in the bed frame and were not properly placed into the corner guards.

Review of the Home's Facility Entrapment Inspection Sheet dated January 2, 2012 revealed the following:
a) 93 bed frames, mattresses and side rails were reviewed out of a possible 106 beds
c) 64 / 93 beds (69%) of these beds received a failure rating in at least one zone between zone 1 and 4.
d) the home confirmed 18 new mattresses and bed frames were purchased and installed since 2012.
e) the home was unable to provide any documentation to confirm corrective action was implemented to correct the failures in zone 1-4.

Interview with the Operations Manager (OM) confirmed the absence of documentation to support corrective action was implemented post failure assessments in January 2012. The OM confirmed the home's expectation that all bed systems will be safe for residents residing in the home.

(172)

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

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

May 04, 2015

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

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

(A1)
The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79 10, s. 15.(1) (b), to ensure that the resident-staff communication and response system is available in every area accessible by residents.

The plan must include how the home will ensure a resident-staff communication and response system will be available in the first and second floor North Lounges, the Crow s nest, the second floor sitting area and the second floor common area.

Please submit the plan, in writing, to Julie Lampman, Long-Term Care Homes
Inspector, Ministry of Health and Long-Term Care, Performance Improvement
and Compliance Branch, 130 Dufferin Avenue, 4th floor, London, ON N6A 5R2,
by email at julie.lampman@ontario.ca, by April 1, 2015.

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

Grounds / Motifs :

1. The licensee has failed to ensure that the resident-staff communication and response system is available in every area accessible by residents.

During the initial tour of the home observations revealed there is no resident-staff communication and response system in the first and second floor North Lounges, the Crow's nest, the second floor sitting area and the second floor common area. These home areas were located at opposite ends of the hallway from the nurses stations. This was confirmed by the Operations Manager.

Interview with the Director of Operations confirmed the home's expectation that a resident-staff communication and response system is available in every area accessible by residents and without one in place there is a safety risk for residents and staff.

(538)

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

Oct 30, 2015(A3)

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

(A1)
The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79 10, s. 30.(1) to ensure that interdisciplinary programs required under section 48 of the Regulations are evaluated and updated at least annually in accordance with evidenced based practices and if there are none in accordance with prevailing practices.

Please submit the plan, in writing, to Julie Lampman, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London, ON N6A 5R2, by email at julie.lampman@ontario.ca, by April 1, 2015

Grounds / Motifs :

1. The licensee has failed to ensure that the following is complied with in respect of each of the organized programs required under section 8-16 of the Act: The program must be evaluated and updated at least annually in accordance with evidenced based practices and if there are none in accordance with prevailing practices.

Review of the home's policy related to Personal Support Services documentation of the provision of resident care by Personal Support Workers (PSW's) revealed the home's policy had not been updated since June 2005.

Review of the home's Charting-Flow Sheets policy NDM-III-130 dated June 2005 revealed, "A daily record of actual care given to the resident by the Nurse Aide shall be made on the Flow Sheet and maintained in the permanent record."

Interview with the Director of Care (DOC) revealed the PSW's document the provision of resident care on Point of Care (POC). The DOC confirmed the electronic documentation system was implemented in the home the end of 2013.

Interview with the Operations Manager confirmed that the home had not reviewed and updated the Charting Flow Sheet policy to reflect that documentation is completed by Personal Support Workers on POC. (522)

2. The licensee has failed to ensure that interdisciplinary programs required under section 48 of the Regulations are evaluated and updated at least annually in accordance with evidenced based practices and if there are none in accordance with prevailing practices.

Interview with the Operations Manager (OM) confirmed the home has not completed an annual evaluation of the required programs – skin and wound care, pain management, continence care and bowel management and falls prevention and management.

The OM confirmed the home is aware an evaluation of required programs is to be done annually. (522)

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

Dec 17, 2015(A1)

Order # /
Ordre no : 006

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

Pursuant to / Aux termes de :

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

O.Reg 79/10, s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:

1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week.
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week.
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Order / Ordre :

The licensee must ensure the home has an Administrator that works regularly in that position on site for at least 35 hours per week.

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

Grounds / Motifs :

1. The licensee has failed to ensure the home's Administrator works regularly in that position on site for at least the following amount of time per week: In a home with 97 or more licensed beds, at least 35 hours.

Upon entering the home for the start of the Resident Quality Inspection the Controller informed the Inspectors that the Administrator and Director of Care were on vacation and that the Controller would contact the Operations Manager who was off site.

Review of the list of the home's key personnel and their office locations provided as part of the Resident Quality Inspection revealed the absence of the name and location of an Administrator.

Interview with two members of the Resident's Council revealed the residents' were unaware of who the Administrator of the home was.

Interview with the Director of Care (DOC) revealed she worked 35 hours or more in the DOC role.

Interview with the Controller revealed she worked 35 hours or more in the Controller role and the Operations Manager worked 15 hours a week.

Interview with the Operations Manager confirmed he is on site two days per week and accessible by phone the remainder of the time.

Interviews with the Operations Manager, Director of Care and Controller confirmed that there is no Administrator on site 35 hours per week. (522)

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

May 04, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

Ontario

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

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The licensee must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 50.(2) to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds have been have been reassessed at least weekly by a member of the registered nursing staff, received immediate treatment and interventions to reduce or relieve pain and have been assessed by a registered dietitian who is a member of the staff of the home.

The plan must include confirmation that two specific residents received weekly skin assessments, have received pain assessments and have been assessed by a Registered Dietitian.

The plan must also identify how and when education will be provided to Registered Nursing staff related to weekly skin assessments, pain assessments and referrals to a Registered Dietitian as part of the skin and wound care program.

Please submit the plan, in writing, to Julie Lampman, Long-Term Care Homes
Inspector, Ministry of Health and Long-Term Care, Performance Improvement
and Compliance Branch, 130 Dufferin Avenue, 4th floor, London, ON N6A 5R2,
by email at julie.lampman@ontario.ca, by April 1, 2015.

Grounds / Motifs :

1. Interview with a member of the Registered Staff revealed that pain assessments are not completed on residents as part of their skin and wound care program.

Review of a specific resident 's chart revealed the absence of pain assessments for the resident who has altered skin integrity.

Interview with Director of Care confirmed there were no pain assessments completed on the resident and it is the home's expectation that pain assessments will be completed using assessments for cognitively alert or cognitively impaired residents. (172)

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain.

Interview with a Registered Nurse revealed that a specific resident had altered skin integrity at the time of the interview.

Interview with a member of the Registered Staff revealed that pain assessments are not completed on residents as part of their skin and wound care program.

Review of the resident's clinical record revealed the absence of a documented pain assessment related to the resident's altered skin integrity. This was confirmed by a Registered Nurse.

Interview with the Director of Care confirmed the expectation that pain assessments will be completed using assessments for cognitively alert or cognitively impaired residents. (522)

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

Interview with a Registered Staff revealed that a specific resident currently has altered skin integrity.

Review of the resident’s clinical record revealed on a specified date the Registered Staff was alerted to the altered skin integrity.

Further review revealed the absence of a referral to the home’s Registered Dietitian related the altered skin integrity.

Interview with a member of the Registered Staff revealed a referral to the home's Registered Dietitian should have been made for the resident.

Interview with the Director of Care confirmed it is the home's expectation that a referral will be made to the Registered Dietitian when a resident has an alteration in skin integrity, as per the home's policy.
(522)

4. Chart review revealed the Wound Care Specialist completed two assessments on a specific resident related to altered skin integrity.

Chart review revealed a referral was made to the home's Registered Dietitian.

Interview with a member of the Registered Staff revealed that he/she was unaware of any criteria related to when a referral to a Registered Dietitian would be made for altered skin integrity.

Interview with the Director of Care confirmed it is the home's expectation that a referral will be made to the Registered Dietitian when a resident has an alteration in skin integrity, as per the home's policy.
(172)

5. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the Registered Nursing staff, if clinically indicated.

Interview with a Registered Nurse revealed that a specific resident currently has altered skin integrity.

Review of the resident's clinical record revealed on a specified date the Registered Nurse was alerted to the altered skin integrity.

Review of the resident's electronic Treatment Administration Record revealed weekly skin assessments were not completed consistently. Also, there was no consistency in the contents of these assessments.

Interview with the Director of Care confirmed there were omissions and lack of information on the weekly assessments and it is the home's expectation that weekly assessments will be completed by a member of the Registered Staff weekly.
(522)

6. Chart review revealed two completed assessments by the Wound Care Specialist related to a specific resident's altered skin integrity.

Review of the resident's electronic Treatment Administration Record's revealed weekly skin assessments were not completed consistently. Also, there was no consistency in the contents of these assessments.

Interview with Director of care confirmed there were omissions and lack of information on the weekly assessments and it is the home's expectation that weekly assessments will be completed by a member of the Registered Staff weekly and not only by the Skin and Wound Care Specialist.
(172)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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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

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

May 29, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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 6 day of October 2015 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MELANIE NORTHEY - (A3)

Service Area Office /
Bureau régional de services : London