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
Oct 5, 2015	2015_337581_0016	H-003231-15	Resident Quality Inspection

Licensee/Titulaire de permis

NORFOLK HOSPITAL NURSING HOME (THE)
365 WEST STREET SIMCOE ON N3Y 1T7

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

THE NORFOLK HOSPITAL NURSING HOME
365 WEST STREET SIMCOE ON N3Y 1T7

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

DIANNE BARSEVICH (581), CYNTHIA DITOMASSO (528), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 14, 15, 16, 17, 18, 21, 22 and 23, 2015.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW), RAI Coordinator Back-Up, Activity Director, Housekeeper, Laundry staff, Director of Personal Support Services, Food Service Supervisors, Dietary staff, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **15 WN(s)**
- **9 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. (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. (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 failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. In March 2015, the Minimum Data Set (MDS) Assessment for resident #15 identified under Section "E. Mood and Behaviour Patterns" that the resident demonstrated one responsive behaviour one to three days a week which was not easily altered. In May 2015, the MDS Assessment under the same section identified that the resident demonstrated two responsive behaviours one to three days a week and both were not easily altered. The resident had no change in their behavioural symptoms. The Resident Assessment Protocol (RAP) for May 2015 and progress notes, documented increased confusion and responsive behaviours during the Assessment Review Date (ARD) period. Interview with the RAI-Coordinator confirmed that the resident's behaviour patterns changed from the ARD in May 2015, when compared to March 2015 and that the MDS Assessment from May 2015, did not complement the RAPS and progress notes from the ARD, related to a change in resident #15's behaviour patterns.

B. The MDS Assessments for resident #16 from March to September 2015, identified under Section "I. Disease Diagnosis" that the resident had an infection. Review of the plan of care, specifically progress notes, revealed that the resident was treated for an infection in February 2015, only. Interview with the RAI Coordinator Back-Up confirmed that the MDS Assessments from June and September 2015, were not consistent with the assessments completed by registered staff in the progress notes, related to the infection.

C. The plan of care for resident #11 indicated they had urinary incontinence. The (MDS) assessments from April and June 2015, identified the resident was frequently incontinent of bladder and the MDS assessments from October 2014 and January 2015, indicated the resident was occasionally incontinent of bladder. The (RAP) in April 2015, indicated the resident was more incontinent over the quarter and were now frequently incontinent; however, the change in urinary continence in the MDS assessment in April 2015, indicated there was no change. Interview with the RAI Coordinator-Back Up stated their urinary continence had deteriorated and confirmed that the MDS assessment was inconsistent with the RAP assessment and staff did not collaborate with each other in the completion of the assessments.(581)

D. Resident #14 demonstrated responsive behaviours. The RAI MDS assessment completed in February 2015, identified that the resident demonstrated wandering behaviour which occurred four to six days but less than daily and was not easily altered. The RAI MDS assessment completed in May 2015, indicated they demonstrated wandering behaviour which occurred daily and was not easily altered. This assessment also noted that there was no change in behavioural symptoms. The RAP assessment completed in May 2015, identified they wandered on the unit daily. Interview with RAI Coordinator-Back Up confirmed that the resident's behavioral symptoms had deteriorated and the MDS assessment was inconsistent with the RAP assessment and staff did not collaborate with each other in the completion of the assessments as they were not consistent and did not complement each other.(581)

E. Resident #18 demonstrated responsive behaviours. The RAI MDS assessment completed in February 2015, identified that the resident demonstrated three behavioural symptoms and the RAI MDS assessment completed in May 2015, indicated they demonstrated five behavioral symptoms and all behaviours were not easily altered. This assessment also noted there was no change in behavioural symptoms in the past 90 days. The RAP assessment in May 2015, identified that the resident had increased responsive behaviours towards staff. Interview with the RAI Coordinator-back up

confirmed that the resident's behavioural symptoms had deteriorated and that staff did not collaborate with each other in the completion of the assessments as they were not consistent and did not complement each other. (581) [s. 6. (4) (a)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

Resident #22 was identified as high nutritional risk related to poor appetite and chewing difficulties, as evidenced by significant weight loss in September 2015. On September 22, 2015, the resident was offered an afternoon drink and snack which was refused. A PSW re-approached to offer chocolate milk, which the resident consumed. Two PSWs reported the resident would regularly consume chocolate milk when they refused other nourishment options; however, stated it was not in the resident's plan of care. Interview with registered nursing staff familiar with the resident reported they were unaware of this intervention being part of their plan of care. [s. 6. (4) (b)]

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

Resident #22 was identified as high nutritional risk related to poor appetite due to difficulty with chewing as evidenced by significant weight loss in September 2015. The resident's plan of care stated they were to receive custard as a meal supplement at breakfast. During breakfast on September 22, 2015, the resident did not receive custard. Dietary staff were interviewed and stated the resident did not receive custard. A PSW and registered nursing staff confirmed the resident was to receive custard at breakfast and the care set out in the plan of care was not provided as specified in the plan. [s. 6. (7)]

4. The licensee 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. In September 2015, the written plan of care for resident #16 identified that the resident had an alteration in health status related to an infection. Staff were directed to monitor the resident's temperature every four hours until within acceptable limits and then daily until resolved. Review of the clinical health record revealed that the resident had an

infection in February 2015, which required staff to monitor the resident's temperature and was resolved within the same month. The plan of care was not revised when the care set out in the plan, related to frequent monitoring of temperature was no longer necessary. Interview with the RAI Coordinator Back-Up confirmed that the plan of care was not revised.

B. Review of the plan of care for resident #18 indicated they were transferred for toileting with assistance of two staff or with the sit and stand lift as required. Interview with PSW stated the resident was transferred with the hoyer lift and the hygiene sling was used for toileting. On September 17, 2015, the resident was observed using the hygiene sling. Registered staff stated they were no longer transferred with the assistance of two staff or the sit and stand lift and the written plan of care was not updated when their transfer needs changed to a hoyer lift. (581)

C. Review of the plan of care for resident #18 indicated they used a urinal for continence care. Interview with PSW stated the resident no longer used a urinal and was incontinent of bladder and bowel. Registered staff confirmed the resident did not use a urinal and the written plan of care was not updated when the care set out in the plan was no longer necessary related to continence care interventions. (581)

D. Review of the plan of care indicated the resident wore a pull up during the day and a large brief at night. Interview with PSW stated the resident wore a pull up during the day but for the past month they wore two continence products at night as this was the resident's preference. Review of the written plan of care did not include the two continence products for night incontinence. Registered staff confirmed that the written plan of care was not updated when the resident's night continence products changed. (581)

E. Review of the plan of care for resident #19 indicated they required one, two third bed rail raised when in bed for turning and positioning. On September 15 and 17, 2015, one, two third bed rail was observed raised on the bed. Interview with PSW stated the resident had one bed rail raised when in bed at night. Review of the written plan of care identified that two bed rails were to be raised at all times when in bed for safety and bed mobility. Registered staff confirmed the resident only had one bed rail raised when in bed and the written plan of care was not updated when the care set out in the plan was no longer necessary. (581) [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 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 changed or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

Throughout the course of the inspection it was observed that the outdoor area attached to the activity room was not equipped with a resident-staff communication and response system. Interview with activity staff stated that some residents were able to spend time outside independently. Staff confirmed there was no call bell available in the outdoor area and the closest call bell was located indoors in the activity room. [s. 17. (1) (e)]

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 equipped with a resident-staff communication and response system that is available in every area accessible by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included physical assistance or cueing to help a resident who cannot, for any reason, brush his or her own teeth.

Resident #16 had a plan of care to receive constant supervision with extensive physical assistance for hygiene and grooming, which included oral care. On September 15, 2015, in the late morning, the resident was noted to have debris stuck in their teeth with mouth odour present. The resident stated they required assistance from staff for oral care and received help once and a while.

On September 22, 2015, in the afternoon, the resident reported they did not receive assistance to brush their teeth in the morning and toothpaste and a toothbrush were observed set up by their sink. The PSW providing care on the shift stated they required set-up help; however, confirmed the resident did not actually brush their teeth as their toothbrush had not moved. Registered staff confirmed the resident required constant supervision with extensive assistance to ensure they received adequate oral care. [s. 34. (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 each resident of the home receives oral care to maintain the integrity of the oral tissue that includes physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth, to be implemented voluntarily.

WN #4: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).**

**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:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).**

**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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).**

**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).**

**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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).**

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

Findings/Faits saillants :

1. The licensee failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

In an interview with Residents Council (RC) President, they were unable to recall if meal

and snack times were reviewed with the RC. Review of RC minutes from 2015, did not include a review of the meal and snack times. Interview with the home's activity staff and dietary staff, who attend meetings, confirmed that meal and snack times had not yet been reviewed with RC. [s. 73. (1) 2.]

2. The licensee failed to ensure that the dining service included, at a minimum, monitoring of all residents during meals.

On September 14, 2015, at the end of lunch in the main dining room, residents were observed seated with food and fluids still at their place settings and no staff present to monitor. On September 22, 2015, at the end of breakfast in the main dining room, residents were observed seated with food and fluids still at their place settings, several still eating and drinking and no staff present to monitor. PSWs interviewed stated they were portering residents out of the dining room to provide care, that they were not monitoring the remaining residents and were unaware of who was responsible to do so. Registered staff stated they were unaware who was responsible for the monitoring residents through to the end of the meal and there was no plan available to inform staff on who was responsible. [s. 73. (1) 4.]

3. The licensee failed to ensure that the dining and snack service included, at a minimum, foods and fluids being served at a temperature that was both safe and palatable to the residents.

On September 21, 2015, during lunch in the main dining room:

i) Pre-portioned oatmeal was placed at resident #22's place setting at least ten minutes prior to their arrival. The oatmeal was not hot to touch and when the resident arrived, they reported their oatmeal was not hot.

ii) Grilled cheese, french fries and omelettes were on the menu. Resident #86, who was one of the last served, reported the items were not hot. Resident #87 who was served an omelette also reported the food was not hot. The grilled cheese was probed and recorded at 51.1 degrees Celsius, french fries 58 degrees Celsius and omelette 51 degrees Celsius. The dietary aide serving reported at times it was difficult to maintain hot food temperatures. A Food Service Supervisor (FSS) confirmed that hot foods were to remain at 140 degrees Fahrenheit (60 degrees Celsius) during meal service. [s. 73. (1) 6.]

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

During all dining observations conducted in the main dining room, meals were not served course by course. Residents were served courses without them finishing the previous one and dishes were not removed until the end of meal service. Tables appeared cluttered with dishes, cutlery and containers. Resident #90 reported they were served courses before finishing the previous one, that their table was cluttered which they found overwhelming and that meal service felt rushed. Staff confirmed dishes were not removed until the end of the meal by dietary staff. [s. 73. (1) 8.]

5. The licensee failed to ensure that the homes dining and snack service that included, at a minimum, provided residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A. Resident #40 required supervision and set up with meals but was able to eat independently. During breakfast service on September 18, 2015, staff placed a bowl full of oatmeal on the table in front of them. They were seated in a tilt wheelchair with a tabletop tray and were unable to reach the oatmeal. The resident called out for assistance, at which time, staff replied, "The nurses will be in soon". The resident attempted to reach the oatmeal for approximately ten minutes before a staff member placed the oatmeal and spoon on the resident's tabletop tray and then they began to feed themself. Staff did not provide resident #40 with the assistance of set up required for the resident to safely eat as comfortably and independently as possible until ten minutes after food was placed in front of them.

B. Resident #80 was at high nutrition risk, related to dementia, requirement for ongoing encouragement, chronic poor fluid intake and appetite, as reported by registered nursing staff.

i) On September 14, 2015, during lunch, the resident was observed in a wheelchair with a table top tray, sitting in front of their table. Their soup and drinks were served, placed on the table out of their reach. The main course was placed on the table out of their reach for fifteen minutes. PSW staff confirmed food and fluids were not placed on the tray and the resident was not provided the personal assistance they required to eat and drink.

ii) On September 21, 2015, during lunch, the resident's drinks and soup were placed on the table out of their reach and not placed on their tabletop tray for the course of the meal. A PSW present at the table confirmed the resident was not provided with the personal assistance and encouragement they required to consume their fluids.

iii) A review of the resident's fluid intake records revealed their intake was less than 1000 milliliters twelve out of fifteen days in September 2015. Registered staff confirmed their fluid intake was regularly low, were on fluid watch and their fluids should have been placed within reach. (585)

C. On September 14 and 21, 2015, during lunch, resident #81 was observed in a wheelchair with a table top tray, sitting in front of the table. Both days the resident reported to the inspector they could not reach the drinks as they were placed on the table. Registered staff confirmed drinks should have been provided to them within reach. (585) [s. 73. (1) 9.]

6. The licensee failed to ensure that residents who required assistance with eating or drinking were served their meal only when someone was available to provide assistance.

During meal observations on September 14, 21 and 22, 2015, drinks were observed poured and served to residents prior to entering the dining room or shortly after. Several residents, including resident #21, resident #82, resident #83 and resident #84 required total assistance with eating as observed and indicated by staff.

i) On September 14, 2015, at 1230 hours, residents #82, resident #83 and resident #84 were observed with fluids in front of them and resident #83 was noted to be looking at their fluids. The three residents did not receive assistance for fifteen minutes. Resident #21 was served soup and fluids at 1235 hours and did not receive assistance with eating or drinking for ten minutes. Resident #21 reported their soup was not hot by the time they received assistance and staff do not always come right away when fluids or food was served.

ii) On September 21, 2015, at 1230 hours, resident #82 was observed sitting with drinks and pudding in front of them, with no assistance for ten minutes. Resident #84 was observed with beverages sitting for fifteen minutes before receiving assistance.

iii) On September 22, 2015, at 0835 hours, resident #83 and resident #84 had fluids set out in front of them for approximately twenty minutes before receiving assistance from staff.

PSWs reported residents who required total assistance with meals were to be served only when someone was available to help, which was confirmed by registered staff. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the dining service includes, at a minimum, monitoring of all residents during meal, that the home has a dining and snack service that includes, at a minimum, course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs, that the homes dining and snack service that includes, at a minimum, provides residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible and to ensure that residents who require assistance with eating or drinking are served their meal only when someone is available to provide assistance, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD used under section 33 of the Act was applied by staff in accordance with any manufacturer's instructions.

A. On September 15, 2015, resident #22 was observed sitting in a wheelchair with a front fastening lap belt applied, four finger widths from their torso. The resident was unable to release the belt when requested and stated they did not have the strength. A PSW reported the belt was used to prevent falls and was loose; however, was unaware of how it was to be applied. Registered staff confirmed the belt was used as a PASD to prevent falls and would be no more than two finger widths from the resident's torso.

B. On September 15, 2015, resident #40 was observed sitting in their wheelchair tilted with a lap belt applied eight finger widths from their torso. Registered staff confirmed the lap belt was too loose and was not properly applied according to manufacturer's instructions. (581) [s. 111. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a PASD used under section 33 of the Act is applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #6: 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 failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

A. On September 18, 2015, at approximately 1100 hours, the medication cart was noted to be sitting outside of the medication room unattended. The cart was locked; however, three pill cups were sitting on the top of the cart labeled with pills inside of them. When the RPN returned to the cart approximately a minute later, they confirmed that one of the pill cups contained a controlled substance, which was not safely stored as required. [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 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 #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

On September 21, 2015, during breakfast service, the RPN was observed administering medications to residents in the dining room. The medication cart was sitting outside of the dining room in the hallway and was noted to be unlocked and unattended. The LTC Homes Inspector was able to open and close the medication cart drawers without the RPN being aware, at which time, the RN approached the medication cart and confirmed it should be locked when unattended. When the RPN returned to the cart approximately two minutes later the RN reminded the RPN to lock the cart when unattended. [s. 130. 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 all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to provide training related to continence care and bowel management to all staff who provided direct care to residents on an annual basis.

Information provided by the home confirmed that 4.1 percent of the front line staff and 0 percent of the registered staff who provided assistance to the residents received training in Continence Care and Bowel Management from September 2014 to September 2015. The DOC confirmed that not all staff received training and no training was planned for the remainder of 2015. [s. 221. (1) 3.]

2. The licensee failed to ensure that all staff who provided direct care to residents, received training related to abuse recognition and prevention annually.

Information provided by the home confirmed that less than 50 percent of the front line staff and registered staff who provided assistance to the residents received training in abuse recognition and prevention between November 2014 and September 2015. The DOC confirmed that not all staff received training and no training was planned for the remainder of 2015. [s. 221. (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 provide training related to continence care and bowel management to all staff who provide direct care to residents on an annual basis and that all staff who provide direct care to residents, receive training related to abuse recognition and prevention annually., to be implemented voluntarily.

WN #9: 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 failed to ensure that staff participated in the implementation of the Infection Prevention and Control Program.

A. The home's policy "Hand Hygiene PRE-001", last revised October 2012, outlined general indications for hand hygiene which included but were not limited to, before and after contact with a resident or items in their environment, before preparing handling or administering medication, before preparing handling serving food.

On September 18, 2015, at approximately 0830 hours medication administration was observed. The RPN administered medications to five residents including: administration of eye drops inhalers and tablets, tablets were crushed and fed to residents, medications were handled and residents and their environments were touched. From 0830 to 0855 hours, hand hygiene was not observed consistently before and after contact with the residents, items in their environment, or before preparing handling and administering medications. Interview with registered staff confirmed that hand hygiene should be completed between medication administration of each resident. [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 #10: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system in place was complied with.

As part of the home's nursing and nutrition manual, their policy, "Hydration, II-c-85", effective February 1, 2011, indicated housekeeping staff were to portion fluids based on the menu and fluid list on the fluid cart in the dining room. The fluid list stated all residents were to receive six ounces of fluid at meals unless otherwise indicated on the home's fluid sheets, as noted on a sheet attached to the beverage cart.

On September 21, 2015, during lunch, a housekeeper filled less than half of a six ounce glass of lactose free milk for resident #15. The fluid list was reviewed and did not indicate they were to receive less than six ounces. The housekeeper reported they regularly did not fill the resident's cup and also stated they conducted this practice with other residents. A Food Service Supervisor was interviewed and reported the cup should have been filled unless otherwise indicated on the fluid sheet and the home's hydration policy was not followed. [s. 8. (1) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The plan of care for resident #17 identified that the resident had areas of altered skin integrity which required daily monitoring and treatment. Review of the electronic treatment administration records from June to August 2015, revealed five days where staff did not document that daily monitoring and treatments of the areas were completed. Interview with the RN confirmed that daily checks were completed but not documented as required. [s. 30. (2)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

A. In June 2015, a bed rail assessment for resident #15 identified that the resident required two, two third bed rails raised when in bed for safety and positioning. Review of the progress notes confirmed that the home obtained consent for any changes in treatments from the resident's substitute decision-maker (SDM); however, the plan of care did not include consent for bed rails. Interview with the DOC confirmed that after an assessment was completed for resident's requiring bed rails, the home did not obtain consent for the use of bed rails.

B. Review of the written plan of care for resident #19 indicated they used one, two third bed rail raised when in bed for turning and positioning. Interview with the registered staff and PSW stated they used one bed rail at night for bed mobility. Review of the plan of care identified there was no consent for the use of the bed rail as a PASD and this was confirmed by the DOC. [s. 33. (4) 4.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

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

Findings/Faits saillants :

1. The licensee shall ensure that each resident was offered a minimum of three meals daily.

On September 14, 2015, resident #91 was not present during lunch in the main dining room. At 1350 hours, the resident was in their room in absence of food or fluid. A PSW reported the resident did not usually come for lunch but still should have been offered thickened fluids, which did not occur. The PSW approached the resident who requested a juice. Registered staff confirmed the resident should been offered lunch. [s. 71. (3) (a)]

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

A. During dining observations on September 14, 21 and 22, 2015, prior to meal service, drinks were observed set out on tables for residents who had yet to arrive at tables. On September 14, 2015, a housekeeper responsible for pouring beverages reported every day residents get served what is on the drink list. Resident #87, who arrived in the dining room after the drinks were poured was asked if they were offered choice of drinks and replied, "No, these are just here when I get here". A FSS reported that drinks were served prior to meal service and that residents were not offered choices of drinks.

B. On September 22, 2015, during afternoon snack pass, sorbet was the on the menu as the puree food nourishment. The snack cart was observed and did not contain any puree food nourishment. The PSW serving reported they only had pudding thick cranberry juice available. Resident #89 who was at high nutritional risk was not offered nourishment, as confirmed by the PSW. The PSW later noted sorbet was available in the freezer. The FSS confirmed the resident should have been offered the nourishment. [s. 71. (4)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices: (i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs, (ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids and (iii) contact surfaces.

The plans of care for residents #10 and #21 identified that they were a high risk for altered skin integrity and required a Prius low air loss mattress. Throughout the course of the inspection the following observations were made:

i. On September 15 and 17, 2015, the top mattress cover of resident #10's air mattress was noted to have a large dried brown stain in the middle of the bed with dried stains down the right and left sides of the bed. On September 21, 2015, the brown stain in the middle of the bed was a smaller size but still present along with the other stains initially observed.

ii. On September 15, 17 and 21, 2015, the top mattress cover of resident #21's air mattress was noted to have four small dried brown stains on the bottom half of the bed and dried white stains to the right of the head of the bed.

iii. Review of the manufacturer instructions for cleaning the Rhythm-Multi Alternating and Low Air Loss Pressure Relief System directed staff to clean the mattress overlay weekly using a damp cloth and mild detergent. If the top or bottom cover became severely soiled it would be removed, cleaned, and replaced with a clean cover. Covers would be washed and thermally disinfected in a washing machine. Further instructions were outlined related to time and type of wash.

iv. Interview with PSW staff stated that the when the air mattress covers were soiled, they were to be sent to laundry and replaced. PSW staff confirmed the home had extra covers in the storage room and that the mattress covers for residents #10 and #21 were soiled and should have been sent to be laundered. [s. 87. (2) (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of laundry services that procedures were developed and implemented to ensure that, there was a process to report and locate residents' lost clothing and personal items.

The home's policy," Missing Resident Laundry, Policy No: I-a-60", indicated that all reported resident personal laundry that was missing would be recorded on the Resident Missing Laundry Form which was to be posted at each nurses' station. Staff were to report the lost item to laundry staff and /or housekeeping supervisor if not found.

Resident # 19 and #20 were interviewed and stated they reported missing clothing to PSW's and registered staff in the past two months and their clothing items were still missing. Interview with PSW's and registered staff stated that when a resident reported missing clothing they put a note of the missing item at the nurses station on a scrap piece of paper and notified laundry. Interview with laundry staff stated that they recorded the missing clothing in a lost and found binder if the clothing item was not found. Review of the laundry lost and found binder revealed that both residents' missing clothing was not listed. Interview with the DOC stated that staff were to list all missing clothing items on the Missing Laundry Form and confirmed that this process was not implemented by the staff. [s. 89. (1) (a) (iv)]

Issued on this 2nd day of November, 2015

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

Original report signed by the inspector.