Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 25, 2016	2015_269627_0008	032276-15	Resident Quality Inspection

Licensee/Titulaire de permis

1895357 Ontario Inc.
1202 Highway 94 R.R. #1 Corbeil ON P0H 1K0

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

NIPISSING MANOR NURSING CARE CENTER
1202 Highway 94 Box 40 Corbeil ON P0H 1K0

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

SYLVIE BYRNES (627), GILLIAN CHAMBERLIN (593), JENNIFER KOSS (616)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 2015.

A complaint related to refusal of admission and two critical incidents related to abuse/neglect, were also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care, Executive Assistant to the Administrator (EA), Administrative Assistant, Life Enrichment Co-ordinator, Unit Clerk, Dietary Aid, Maintenance personnel, Registered Staff (RNs and RPNs), Residents and family members.

Throughout the inspection, the inspectors observed the delivery of care and services to residents, reviewed residents' health care records, reviewed policies and procedures

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Trust Accounts

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On December 10, 2015, Inspector #616 observed medical equipment at resident #011's bedside.

According to their health record, the resident was treated for an illness. Further review of the health record revealed a fax requisition for a specific medical treatment sent to an outside company. However, the physician's order transcribed as a telephone order on the same date prescribed a different treatment. Noting the difference in the two orders, the Inspector reviewed the resident's Medication Administration Record (MAR) with RPN #117 for clarification. They confirmed there was no order for the treatment on the resident's MAR for a one week period.

The Inspector met with RN #103 who also reviewed the health records of the two different orders, the resident's MAR and the care plan in effect at this time which indicated the medical treatment. They confirmed the resident had not received the medical treatment for a one week period in 2015 as set out in the plan of care. [s. 6. (7)]

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

Resident #011 had two documented falls in 2015, each time with injury. No transfer to hospital occurred as per the documentation. Inspector #616 reviewed the plan of care for resident #011 related to fall risk and prevention which included the resident's health record for progress notes, fall risk assessments, the daily flow sheets, and the current care plan dated December 2015.

The care plan identified the resident as high risk for falls, as did the fall risk assessment completed prior to the documented falls. During staff interviews with PSW #119 and PSW #121, both stated the listed care plan intervention of a "falling star" sticker outside the resident's room on the nameplate, and the placement of a yellow "fall caution" sticker on the resident's kardex were communication tools for staff awareness of the resident's increased risk for falls. Both staff confirmed this intervention was not in place as per the care plan and should have been. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to falls prevention.

Resident #008 had a documented fall in 2015, with minor injury and a second fall in 2015 without injury. Inspector #616 reviewed the plan of care for resident #008 related to fall risk and prevention. This included the resident's health record for progress notes, fall risk assessments, the daily flow sheets and the current care plan.

The care plan identified the resident as high risk for falls, as did the fall risk assessment completed prior to the documented falls. During staff interviews with PSW #119 and PSW #121, both stated the listed care plan intervention of a "falling star" sticker outside the resident's room on the nameplate and the placement of a yellow "fall caution" sticker on the resident's kardex were communication tools for staff awareness of the resident's increased risk for falls. The Inspector and PSW #122 confirmed the fall precaution sticker was missing from the kardex. PSW #122 confirmed that a sticker should have been placed in the kardex and it was not. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to falls prevention.

Resident #013 had a documented fall resulting in a head injury without transfer to hospital. Inspector #616 reviewed the plan of care for resident #013 related to fall risk and prevention. This included the resident's health record for progress notes, fall risk assessments, the daily flow sheets and the current care plan.

The care plan identified the resident as high risk for falls, as did the fall risk assessment completed on the same date as the fall. During staff interviews with PSW #119 and PSW #121, both stated the listed care plan intervention of a "falling star" sticker outside the resident's room on the nameplate and the placement of a yellow "fall caution" sticker on the resident's kardex were communication tools for staff awareness of the resident's increased risk for falls. The Inspector and PSW #122 confirmed the falling star sticker was not on the nameplate outside the resident's room as per the care plan and should have been. [s. 6. (7)]

5. The licensee has failed to ensure that the staff and others who provided direct care to the resident were kept aware of the content of the resident's plan of care related to skin integrity and had convenient and immediate access to it.

Resident #006's health record indicated the resident had a history of altered skin integrity. PSW #119 reported to Inspector #616 that there was currently no altered skin integrity beyond redness that was alleviated with off-loading pressure through repositioning. They added the resident had a repositioning schedule when in a wheelchair or in bed. The staff initialed the repositioning log when repositioning was completed. They produced the repositioning log for the month of December to date which confirmed through staff signature that repositioning had occurred every 2 hours as required. They also reported additional strategies to reduce the risk of altered skin integrity were to apply protective devices which covered the bony prominence of the resident while in bed and the use of a therapeutic device.

PSW #119 stated to the Inspector that they found this information in the flow sheets. The staff signed the flow sheets when care was completed. Together the Inspector and PSW #119 reviewed the resident's flow sheets and were unable to locate any related skin care focus. PSW #118 and RN #103 also reviewed the flow sheets and the paper care plan dated December 11, 2015, located in the hallway binder, and found no reference or direction for staff related to skin integrity. All three staff members reported they expected to find a skin care focus in the resident's paper care plan and flow sheets located in the hallway binder and there was none.

Inspector #616 reviewed the electronic care plan dated June 2015 which listed the interventions PSW #119 reported. This included the use of protective devices to be worn while in bed, turn and reposition, complete positioning log every 2 hours while in bed/chair when awake and at least twice during the night and utilizing a therapeutic device.

This electronic care plan related to skin integrity was not available to front line staff. [s. 6. (8)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that care is provided to each resident as specified in the plan of care, that staff and others who provide care are kept aware of the plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #2: 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 were used; the resident was assessed and their bed system was evaluated in accordance with evidence-based practice and, if there was none in accordance with prevailing practices to minimize risk to the resident; steps were taken to prevent resident entrapment which took into consideration all potential zones of entrapment and other safety issues related to the use of bed rails were addressed including height and latch reliability.

On December 8, 2015, Inspector #627 observed resident #006's bed had two 1/4 bed rails in the up position.

A review of the care plan dated June 2015, revealed two 1/4 bed rails were to be used for safety and comfort.

A review of the clinical record for resident #006 revealed no resident specific bed rail entrapment risk assessment was completed prior to the application of bed rails.

An interview with the Administrator confirmed that it was the expectation of the home that a resident specific bed rail entrapment risk assessment was completed prior to the application of bed rails for resident #006. This did not occur and should have. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails were used; the resident was assessed and their bed system was evaluated in accordance with evidence-based practice and, if there was none in accordance with prevailing practices to minimize risk to the resident; steps were taken to prevent resident entrapment which took into consideration all potential zones of entrapment and other safety issues related to the use of bed rails were addressed including height and latch reliability.

On December 9, 2015, Inspector #627 observed that resident #011's bed had the right bed rail in the up position.

A review of the current care plan revealed the use of the right sided bed rail for self positioning.

A review of the clinical record for resident #011 revealed no resident specific bed rail entrapment risk assessment was completed prior to the application of bed rails.

An interview with the Administrator confirmed that it was the expectation of the home that a resident specific bed rail entrapment risk assessment was completed prior to the application of bed rails for resident #011. This did not occur and should have. [s. 15. (1) (a)]

3. The licensee has failed to ensure that where bed rails were used; the resident was assessed and their bed system was evaluated in accordance with evidence-based practice and, if there was none in accordance with prevailing practices to minimize risk to the resident; steps were taken to prevent resident entrapment which took into consideration all potential zones of entrapment and other safety issues related to the use of bed rails were addressed including height and latch reliability.

On December 8, 2015, Inspector #627 observed that resident #012's bed had two 1/4

bed rails in the up position.

A review of the current care plan for resident #012 revealed the use of two 1/4 bed rails for safety and comfort.

A review of the clinical record for resident #012 revealed no resident specific bed rail entrapment risk assessment was completed prior to the application of bed rails.

An interview with the Administrator confirmed that it was the expectation of the home that a resident specific bed rail entrapment risk assessment was completed prior to the application of bed rails for resident #012. This did not occur and should have. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident specific bed rail entrapment risk assessment is performed prior to the use of bed rails for every resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and where the condition or circumstances required a post-fall assessment, the assessment was conducted using a clinically appropriate assessment instrument that

was specifically designed for falls.

Resident #013 had an unwitnessed fall documented by a registered staff member. Inspector #616 reviewed the fall report for the investigation details and found the report to be incomplete. Blank assessment details included the time and cause of fall, list of medications received in the last four hours, interventions to be implemented to prevent future falls, and whether the nursing care plan was updated. In addition, the Power of Attorney notification, identification of a change to the resident's fall risk level, if the resident was transferred to hospital and notification to the Ministry of Health and Long-Term Care were also incomplete in the fall report.

A fall risk assessment completed prior to the fall indicated the resident was a high risk for falls. The care plan in effect at the time of the fall also indicated they were a high risk with a history of falls with sustained injuries.

The home's falls policy indicated that fall investigations are to be completed by registered staff using a Resident Fall Incident Report at the time of the fall and strategies implemented at that time to prevent recurrence. The Acting Director of Care confirmed this policy dated March 2015, to be current. They further added that the fall report was no longer paper but completed by staff electronically in the resident's health record. The Acting Director of Care reviewed the post-fall report for resident #013 and confirmed it lacked the assessment details required as a post-fall assessment and did not follow the procedure for report completion as per the home's policy. [s. 49. (2)]

2. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and where the condition or circumstances required a post fall assessment, the assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A complaint to the Director was received in 2015. It was reported that resident #010 sustained a fall which the family reported to a PSW as it was unwitnessed. It was later discovered that the fall had caused a fracture.

A review of resident #010's care plan current at the time of the fall, found that resident #010 was at high risk for falls as per the most recent fall risk assessment. Multiple interventions were listed to address this.

A review of resident #010's health care record was completed and identified that a post

fall assessment was not conducted after the resident had a fall.

A review of the home's policy, Nipissing Manor Falls Team reviewed March 2015, indicated that when a resident had fallen, the registered staff completed a Resident Fall Incident Report and the Nurse Manager completed a post fall investigation and identified immediate interventions to prevent a recurrence.

The Acting Director of Care confirmed that a post fall assessment should be completed with any suspected or unwitnessed falls. In this situation, a post fall assessment should have been completed after the fact when the injury was discovered and linked to the unwitnessed fall. This was not done. [s. 49. (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 by ensuring that where the condition or circumstances of the resident require, a post fall assessment is completed for residents who have had a witnessed, unwitnessed or suspected fall using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed at least weekly by a member of the registered nursing staff.

Resident #013 was identified through Resident Assessment Instrument-Minimum Data Set (RAI-MDS) as a high risk for pressure ulcers. Inspector #616 reviewed the RAI-MDS Assessment documentation completed in during two seperate months. Both assessments identified the resident had two pressure ulcers. The care plans in effect at the time of both assessments confirmed this altered skin integrity through focus, goals and interventions.

Both PSW #132 and RN #131 reported to the Inspector that resident #013 was known to have ongoing altered skin integrity, RN #131 confirmed the resident did not have a weekly wound assessment completed by a registered staff member when the pressure ulcers were present.

The Acting Director of Care confirmed through review of the electronic documentation in resident #013's health record that there had not been a weekly wound assessment completed by registered staff when the pressure ulcers were present. [s. 50. (2) (b) (iv)]

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

Resident #006 was identified through Resident Assessment Instrument-Minimum Data Set (RAI-MDS) as a high risk for pressure ulcers. Inspector #616 reviewed two RAI-MDS Quarterly Assessment. Both assessments identified the resident had two pressure ulcers. The care plan in effect at the time of both assessments confirmed this altered skin integrity through focus, goals and interventions. One of the interventions noted the resident's wound healing progress would be monitored by the Skin Review Team.

A progress note described the altered skin integrity as a superficial, open area and an ointment had been applied. The next documented reference of altered skin integrity to the same area was three months later with the same application of an ointment. A review of the resident's health record which included the chart-current and archived, was reviewed by RPN #129, member of the interdisciplinary team #130, and the Inspector in search of a paper wound assessment record. No record of a weekly skin assessment completed by registered staff was located.

RPN #129 reviewed the Skin Review Team documentation for record of the resident's wounds as per the progress notes and found none. They confirmed the resident should have been included in the review but was not. The details of wound healing were unknown as there was no clinical record. According to RPN #129 and PSW #119, the resident did not currently have any open wounds.

The Acting DOC confirmed through review of the electronic documentation in resident #006's health record there had not been a weekly assessment completed by registered staff for resident #006's altered skin integrity. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed weekly by a member of the registered nursing staff using a clinically appropriate wound assessment tool, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle included alternative beverage choices at meals and snacks.

On December 10, 2015, Inspector #593 observed PSW #126 providing water to residents in two separate wings during the morning nourishment pass. There were no other beverages available to the residents at this time.

During an interview, multidisciplinary staff member #134 reported that the morning nourishment pass was just a water hydration pass and that it has been this way for at least two years. They reported that tea and coffee was available at this time, but only if residents were in the Life Enrichment room on the first floor as it was a safety measure to monitor residents with hot beverages. They further stated that residents cannot always be monitored in their room. [s. 71. (1) (d)]

2. The licensee has failed to ensure that the home included a between meal beverage in the morning.

On December 15, 2015, during the morning nourishment pass, Inspector #593 observed a staff member with the nourishment cart pass by residents #029 and #030 who were both seated in the lounge. Neither resident was offered or provided a beverage as part of the morning nourishment pass.

On December 15, 2015, during the morning nourishment pass, Inspector #593 observed resident #002 seated in their wheelchair in the corridor. PSW #127 had not offered a beverage to resident #002 at this time.

A review of resident #002's current care plan indicated the resident was at risk for dehydration and staff were to ensure fluids were at the bedside. Furthermore, staff were to encourage resident #002 to drink every time they entered the room.

During an interview on December 15, 2015, PSW #127 reported to Inspector #593 that they usually offered resident #002 a beverage in between meals but the resident often refused. PSW #127 further reported that the dietary staff assembled the beverages on the carts for the nourishment rounds and they usually did not allocate a beverage for resident #002 as it was often sent back to the kitchen because the resident often refused the beverage.

During an interview with Inspector #593 on December 17, 2015, a member of the interdisciplinary team reported that resident #002 should always be offered a beverage regardless of their record for refusing.

During an interview with Inspector #593 on December 17, 2015, a member of the interdisciplinary team #116 reported that the dietary staff should have allocated a beverage for resident #002 on the nourishment cart for between meals and the resident should have been offered a beverage during the morning nourishment pass. [s. 71. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that every resident is offered a choice of beverage, in their prescribed texture, at every nourishment pass and meal, to be implemented voluntarily.

WN #6: 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: 7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included sufficient time for every resident to eat at his or her own pace.

On December 7, 2015, during the dinner meal service, Inspector #593 observed the following:

• 1710 hour- All residents had been served a main course.
• 1714 hour - staff were beginning to clear main meal plates from the tables.
• 1715 hour- staff were serving dessert to residents who had finished their main course.
• 1728 hour- 18/40 residents remained in the dining room, 10 residents were finishing their dessert, residents were starting to be seated by staff for the second meal sitting. Resident #022 was told to move from their seat as they needed it for another resident.
• 1733 hour- resident #023 tried to sit at their table however the resident from the first seating was still there and advised them that they were not finished. They turned around and left the dining room.

It was observed by the Inspector that the first meal service was very rushed. The

residents were served dessert as soon as they finished their meal and were being asked if they had finished when there was still food on their plates. Residents were also being escorted from the dining room as soon as they had finished their dessert.

On December 15, 2015, during the lunch meal service, Inspector #593 observed the following:

• 1218 hour- Dietary Aide #124 was observed cleaning tables when residents had not finished their meals including a specific table, where resident #025 was still eating and at another table where residents #026 and #027 were still eating their meals.
• 1220 hour- residents started to be seated for the second service by staff.
• 1222 hour- a member of the interdisciplinary team was observed asking residents #013 and #028 if they were ready to go when they were seated at their table finishing their beverages. The Dietary Aide #124 was observed to clean this table while resident #013 was still seated at the table.
• 1225 hour- Dietary Aide #124 was observed cleaning a table while asking the resident if they had finished.
• 1233 hour- resident #025 was observed to be seated finishing their tea and eating their dessert. There was also a cup of water at their place setting. A staff member was observed removing the cup of water as they were entering the kitchen. The resident was observed to look upset after this occurred.
• 1235 hour- a staff member was observed asking resident #025 if they were finished. The resident covered their dessert and beverage protectively and said no.

During an interview with Inspector #593 on December 16, 2015, a member of the interdisciplinary team #116 reported that they were involved with each meal service as part of their duties. They reported that the meal service was rushed and they tried to ensure the first seating had finished before the second seating arrived, however sometimes there was an overlap. They further reported that they were to aim for 40 – 45 minutes per seating but there were generally a few residents who took longer than this. They further reported sometimes staff had to ask residents to leave the dining room and residents became upset at this and said "you are rushing me".

During an interview with Inspector #593 on December 17, 2015, a member of the interdisciplinary team #134 reported that the expectation was that the first seating at lunch was to commence at 1200h and the second seating was to commence at 1245 hour. They further reported that residents should not be leaving the dining room until 1230 hour and staff should only be escorting residents in and out between 1230 hour

and 1245 hour. When the observations were reported to the member of the interdisciplinary team #134 regarding staff rushing residents, they replied that this was something they could work on to ensure that residents were not feeling rushed during meals.

A review of the documented meal times indicated the first service for lunch in the first floor dining room was to start at 1200 hour and the second service at 1245 hour. For dinner, the first service in the first floor dining room was to start at 1700 hour and the second service at 1745 hour. [s. 73. (1) 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 home has a dining service that includes sufficient time for every resident to eat at their own pace, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program by performing hand hygiene after each resident contact when giving medications

On December 15, 2015, at 0845 hour, Inspector #627 observed RPN #108 administering medication to resident #016. RPN #108 then proceeded to give medications to resident #006. The Inspector observed that no hand hygiene was performed following administering medication from one resident to another.

RPN #108 stated that the home's expectation was that hand hygiene be performed between residents during the medication pass. RPN #108 confirmed that hand hygiene was not performed between administering medications to resident #016 and resident #006.

On December 15, 2015, at 0940 hour, Inspector #627 observed RPN #110 passing medications to resident #017 and resident #018. The Inspector observed that no hand hygiene was performed following administering medication from one resident to another.

RPN #110 stated the home's expectation was that hand hygiene be performed between residents. Staff #110 confirmed that hand hygiene was not performed between giving medication to resident #017 and #018.

On December 15, 2015, at 1025 hour, the Acting Director of Care confirmed that the home's expectation was to perform hand hygiene between residents when giving medications.

The Hand Hygiene policy reviewed March 2015 indicated hand hygiene in health care should be performed before initial patient/patient environment contact and after patient/patient environment contact. [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 hand hygiene is completed after each resident contact when giving medications, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the right for every resident to have their lifestyle and choices respected, was fully respected and promoted.

A review of the Food Committee minutes dated August 18, 2015, found a documented resident concern enquiring if tea and coffee could be provided on the evening nourishment cart. The documented response from the home was that coffee and tea was provided in the Life Enrichment room due to the risk of residents burning themselves on hot beverages.

During an interview with Inspector #593 on December 15, 2015, resident #020 reported that they asked if they could bring a hot beverage to their room. The staff replied absolutely not as it was a danger. Resident #020 further reported that they felt that this was not right as they were capable of having a hot beverage in their room.

During an interview with Inspector #593 on December 17, 2015, Member of the Interdisciplinary Staff #134 reported that tea and coffee were available during the nourishment rounds but only served in the Life Enrichment room as a safety measure as this was risky for some residents as they were unable to be monitored. They further reported that this was a decision made by the Director of Care and a previous member of the interdisciplinary team. [s. 3. (1) 19.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place was complied with related to skin and wound.

Resident #006 was identified through Resident Assessment Instrument-Minimum Data Set (RAI-MDS) as a high risk for pressure ulcers. Inspector #616 reviewed the RAI-MDS Quarterly Assessment documentation completed. Both assessments identified the resident had pressure ulcers.

RPN #129 stated that registered staff vary in where and how they documented wound assessments. A review of the resident's health record which included the current and archived chart was reviewed by RPN #129, PSW #127 and the Inspector in search of a paper wound assessment record. No record of a weekly skin assessment completed by registered staff was located.

The Acting Director of Care confirmed the home's expectation was that staff complied with the skin and wound policy dated March 2015 which stated that registered staff would have completed a weekly wound assessment on all residents with pressure ulcers. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with related to skin and wound.

Resident #013 was identified through Resident Assessment Instrument-Minimum Data Set (RAI-MDS) as a high risk for pressure ulcers. Inspector #616 reviewed the RAI-MDS Assessment documentation completed. Both assessments identified the resident had pressure ulcers.

Both PSW #132 and PSW #131 reported to the Inspector that resident #013 was known to have ongoing altered skin integrity. PSW #131 confirmed that the resident did not have a weekly wound assessment completed and stated they should have.

The Acting Director of Care confirmed the home's expectation was that staff complied with the skin and wound policy dated March 2015 which stated that registered staff must complete a weekly wound assessment on all residents with pressure ulcers. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that a required policy under the Nutrition Care and Hydration Program was complied with.

A complaint to the Director for resident #010 was received in 2015. It was reported that resident #010 had lost a significant amount of weight over a short period of time and a Registered Dietitian (RD) had not assessed this resident until it was requested by the family member.

A review of the home's Policy: Weight Change Management dated March 2015, found that any resident identified by Nursing as having experienced a significant unplanned weight change would be investigated and assessed by the RD. The referrals were to be made to the RD for residents with significant weight loss. Significant weight change was identified in the policy as 5% or more over one month.

A review of resident #010's monthly weight records found that a significant weight loss occurred over a one month period. The resident was weighed a second time during the month and further weight loss was identified.

On December 17, 2015, during an interview with Inspector #593, the Registered Dietitian reported that Nursing had not referred resident #010 after a significant weight loss had occurred. The Registered Dietitian further reported that this resident was assessed after they were identified during a weight review and 17 days after it was identified that significant weight loss had occurred.

During an interview with Inspector #593, the Acting Director of Care reported that all residents were weighed at the start of the month, usually on the first bath day. This was documented electronically by a registered nursing staff. They added that registered staff were required to refer to the Registered Dietitian any changes in condition including a significant weight loss. [s. 8. (1) (a),s. 8. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring.

During the initial home tour on December 7, 2015, Inspector #616 observed three resident rooms that accommodated two to four residents to have unlabelled personal care products in the shared washroom.

The unlabelled personal care products observed in the washroom cupboard included:

2 residents shared room - used black comb, used toothbrush in white container and toothpaste, used stick deodorant, used mouth rinse, and a squeeze container of body lotion on lower shelf in cupboard. On December 18, 2015, Inspector and PSW #133 observed the following unlabelled personal care items in the cupboard: shampoo, used black brush, toothpaste, lotion, and toothbrush. They were unable to identify which resident the items belonged to.

4 residents shared room- On December 18, 2015, the Inspector and PSW #133 observed the following unlabelled personal care items in the cupboard: an electric toothbrush, used mouthwash, used container of zinc, and used tube of toothpaste. They were unable to identify which resident the items belonged to.

4 resident shared room - pink basin unlabelled with 3 tubes of used toothpaste, mouth rinse, specimen cup (empty), 2 tubes gel fluoride toothpaste, one pair nail clippers, denture cup, and toothbrush in white container. On December 18, 2015, Inspector and PSW #133 observed the following unlabelled personal care items in the cupboard: container of lotion, two tubes of used toothpaste, two used toothbrushes, used peri cleanser and used mouth rinse.

PSW #133 reported that all personal care items were labelled on admission and when new items were brought in. They stated the observed unlabelled items should have been labelled.

The Acting Director of Care confirmed the home's expectation was that all personal care items belonging to residents were labelled. [s. 37. (1) (a)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to give persons to whom notice was given, a written notice setting out, a detailed explanation of the supporting facts, as they related to both the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justified the decision to withhold approval and contact information for the Director.

A complaint was received by the Ministry of Health and Long-Term Care related to two separate Long-Term Care (LTC) admission referrals for the same applicant, each refused by the home.

The basis of refusal in the letters was documented as the applicant was a wandering risk and exhibited responsive behaviors. The home did not have a secure unit or wander guard system to manage their safety needs, and the home lacked the staffing level or expertise to ensure the safety and security of other residents in the home.

Inspector #616 reviewed documentation provided by the Community Care Access Center (CCAC). The documents revealed that the home had not included the most current Hospital Minimum data set Home Care (MDS-HC) and the most current Health Assessment available from CCAC in consideration of the applicant's requests for admission.

In both letters, a detailed explanation of the supporting facts based on the applicant's current condition and the requirements for care, an explanation of how these supporting facts justified the decision to withhold approval, and the contact information for the Director was omitted. This was confirmed by the Acting Director of Care. [s. 44. (9)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the annual resident satisfaction survey and in on acting on its results.

During an interview with Inspector #593 on December 15, 2015, resident #032 reported that the Council was not consulted in the development of the annual resident satisfaction survey.

During an interview with Inspector #593 on December 15, 2015, member of the interdisciplinary team #116 confirmed that the Council was not consulted in the development of the annual resident satisfaction survey. [s. 85. (3)]

2. The licensee has failed to seek the advice of the Family Council in developing and carrying out the annual resident satisfaction survey and in on acting on its results.

During an interview on December 14, 2015, family member #021 confirmed the Council members were not asked for input for the resident satisfaction survey.

During an interview with Inspector #627 on December 15, 2015, Multidisciplinary team member #116 confirmed that the Family Council was not consulted in the development of the annual resident satisfaction survey. [s. 85. (3)]

3. The licensee has failed to ensure that the results of the annual resident satisfaction survey are made available to the Residents' Council and to seek their advice.

During an interview with Inspector #593 on December 15, 2015, resident #032 reported that the results of the survey were not shared with the Council nor did they receive a copy of the results.

During an interview with Inspector #593 on December 15, 2015, member of the interdisciplinary team #116 reported that the usual process regarding the annual satisfaction survey was that once the survey was completed, the Administrator attended a Residents' Council meeting and reported the results to the Council. Member of the interdisciplinary team #116 confirmed that the results of the 2014 resident satisfaction survey were not provided to the Council in writing nor were they verbally communicated to the council by the Administrator.

A review of the Resident Council minutes for 2014 and 2015 confirmed that the Administrator did not attend a Residents' Council meeting to report on the results of the 2014 resident satisfaction survey. [s. 85. (4) (a)]

4. The licensee has failed to ensure that the results of the annual resident satisfaction survey were made available to the Family Council to seek their advice.

During an interview, family member #021 confirmed the Family Council were not provided with a copy of the results of the annual resident satisfaction survey and were not asked for advice on the results.

During an interview with Inspector #627 on December 15, 2015, member of the interdisciplinary team #116 confirmed that the Family Council members were not provided with a copy of the results of the satisfaction survey nor had they been asked for advice on the results. [s. 85. (4) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint that was made to the licensee or staff member concerning the care of the resident or the operation of the home was investigated and resolved where possible, and a response was provided within 10 business days of the receipt of the complaint.

During an interview with Inspector #593 on December 16, 2015, it was reported that a personal object that was brought in with the resident upon admission had recently gone missing. They were unsure of the date it went missing. The family member further added that they reported this to a member of the interdisciplinary team upon discovery of the missing item approximately two to three months earlier. Since this was reported, family

member #019 has not heard anything further from the home as to whether the item was located or not. Family member #019 further reported that they also included this on the Resident Satisfaction Survey, however they have not been responded to regarding this either.

During an interview with Inspector #593 in December 16, 2015, the Acting Director of Care reported that if an item went missing, a specific form was to be completed to capture the details and the family was contacted right away with the outcome of whether the item was located or whether they were unable to locate the item.

The inspector reviewed the lost articles binder located at the nurses' station, there was no document related to the missing item reported by family member #019.

During an interview with Inspector #593, December 16, 2015, a member of the interdisciplinary team reported that the missing personal item was reported directly to them however the process was not followed as required. There was no written documentation of the missing item and the family member was not responded to regarding their complaint of the missing item. The member of the interdisciplinary team also confirmed that family member #019 did include a complaint regarding the missing table on the Resident Satisfaction Survey, however they were not responded to regarding this complaint either. [s. 101. (1) 1.]

2. The licensee has failed to ensure that with every written or verbal complaint that was made to the licensee or a staff member, a documented record was kept in the home that included the nature of each complaint, the date the complaint was received, the action taken to resolve the complaint and the final resolution.

During an interview with Inspector #593 on December 16, 2015, it was reported a personal item that was brought in with the resident upon admission had recently gone missing. They were unsure of the date it went missing. They further added that they reported this to the a member of the interdisciplinary team upon discovery of the missing item approximately two to three months earlier. Family member #019 further reported that they also included this complaint on the Resident Satisfaction Survey completed November 2015.

During an interview with Inspector #593 on December 16, 2015, the Acting Director of Care reported that if a family member reported a missing item, a specific form was to be completed to capture the details and this was located in a binder at the nurses' station.

The Inspector reviewed the lost articles binder located at the nurses' station and found no document related to the missing item reported by family member #019.

During an interview with Inspector #593 on December 16, 2015, member of the interdisciplinary team #123 reported that the missing item was reported directly to them however the process was not followed as required. There was no written documentation regarding the complaint of the missing item. Staff member #123 also confirmed that family member #019 had included a complaint regarding the missing item on the Resident Satisfaction Survey, however this was not documented or followed up on. [s. 101. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (7) The licensee shall,
(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).

Findings/Faits saillants :

1. The licensee has failed to provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized statement of the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement.

During an interview with Inspector #593 on December 9, 2015, family member #019 reported that they had not received a recent statement of the trust fund held by the licensee for their family member. They would appreciate a monthly statement as there had been some errors with this account in the past, due to a resident with a similar name.

During an interview with Inspector #593 on December 15, 2015, a member of the interdisciplinary team reported that the home had a new process in place for managing resident trust funds as well as providing statements to residents that hold trust accounts. They anticipated that this system will be fully implemented as of the New Year and this would ensure that all residents and/or their POAs received a monthly statement. This process however was not yet fully implemented and the last statement that was sent to all residents and/or their POAs was in August 2015. Member of the interdisciplinary team #111 further reported that they had no documentation to show that statements were provided during this month including for family member #019.

A review of the home's policy: Trust Accounts, reviewed March 2015, found that a quarterly itemized statement was to be provided to the resident, or to the person acting on behalf of the resident, respecting the money held by the licensee in trust for the resident. [s. 241. (7) (f)]

Issued on this 26th day of January, 2016

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

Original report signed by the inspector.